IN THE PROVINCIAL COURT OF SASKATCHEWAN

Citation: 2014 SKPC 150

Date: July 24, 2014
Information #s: 44658836, 39985092, 44802893, 44659235, 43986724, 43266417, 44330447, 46420419, 42799178, 37290766, 36653086, 44303351, 44303524, 36654811, 44332045, 33303772, 38468315, 44664085, 44664475
Location: Saskatoon

Between:

Her Majesty the Queen

- and -

Marlene Jane Carter

Appearing:

S. Bains — For the Crown
J. Scott — For the Accused

PRELIMINARY VERSION SUBJECT TO EDITING

Decision — **S. P. Whelan, J**

Introduction

[1] The Contents to this decision may be found on page 7.

[2] The Crown brought an application to have Marlene Jane Carter declared a dangerous offender and it sought an indeterminate sentence.

[3] The Defence focussed on Ms. Carter's mental health problems, the treatment that she has received in the custody of Correctional Service Canada over the past five years. Ms. Carter's counsel maintained that her treatment has been inhumane and in breach of sections 7, 12 and 15 of the *Charter*, which provide for the right to: s. 7 - life liberty and security of the person and not to be deprived thereof except in accordance with the principles of fundamental justice, s. 12 - not be subjected to any cruel and unusual treatment or punishment, and s. 15 - equality before and under the law and the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

[4] The Defence sought relief with a view to insuring that in future Ms. Carter would serve her sentence under conditions appropriate to a mental health facility, if not by transfer to Brockville Hospital in Ontario; then under improved conditions at the RPC, should she remain there.

[5] The hearing ran from October 21 to 31, 2013. Argument occurred on March 28, 2014 and it was adjourned to today's date for decision.

[6] The focus of the dangerous offender application and this sentencing hearing has largely been in relation to institutional offences. Set out below are the two most serious convictions on her record, as well as the predicate offences for sentencing:

a. A March 1999 aggravated assault upon another inmate at Pine Grove Correctional, for which she received a two year sentence,

b. An April 2000 incident involving a riot at the Saskatchewan Penitentiary for Women, for which she was convicted of unlawful confinement, assault with a weapon and mischief and received a concurrent and consecutive sentence of two years,

c. The two predicate offences of assault with a weapon for which I found her guilty after trial in the fall of 2012. These offences occurred while in custody at the Regional Psychiatric Centre, Prairie Region, (RPC) where the complainants were employed:

i. Information #44658836, June 13, 2009, assault with a weapon, handcuffs, s. 267(a)
ii. Information #39985092, July 17, 2011, assault with a weapon, hot water, s. 267(a),

d. 17 more assaults for a total of 19 predicate assaults that occurred at the RPC on or between June 13, 2009 and August 20, 2013. Complainants include correctional officers, nurses and fellow patients (inmates).

[7] Ms. Carter's mental health is such that she requires institutional care for the foreseeable future. She has been on remand at the Regional Psychiatric Centre (RPC) since December 6, 2011. As of the date of this decision she will have been on remand for 2 years and 230 days.

[8] A great number of records were filed by counsel and organized by the Defence electronically. Thirteen witnesses testified over the course of eight days. The Defence was assisted by a class of law students enrolled at the College of Law, University of Saskatchewan. Their work was evident in virtually all aspects and from time to time some of them were able to tear away from their studies to attend the hearing. To respond to the *Charter* issues raised, Counsel for the Attorney General of Canada and the Attorney General of Saskatchewan, Constitutional Branch appeared for argument. The Court very much appreciates the work of all counsel and the students in particular in preparing the records electronically.

[9] This is a lengthy decision; attention has been given to the background circumstances provided to the Court. There is a significant record and an unusually high number of charges for sentencing. Ms. Carter's background before and after her encounters with the justice system is important to the decision being made. A great number of fact-based issues were raised by the Defence concerning her treatment at the RPC over the last five years. There has been an attempt to acknowledge Ms. Carter's incredible life story before and during her incarceration by highlighting some of the information shared with the Court. It is hoped that our community may learn from her experiences and make changes where needed and possible, for her sake as well as others with mental health concerns, particularly for those who engage in self-harm.

[10] This Court has been unable to address the many *Charter* issues raised by the Defence; principally due to jurisdictional issues and lacking a sufficient evidentiary basis for a determination; most issues would have to be resolved in the Federal Court of Canada or the Court of Queen's Bench of Saskatchewan and not in the context of a criminal sentencing hearing. Nevertheless, this Court is aware that from a practical standpoint, Ms. Carter is not likely to be able to pursue relief for the issues raised outside of these proceedings. The Office of the Correctional Investigator of Canada has raised many of these issues in the context of Ms. Carters and other federal inmates with self-harming behaviours and I expect that it will continue its work. In the result, I have endeavoured to record a great deal of the information provided I found it reliable, either because it was *viva voce* and firsthand or it

came from one or more documented reliable sources. Information conveyed in many of the Incident Reports was scant and often very little was said of Ms. Carter's mental or physical state.

[11] Ms. Carter is a First Nations woman. While she did not attend a residential school, her suffering can be directly linked to the disintegration of her family as a result of the residential school experience. This was evident from the *Gladue* Report provided to the Court. As one elder was quoted to say:

> Drop a pebble in the water and it's a ripple effect . . . it wasn't just those that attended [residential school] who endured the harms, but generations to come."[1]

[12] In her formative years Ms. Carter experienced terrible abandonment and abuse at the hands of those from whom she was entitled to receive love and support. She was betrayed repeatedly.

[13] She made her pain known to those outside her immediate family with her first attempt at suicide when she was only 13 years of age; there were more suicide attempts to come. Beginning when she was a child and continuing into adolescence and adulthood; she abused a variety of substances: solvents, alcohol and other drugs, perhaps to cope. She became caught up in a spiral of substance abuse and offending behaviour, receiving her first custodial sentence as a youth at the age of 17.

[14] There were two significant gaps in her offending behaviour, the first between 1992 and 1999 during which time she married and became the mother of three boys. The second shorter gap of two years occurred prior to June, 2009.

[15] The full extent of Ms. Carter's early self-harming behaviour; is not known. It was documented in a December 1988 pre-disposition report prepared for Youth Court and it has been quite thoroughly documented since March of 2009.

[16] Ms. Carter was offered resources over time in a number of different ways; at an early age she was apprehended and placed at Ranch Ehrlo in Regina, where despite progress in the programs provided it was noted that she was unable to trust adults and coped with her pain by self-mutilating, running away, withdrawing and abusing alcohol.

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[1] Page 8 of the *Gladue* Report at Tab 64 of the Defence Binder - Exhibit D-1

[17] Moving forward to the time frame most documented in these proceedings; it is Ms. Carter's continuous stay, first in Pine Grove provincial correctional facility on remand in March 2009, and then after receiving a 30 month sentence on June 8, 2009 at the RPC. During this time that her head banging developed into the extreme practice that has become, if not interrupted by a third party; dropping from a standing or kneeling position to the floor, face first. During the five years at the RPC her mental and physical health has continued to deteriorate and a reduction in her intellect was documented.

[18] At the RPC Ms. Carter has been cared for by a good number of dedicated thoughtful individuals: psychiatrists, psychologists, nurses, and corrections staff, including those in a social work or supervising capacity, as well as guards. But she has also been caught up in a system which seems to lack the will or ability to make available a setting which appropriately addresses her mental health needs. Despite repeated recommendations that she be placed in a mental health facility where guards are not the first responders to self-harming behaviour, a hospital in Brockville Ontario; the system has proven unable to act upon this sensible solution. Most recently this move has not been possible as Ms. Carter has been on remand status since December 2011.

[19] While Ms. Carter has resided at the RPC, there has at times been conflict between the "correctional" side and the "clinical" side of the operation. Over time, and during the course of Ms. Carter appearing before this Court, improvements have been made, including: the move from the routine use of the Pinel Board for restraint purposes, to the use of the more comfortable Broda Chair, OC spray use, a tool used by guards to try to halt self-harming behaviour, has apparently been discontinued and Ms. Carter's care whether in segregation or isolation in IPC has been more effectively monitored to reduce the time in restraints and isolation. There is now a dedicated team of guards that work in the Assiniboia Unit where she is currently held. Her self-harming behaviour has continued.

[20] It is not clear to this Court however, that this more humane treatment of Ms. Carter will persist, dependant as it seems to be on the discretion of individuals employed in her care. There remains a correctional system which operates pursuant to legislation, regulation and commissioner's directives which are not geared to the thoughtful and necessarily individualized treatment of those with mental health difficulties on the scale experienced by Ms. Carter. A number of the commissioner's directives, together with governing legislation and regulations have been included in the Appendices. As the Officer of the Correctional Investigator of Canada, Dr. Mela and his treatment team have

recommended; Ms. Carter should be in a facility where a clinical approach governs, where there are sufficient resources to best respond to her mental health needs, and where she would be surrounded by health care providers who, not guards, are the first responders to a self-harming incident.

[21] There are a number of striking aspects to the facts behind this application; after moving past the sheer number of incidents of assault both for sentence and on her lengthy record:

i. While the circumstances of both of the primary designated offences, the assaults with a weapon, met the criteria for conviction and for a dangerous offender application; the circumstances of these assaults place them at the low end of such offences as we typically encounter in the justice system and Ms. Carter's circumstances demonstrate a reduced moral blameworthiness.

ii. Ms. Carter's level of functioning is such that neither she, nor anyone really familiar with her circumstances expects her to live independently or outside an institution in the foreseeable future.

iii. Ms. Carter has suffered permanent brain damage from a number of sources and most concerning and documented since 2009 at the RPC, due to head banging. She is at risk for further impairment and possibly death if it cannot be arrested or controlled.

iv. There is a very sincere concern amongst all who have come to know Ms. Carter that she should, if possible, enjoy a more optimal quality of life.

[22] As will be elaborated upon under XIII Sentencing Decision:

i. I find that Ms. Carter is entitled to the maximum credit for the time that she has spent on remand. The proceedings have been delayed for reasons beyond her control and the conditions under which she has been held warrant the maximum credit pursuant to s. 719(3.1) of the *Criminal Code* - 960 actual days x 1.5 = 1440 days or 48 months.

ii. I decline to find that Ms. Carter is a dangerous offender. I am not satisfied that the Crown has established a pattern, as required in s. 753(1)(a)(i) or (ii) of the *Criminal Code*. I also decline to treat this as an application for a long-term offender designation.

iii. I find that the appropriate global sentence for all of the offences before the Court is a total of 6 years, including the 48 months already served, leaving a further 2 year sentence in a federal correctional facility.

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I Documents Filed

[23] The Crown filed two CSC (Correctional Service Canada) Binders and two Offence Binders. The Defense filed a further Binder of documents, some of which, the Court was told, were obtained by means of an application for production of Third Party Records from Correctional Service Canada, from the Office of the Correctional Investigator, a *Gladue* Report and other research. With assistance from a class of students at the College of Law, University of Saskatchewan, the Defence prepared a

Chronological Index of its documents and a Time Line; both of which were very helpful. The documents were produced in written form and with the kind assistance of the Defense, electronically.

A. Exhibit List

Court Exhibits
C-1 CV Dr. Lohrasbe
C-2 Assessment Report of Dr. Lohrasbe

Crown Exhibits
P-1 Offence Binder 1 of 2
P-2 Offence Binder 2 of 2
P-3 CSC Binder 1 of 2
P-4 CSC Binder 2 of 2
P-5 Agreed Statement of Facts

Defence Exhibits
D-1 Memory Stick with Defence Binder of Electronic Exhibits
D-2 Memorandum dated May 20/09 Pine Grove to Dr. Adelugba
D-3 Defence White Binder

B. Assessment Order and Report of Dr. Lohrasbe

[24] Following upon Ms. Carter having been found guilty of the two predicate offences of assault with a weapon, contrary to s. 267(a) of the *Code*, both serious personal injury offences and primary designated offences within the definition section of s. 752(a)[2], Crown Counsel advised the Court of the intention of bringing an application pursuant to s. 752.1(1) of the *Code* for an assessment.[3]

[25] By order dated April 15, 2013 the Court remanded Ms. Carter for an assessment, to be undertaken by Dr. Lohrasbe and he produced a report[4] and testified at the hearing that followed.

[26] Additionally, contained within the materials filed by the Crown and Defense were a number of psychiatric and psychological reports.

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[2] Information #44658836 - June 13, 2009 assault with a weapon contrary to s. 267(a) and Information # 39985092 - July 17, 2011 assault with a weapon contrary to s. 267(a). See Appendix B for pertinent provisions concerning Dangerous and Long-Term Offenders
[3] The Notice of the Assessment Application, dated November 5, 2012 may be found at Defence Binder Tab 61 - Exhibit D-1
[4] Dr. Lohrasbe's report and CV may be found at Defence Binder Tabs 62 and 63 - Exhibit D-1

C. Psychiatric Reports

- Dr. G. Marcoux, psychiatrist, April 7, 2001 – Interim Psychiatric Assessment – CSC Binder 1 of 2 Tab 34 - Exhibit P-3
- Dr. Mansfield Mela, psychiatrist, April 17, 2003 – Discharge Summary – CSC Binder 1 of 2 Tab 49Tab - Exhibit P-3
- Dr. Robin Menzies, psychiatrist, July 7, 2003 – Psychiatric Court Report – Offence Binder 2 of 2, Tab 16 - Exhibit P-2
- Dr. Mansfield Mela, psychiatrist, July 8, 2003 – Psychiatric Court Report – Offence Binder 2 of 2, Tab 16 - Exhibit P-2
- Dr. Mansfield Mela, psychiatrist, September 14, 2004 – Psychiatric Court Report – Offence Binder 2 of 2 Tab 20, beginning at page 36 - Exhibit P-2
- Dr. Mansfield Mela, psychiatrist, October 19, 2004 – Discharge Summary – CSC Binder 1 of 2 Tab 50 - Exhibit P-3
- Dr. Olajide Adelugba, psychiatrist, March 23, 2006 – Discharge Summary – CSC Binder 1 of 2 Tab 59 Exhibit - P-3
- RPC Duty Doctor's Initial Assessment, June 2, 2009 – Defence Binder Tab 2 - Exhibit D-1
- Dr. Mela psychiatric report, June 8, 2010 – Defence Binder Tab 20 - Exhibit D-1
- Dr. Mansfield Mela, psychiatrist, January 19, 2011 – Psychiatric Court Report – Fitness and Criminal Responsibility – Offence Binder 2 of 2 Tab 24
- Dr. Mansfield Mela, psychiatrist, February 22, 2011 – Progress Note – Defense Binder Tab 42 - Exhibit D-1
- Dr. Olajide Adelugba, psychiatrist, May 16, 2012 – Psychiatric Court Report concerning Ms. Carter's appearance in person or by CCTV – Offence Binder 2 of 2 Tab 25 - Exhibit P-2

D. Psychological Reports

- Psychological Intake Assessment Screening Report dated July 21, 1999, CSC Binder 1 of 2 Tab 29 Exhibit - P-3
- Psychological for Segregation, Dr. James Seager, Chief Psychology, Saskatchewan Penitentiary, April 17, 2000 CSC Binder 1 of 2 Tab 31 - Exhibit P-3
- Psychological Assessment Report, Tara Turner, Psychology Intern, Dr. L. D. Pressé, August 9, 2000, CSC Binder 1 of 2 Tab 32 - Exhibit P-3
- Psychological Assessment for National Parole Board, Dr. L.D. Pressé, May 21, 2001, CSC Binder 1 of 2 Tab 37 - Exhibit P-3
- Psychological Report regarding DBT program, Dr. Linda Rose, September 6, 2006, CSC Binder 1 of 2 Tab 65 - Exhibit P-3
- Psychological Activity Notes, Dr. Sojonky, Psychologist, all in CSC Binder 2 of 2 - Exhibit P-4:
  - July 7, 2010, Tab 110
  - July 7, 2010, Tab 112
  - July 14, 2010, Tab 113
  - July 19, 2010, Tab 114
  - July 21, 2010, Tab 115
  - July 28, 2010, Tab 116
  - August 19, 2010, Tab 118

- September 2, 2010, Tab 119
- November 4, 2010, Tab 127

- Psychological Assessment Report, Dr. Sojonky, Psychologist, November 5, 2010, CSC Binder 2 of 2 Tab 128 - Exhibit P-4

E. Medical Investigations

[27] There were also a number of medical investigations and reports concerning potential brain injury connected to repeated head banging, restraint over an extended period and management of her diabetes. Some of the materials are noted below. Some of the materials are handwritten doctors' notes and difficult to decipher confidently:

- December 3, 2010, RUH Emergency, Clinical Neurophysiology, CT Head and CT Facial bones and letter from Dr. Dallas Pearson of November 26, 2009 to Dr. L. Pilot RPC – Defence Binder Tab 5 - Exhibit D-1
- Medical Imaging Department, Royal University Hospital to RPC, December 1, 2010 and Patient Diagnostic Report concerning CT Scan performed April 6, dated April 12, 2010 – Defence Binder Tab 6 - Exhibit D-1
- SCH Emergency, CT Head and Orbits, February 3, 2010 and January 29, 2010 Patient Diagnostic Reports - Defence Binder Tab 9 - Exhibit D-1
- August 3, 2010 letter from Dr. Mansfield Mela, RPC Psychiatrist to Dr. Kirk Neurology regarding neurological causes regarding the emergence of incoherence – Defence Binder Tab 23 - Exhibit D-1
- Referral for Consultation and Report concerning need for physio due to prolonged immobilization on Pinel and restraint chair, dated June 9, 2010 – Defence Binder Tab 23 - Exhibit D-1

II Remote appearance by CCTV

[28] Over the course of her many appearances Ms. Carter attended remotely by CCTV from the RPC as her mental health did not for allow her to attend in person. The Court requested an opinion about Ms. Carter's ability to appear in person and received a report dated May 16, 2012 from Dr. Adelugba, psychiatrist, who advised that she was capable of appearing in person at her hearing. Her condition subsequently deteriorated and her counsel took the position that she should appear remotely by CCTV. She was always restrained in a Broda Chair and at times her head was bandaged or evidently injured, presumably due to persistent self-injurious head-banging. During the hearing itself, she often had to be roused as she appeared to drift off to sleep. Under these conditions, the hearing proceeded without

significant disruption, but from time to time, she would yell out, sometimes understandably and in context and other times nonsensically.

III Remand Time

[29] Ms. Carter has been on remand at the RPC since December 6, 2011, a total of 2 years, 230 days. She has been at the RPC continuously since June 8, 2009 when a 30 month sentence was imposed.

IV Dangerous Offender Application & Sentencing Hearing

[30] Following convictions on the two predicate offences of assault with a weapon, contrary to s. 267(a) of the *Code*: Information #44658836, a June 13, 2009 incident and Information #39985092, a July 17, 2011 incident, the Prosecutor brought an application pursuant to s. 752.1 (1) for assessment for an application pursuant to s. 753 or s. 753.1 and a finding that Ms. Carter is a dangerous or long-term offender.

[31] Ms. Carter's full record for significant convictions of violence is reproduced and discussed further in this decision. Her predicate offences are enumerated immediately below.

a) Two offences of assault with a weapon of which she was found guilty after trial:

i) Information #44658836, June 13, 2009, assault with a weapon, handcuffs, s. 267(a)
ii) Information #39985092, July 17, 2011, assault with a weapon, hot water, s. 267(a)

d) Ms. Carter entered guilty pleas to 17 more offences for a total of 19 charges of assault. The Crown election for each of the following was by indictment:

iii) Information #44802893, June 26, 2009, assault, s. 266
iv) Information #44659235, November 5, 2009, assault, s. 266
v) Information #43986724, February 28, 2010, assault peace officer, s. 270(1)(a)
vi) Information #43266417, June 20, 2010, assault peace officer, s. 270(1)(a)
vii) Information #44330447, October 7, 2010, assault peace officer, s. 270(1)(a)
viii) Information #46420419, between February 7 and 8, 2011, assault, s. 266
ix) Information #42799178, February 11, 2011, assault, s. 266
x) Information #37290766, May 26, 2011, assault, s. 266
xi) Information #36653086, June 6, 2011, assault, s. 266
xii) Information #44303351, July 26, 2011, assault on two persons, s. 266
xiii) Information #44303524, August 8, 2011, assault peace officer, s. 270(1)(a)
xiv) Information #36654811, October 22, 2012, assault, s. 266

xv) Information #44332045, January 17, 2013, assault peace officer, s. 270(1)(a)
xvi) Information #33303772, May 12, 2013, assault, s. 266
xvii) Information #38468315, June 29, 2013, assault, s. 266
xviii) Information #44664085, July 12, 2013, assault peace officer, s. 270(1)(a)
xix) Information #44664475, August 20, 2013, assault peace officer, s. 270(1)(a)

Documents filed with the Court indicate many more assaults of a similar nature, for which no charges were laid. There has also been a great number of incidents of self-harm from head banging documented in the correctional environment beginning in 2009 and continuing.

[32] Ms. Carter's mental health was a significant consideration in this hearing. Criminal responsibility and fitness to stand trial was canvassed by Dr. Mela in relation to offences occurring on or between June 13, 2009 and October 10, 2010. He concluded that she was not criminally responsible with respect to 3 alleged assaults on February 12 and 14, 2010 but was otherwise fit to stand trial. She was found to be criminally responsible for the predicate offence of assault with a weapon, occurring on June 13, 2009.[5] Dr. Adelugba in his May 16, 2012 report found Ms. Carter fit to stand trial.[6]

V Background

A. Record of Convictions[7]

[33] Ms. Carter's criminal offence history began when she was a young person and continued with little interruption until 1992. At age 17 she was sentenced May 16, 1989 to a robbery for which she received 16 moths of secure custody, later reviewed to open custody. She was in the community following a sentence in April 27, 1992 for a mischief for which she received time served and one year of probation. Her record resumed January 28, 1999 as an adult when she received a 9 month concurrent sentence for a number of nonviolent offences. It was while serving this sentence that she committed an aggravated assault upon another inmate at Pine Grove Correctional Centre. During that federal sentence of 2 years, she was convicted of assault with a weapon and sentenced to 2 years for assault with a weapon and forcible confinement. As a result Ms. Carter was continuously in custody from January 28, 1999 to April 22, 2003. She was in and out of custody for a variety of lesser matters until her conviction and sentence on November 23, 2004 for several assaults including an assault causing bodily

[5] Offence Binder 2 od 2 Tab 24 - Exhibit P-2
[6] Offence Binder 2 of 2 Tab 25 - Exhibit P-2
[7] Ms. Carter's complete record of convictions as well as a list of the matters for sentence may be found at Appendix A.

harm upon a stranger on the street. Released on statutory release March 24, 2006, at some point her release was revoked and she returned and served her sentence until warrant expiry on November 22, 2006. Thereafter she remained in the community until her arrest on March 18, 2009 and remained on remand until a conviction and sentence of 30 months for two common assaults and two assaults upon peace officers on June 8, 2009. Marlene Carter has been in custody continuously since then.

B. Significant Violent Offence Convictions

[34] This discussion covers the circumstances of Ms. Carter's most significant offences of violence including the first and second predicate offences of assault with a weapon occurring in June 2009 and July 2011.

a) *Young Offenders Act* – April 25, 1989 robbery – sentenced May 16, 1989 to 16 months secure consecutive at age 17

[35] Ms. Carter pled guilty on her first appearance, while in custody. She was self-represented. The offence was committed while she was at large on a one year sentence for 16 property offences; 15 break and enters and 1 mischief. Four months into that sentence it was reviewed and she was placed in a community home on April 12th and took off 3 days later.

[36] The predisposition report outlines the circumstances.[8] While at large she partied. She and some others decided to do a robbery. They visited a gas station/convenience store at 3:20 a.m., returning at 5:10 a.m. They ordered food items. As the victim placed the items outside the door, Marlene punched her in the face and she and two others pushed their way into the store. One other stood watch. Marlene "grabbed the victim's neck and pushed her head down so she could not see them". Pushed to the floor, she was struck six or seven times. While the victim opened the cash register she was threatened that if she made one false move, she was dead.

[37] The report refers to Marlene's traumatic upbringing: "Marlene has an extensive history of physical, sexual and substance abuse, as well as being suicidal." The writer expresses the view that while Ms. Carter does not express remorse, nor does she offer any excuses.

[8] Offence Binder 1 of 2, Tab 4 - Exhibit P-1

[38] This sentence was reviewed on March 8, 1990 to open custody. There were five objectives during sentence: address issues of sexuality, attend therapy, alcohol and drug abuse, surviving sexual assault, and anger control. The review report identifies self-harm: "slashing" and reports that she completed six weeks of inpatient drug and alcohol treatment, where she had done very well.

b) March 12, 1999 aggravated assault – sentenced April 23, 1999 to 2 years consecutive

[39] This occurred while Ms. Carter was serving a sentence of 9 months at the Pine Grove Correctional Centre. The victim and Marlene Carter were working in the sewing room under the supervision of a staff member. Ms. Carter was cutting material with scissors. She stabbed the victim once with the scissors in the lower right side of her back. There were no internal organ injuries. Her initial remark was that she didn't know why she did it. In a warned statement Ms. Carter said she wanted to have a relationship with a person with whom the victim was in a relationship. Ms. Carter gave contradictory statements of both concern and lack of concern for the victim.

[40] Defense counsel referred to a pre-sentence report which identifies suicide and issues of self-harm. He described Ms. Carter's brash statements as "bravado". Having spoken to staff at Pine Grove, he was advised that upon admission on January 29, 1999, there were concerns around depression, suicide and self-mutilation (slashing) and he recounted a minimal institutional response to what he described as a "cry for help". Crown counsel noted a reference in the report to "burning herself and stopped eating". He described the assault as impulsive, random and irrational. Ms. Carter instructed her counsel to ask for a two year sentence.

c) April 6 to 7, 2000, unlawful confinement, assault with a weapon and mischief – July 12, 2000 – 2 years concurrent and consecutive

[41] About a year into her previous penitentiary sentence, Ms. Carter was charged with six other inmates. On her first appearance, while self-represented, she entered guilty pleas. The Crown briefly reported that Ms. Carter took orders from three ringleaders (The court had already heard likely more extensive facts concerning co-accused that afternoon). At one point Ms. Carter hit the hostage with a chain and at another time held a glass to her throat. She assisted in tying her hands and feet with shoelaces. She kicked at her and took turns holding the chain around her neck. She broke some windows in the unit. Ms. Carter did not want a lawyer nor did she say anything on her own behalf.

[42] Having been in custody continuously since her January 28, 1999 sentence of 9 months to Pine Grove, and receiving two consecutive two year sentences, Ms. Carter was released at warrant expiry on April 22, 2003 to the North Battleford Hospital where she incurred a threats charge and received a 45 day sentence to Pine Grove. After her release she was very transient, incurring short periods of incarceration. She lived in Prince Albert, Saskatoon and Edmonton with friends and relatives and on the streets and worked as a prostitute to sustain herself. While in Edmonton she was convicted of two assaults and sentenced to probation. Her next jail sentence came about with a theft conviction, for 60 days followed by probation. She was arrested as a result of failing to report to her probation officer and was in custody when these next offences occurred.

d) Between May 25, 2004 & September 20, 2004 assault x 3, assault peace officer x 3, assault causing bodily harm x 2 - Sentenced November 23, 2004 to 2 years concurrent and consecutive.

[43] On August 13, 2004 Ms. Carter was remanded to the RPC. The Court received a psychiatric report dated September 14, 2003 from Dr. Mansfield Mela who was familiar with her from previous admissions to the RPC.[9] He referred to her suicidal and self-harming history which did not include head banging but included hitting her nose on hard surfaces. He reported a hanging attempt in 1998 to which he attributed subsequent hypoxic brain injury.

[44] Dr. Mela indicated that Ms. Carter's level of functioning had deteriorated over the years and he felt that her aggression had turned outward toward others, rather than herself. Dr. Mela was asked to address the issue of criminal responsibility; he diagnosed her with a:

> "mental disorder in the form of significant anxiety resulting from possible brain disorder. She is traumatized by the intrusive images that she experiences. This picture is complicated by personality disorder and significantly by substance use disorder, especially alcohol and solvent."

[9] CSC Binder 2 of 2 Tab 20 - Exhibit P-4.

[45] The transcript reveals, as Dr. Mela described, a pattern of assaulting inmates and corrections officers. These offences occurred with little or no warning or reason. With the exception of the assault causing bodily harm, the injuries were not serious.

Information #40155344

i. **Count 1 May 25, 2004 – assault on an inmate** – During transport to Pine Grove, a fight ensued with an inmate. When she fell to the ground, Ms. Carter kicked her in the back.

ii. **Count 2 – June 24, 2004 – assault peace officer** – While assisting the inmate in the next described assault, the guard was struck in the left jaw, left temple and left side of her chest.

iii. **Count 3 – June 24, 2004 – assault on another inmate** – For little apparent reason she began punching her over the head. She received a lump on the back of her head.

Information #40004201 – two assaults on the same person

iv. **Count 1 and**

v. **Count 2 – June 26, 2004 – assault peace officer and assault causing bodily harm** – While being escorted she hit the officer with a closed fist. Photos showed bruising to the face, under the left eye and to both arms. She was wearing glasses at the time.

Information #40004215 – June 29, 2004 – summary conviction proceedings

vi. **Assault peace officer** – While being escorted in a body belt and shackles, she struck the officer twice "upside" on the head with a closed fist.

Information #24205987

vii. **Assault causing bodily harm – August 12, 2004** – At the Prince Albert RCMP detachment, she punched a matron in the face, causing a cut to the right eyebrow, requiring five stitches. Her nose and eye were black.

Information #24220122

viii. **Assault on an inmate – September 20, 2004** – She was being escorted out of the cell and without warning swung both arms and lunged toward the matron who received a black eye. Her counsel remarked in support of the joint submission for 2 years:.

> There's some question about maybe whether her problems are organic in nature. . . it doesn't matter how much medication she's given it doesn't really control the problems that she's got.

The Court was sympathetic to her personal circumstances:

> Alcoholic parents, child abuse, domestic violence up until the age of five or six, abused by the - - by Aunt Julia after that, abused by her partner after that, And she's unfortunately victimized over and over and over. A number of foster homes and has suicide attempts. . . So it's very unfortunate.

e) March 18 & 19, 2009[10]

i. **March 18, 2009 – assault x 2 and assault peace officer – Sentenced June 8, 2009 to 24 months for the first assault and 3 months' time served concurrent for the remaining two offences**
ii. **March 19, 2009 – assault peace officer – Sentenced June 8, 2009 to 6 months consecutive for a total of 30 months**

It would seem from the documents that Ms. Carter was released on her statutory release date for her last 2 year sentence on March 24, 2006[11]. However she was again in the RPC September 5, 2006[12] and before the Court and sentenced to time served, as a serving prisoner, on October 11, 2006[13]. Presumably, her statutory release was revoked and she returned to serve out her sentence to warrant expiry on November 22, 2006. She then remained in the community until her arrest on these offences on March 18, 2009.

i. Assault March 18, 2009 – assault

The first assault on a civilian was the subject of trial. The transcript[14] reveals that the only issue was whether the incident was an assault causing bodily harm or an assault. The complainant, a stranger to Ms. Carter, was walking on the sidewalk toward her. Without warning or reason Ms. Carter kicked the complainant. She tried to get away but Ms. Carter followed her and grabbed her backpack. The complainant was swung around, lost her balance and fell on the front of her body onto the pavement. Ms. Carter then straddled her and punched

[10] Offence Binder 2 of 2 Tabs 23 - Exhibit P-2 - a-c contains the Informations as well as the trial transcript for the March 18th assault on the civilian.
[11] CSC Binder 1 of 2 - Exhibit P-3 - Tabs 58, 60 to 63 meeting with Regina Parole Office in community.
[12] CSC Binder 1 of 2 - Exhibit P-3 -Tab 64 DBT Participant Evaluation at RPC.
[13] Tab 21 - Time served for breach or recognizance and breach of probation.
[14] Offence Binder 2 of 2 - Exhibit P-2 -Tab 23c.

her with both fists approximately 15 times. She received some bruising around the nose, cuts on her nose and a goose egg bump on her forehead and some bruising of both her eyes.

March 18, 2009 – assault

Following her arrest in cells, Ms. Carter was asked to remove her sweater so that the matron could conduct a search. While removing her sweater, Ms. Carter turned toward the matron and punched her on the left side of her face.

March 18, 2009 – assault peace officer

In cells, the police noticed that Ms. Carter was wearing a necklace and ordered her to remove it. She refused. As the officers approached, she punched one of them in the left shoulder. Prior to this in the 5 hours that she'd been in the cells the officers noted that she had been pacing back and forth, yelling and swearing at passersby. She mumbled to herself, went down on her knees and had fallen forward, stopping her head from hitting the ground by placing her hands in front of her at the last minute.

ii. **March 19, 2009 – assault**

During escort to the cell area of the Regina detachment provost cells, she was instructed to remove her outer clothing and shoes. She was then instructed to stand and face the wall so that she could be searched. She started to turn away then suddenly turned and hit the officer on the left side of her jaw with a closed fist. The officer suffered a chipped tooth and sore jaw.

C. Predicate Assaults With a Weapon

[46] Ms. Carter was convicted after trial on each of these offences.[15] The circumstances follow.

a) June 13, 2009, assault with a weapon, to wit: handcuffs contrary to s. 267(a) *Code* Information #44658836

[47] Ms. Carter had been in the Intensive Psychiatric Care (IPC) area of the Churchill Unit of the RPC for 2 days on an emergency admission as a result of self-harming behaviours.[16] Her security level

[15] Offence Binder 2 of 2 Tab 25 - Exhibit P-2

was such that she was only permitted out of her cell for 1 hour for exercise and a shower. She was to remain with her hands cuffed behind her back during this time. Three corrections officers were present.

[48] The assault took place in the courtyard of the Churchill Unit, where Ms. Carter was taken for exercise. Within about five minutes of her arriving there, Ms. Carter was seen crawling on the ground, eating dirt. Officer Tokarchuk asked what she was doing. She stood up. It was pointed out to Officer Tokarchuk that Ms. Carter's left hand was free of the handcuffs. Ms. Carter was asked if she would comply with the cuffs being reapplied and she agreed.

[49] While putting her arm out to reapply the cuffs she struck out at Officer Tokarchuk with a closed fit and according to this officer may have hit her on the top of her head with the free handcuff; she could not be sure. She noted cuts on the top of her head. She could not say whether the cuffs were in Ms. Carter's hand or swinging free. Another officer who witnessed the incident said that he saw Carter holding the free bracelet of the handcuff in her right hand when she swung at Officer Tokarchuk and hit her in the nose area. Officer Tokarchuk suffered an injury which included bleeding from her nose, swelling and bruising and she was taken to hospital. She was subsequently referred for a septoplasty and underwent day surgery to straighten her nose.

[50] In the subsequent attempt to regain control of her, Ms. Carter began to swing the handcuff toward the third officer present. OC spray was used twice; after the first time, she continued to swing the handcuff at the officer with the OC spray.

[51] During the course of the trial after a break the Court was advised that Ms. Carter had injured herself and a nurse had been called.

[52] At trial the issue for the defense was whether the handcuffs were deliberately used to cause injury. In rendering my decision on October 12, 2012, I held that it was immaterial in making out the Crown's case whether the handcuffs where held in the hand or dangling from the wrist when the

[16] Exhibit D-2 - In his report Dr. Adelugba relied upon a May 20, 2009 memo from Jamie Luisis of Pine Grove, that provided background to the admission: Prior to admission at Pine Grove on March 20, 2009, she was a patient at the Regina General Hospital from January 16, 2009 to February 19, 2009, where she needed to be restrained chemically and physically for the first two or three weeks of hospitalization.

complainant was struck. That distinction is more important for the purpose of sentencing. My full reasons are on the record on October 4, 2012.[17]

[53] For the purpose of sentence, I have resolved the question of her intention insofar as it affects her culpability in favour of Ms. Carter. There was no planning to this assault. Immediately beforehand she was eating dirt in the courtyard. Dr. Mela, who conducted an assessment of her fitness to plead and criminal responsibility with respect to several events, including this one, wrote in his January 2011 report[18]:

> The explanatory themes in this incident include; the opportune event of her hand released from the cuff, psychotic concerns about the safety of her children. Without evidence, she has held unshakably to the belief that something is wrong with the children. In addition to the seemingly bizarre behaviours including the bizarre earing of dirt and an unprovoked attack, it will appear that she was in a disturbed mental state. Ms. Carter however said that she knew it was an attack on a person but had to do it impulsively. She felt she had to respond to her concerns about her children. These concerns have regularly been of a psychotic nature.

Ms. Carter's culpability was very low with respect to this incident.

b) July 17, 2011, assault with a weapon, to wit: hot water, contrary to s. 267(a) *Code*
Information #39985092

[54] At the time Ms. Carter was being kept in an isolation cell and was restrained in a Broda Chair for 23 hours a day with 1 hour for exercise and a shower. She was being allowed out of her cell in the Broda Chair for some of the day.

[55] The complainant, a corrections officer, at the request of Ms. Carter, brought her some hot water to make tea. The officer poured the water from the tea kettle into a coffee cup and handed it to Ms. Carter who then threw the hot water in the cup at the officer. The officer testified that she was hit by the cup on the left side of her face. The incident was caught on camera in the cell and based on my in-court observations of the video and assessment of the evidence; I found that Ms. Carter threw the hot water at the officer, only. The water had been boiling but had cooled somewhat as the corrections officer attended to the request of another inmate after the kettle had stopped boiling. The officer

[17] Offence Binder 2 of 2 Tab 25 - Exhibit P-2
[18] This report, prepared in response to an order of the Court on September 16, 2010, is undated but bears a fax date of January 19, 2011. Offence Binder 2 of 2 - Tab 24 Exhibit P-2

received medical attention immediately from a nurse and subsequently saw a doctor. She missed two days of work and said that she experienced discomfort for some days including blurred vision and the skin stayed red and puffy for up to 2 ½ weeks. The event was unexpected and apparently without reason.

[56] At trial the issue for the defense was whether the cup of hot water met the definition of a weapon and specifically whether there was intention to use the cup or hot water as a weapon. The Crown asked the Court to find that the officer was struck with the cup as well as the hot water. In finding her guilty of assault with a weapon, I held that the hot water was thrown at the officer and that it was reasonably foreseeable that the water was hot. My full reasons are a matter of record, dated October 4, 2012.

D. Seventeen Further Predicate Assaults[19]

a) Information #44802893 – June 26, 2009 – assault s.266 *Code*

[57] While taking Ms. Carter to the courtyard of the Churchill unit of the RPC for exercises, this correctional officer was struck in the right upper arm with a closed fist. There was no bruising or redness.

b) Information #44659235 – November 5, 2009 – assault s. 266 *Code*

[58] Following the completion of a shower, Ms. Carter was secured in her cell. She was seen to be breathing deeply and when the correctional officer opened the door to see if she was okay, Ms. Carter lunged toward the officer, hitting in the jaw area. There was no bruising.

[19] Police reports for the offences listed i) to xiii) are at Offence Binder 2 of 2 Tab 24 - Exhibit P-2. Counsel filed an Agreed Statement of Facts, Exhibit #P-5, which provide the circumstances for the remaining offences listed at xiv) to xvii). It further provides with respect to Information #44664276, which is to be stayed upon the completion of sentencing: On July 18, 2013, a correctional officer was escorting Ms. Carter back from attempting to phone her mother by phone, when she lunged at the officer and punched her twice in the neck with a closed fist. She was then taken to the ground.

c) Information #43986724 – February 28, 2010 – assault corrections officer s. 270(1)(a) *Code*

[59] While moving in to assist Ms. Carter, whom she thought was stumbling; she was kicked in the shins. She was not seriously injured.

d) Information #432266417 – June 20, 2010 – assault peace officer s. 270(1)(a) *Code*

[60] She was kicked in the left upper arm while assisting another officer in moving Ms. Carter from a Broda Chair to another cell. She had a bruise but it did not interfere with work.

e) Information #44330447 – October 7, 2010 – assault peace officer s. 270(1)(a) *Code*

[61] In the process of transferring Ms. Carter from a Broda Chair into her cell, she struck her with a free hand in the back.

f) Information #46420419 – between February 7 and 8, 2011 – assault s. 266 *Code*

[62] Ms. Carter twice assaulted another female inmate, by punching her in the face about three times. The next day Ms. Carter walked up behind her while she was waiting for her medication, pulled her to the ground, got on top of her and began punching her repeatedly in the head and face area. She received a bloody nose from the second incident.

g) Information #42799178 – February 11, 2011 – assault s. 266 *Code*

[63] This correctional officer was assisting Ms. Carter in the washroom. As she attempted to handcuff her to apply restraints, Ms. Carter struck her with her fist in the right bicep.

h) Information #37290766 – May 26, 2011– assault s. 266 *Code*

[64] This was an assault on a fellow female inmate. While whispering in Ms. Carter's ear, she was grabbed on the side of her neck, spun around and placed in a choke hold. Her back and neck were sore

but no injuries were visible. She was fearful of Ms. Carter, telling of an incident early that month when she said Ms. Carter attempted to assault her.

i) Information #36653086 – June 6, 2011– assault s. 266 *Code*

[65] She had been sitting across from Ms. Carter in the courtyard. She got up suddenly when Ms. Carter kicked her in the stomach. She fell to the ground. She was 2 ½ months pregnant and experienced some cramping and bleeding and received medical treatment. Carter said to her "Some people aren't meant to have children."

j) Information #44303351– July 26, 2011– assault s. 266 *Code* – *two complainants*

[66] A staff person assisted Ms. Carter with her shower. Once she was dressed, Ms. Carter began smashing her head on the floor. She was directed to lay still and place her hands behind her head. As staff attempted to gain control of her, she began punching and wailing her fists in the air, connecting with her face numerous times, causing her glasses to break.

[67] The other complainant, a correctional officer directed Ms. Carter to stop banging her head and instructed her to prone out on the shower floor. She and several guards then entered the area to gain control of Ms. Carter. She was hit in the face with a closed fist, her head hit the shower wall and she was hit again on her forehead. OC spray was deployed. Ms. Carter continued to hit her three more times at the back of her head before they gained control.

k) Information #44303524 – August 8, 2011 – assault peace officer s. 270(1)(a) *Code*

[68] The case summary merely states that the correctional officer was transferring Ms. Carter from a restraint chair to a bed and was assaulted when the right handcuff was removed.

l) Information #36654811 – October 22, 2012 – assault s. 266 *Code*

[69] A nurse was assisting Ms. Carter to disrobe as she sat in the bath chair. While squatting in front of her, Ms. Carter screamed out and grabbed her hair with both hands, ripping out some hair. The nurse

pulled back landing on her tail bone. Ms. Carter then raised her right leg in what appeared to be an attempt to kick the nurse, but this was thwarted by corrections staff. She told police, she simply doesn't like white girls.

m) Information #44332045 – January 17, 2013 – assault peace officer s. 270(1)(a) *Code*

[70] The correctional officer was hit in the head twice with a closed fist. There were no observable injuries.

n) Information #33303772 – May 12, 2013 – assault s. 266 *Code*

[71] The assault took place in the courtyard. Without provocation Ms. Carter punched another patient in the face and head area 17 times before being restrained by staff. A large goose egg and scratches were observable on the complainant's forehead. She was also bleeding from her lip. Ms. Carter appeared to be disoriented after the assault.

o) Information #38468315 – June 29, 2013 – assault s. 266 *Code*

[72] A nurse was changing the dressing on Ms. Carter's wound. Two legs and an arm were restrained when Ms. Carter struck the nurse on the wrist with her free arm. She continued to swing and attempt to grab at her and other nurses as they backed away. Ms. Carter said she was having a "bad day".

p) Information #44664085 – July 12, 2013 – assault peace officer s. 270(1)(a) *Code*

[73] While being escorted back from her recreational time, Ms. Carter punched a correctional officer on the arm. There was a small red mark. She was taken to the ground and placed in restraints.

q) Information #44664475 – August 20, 2013 – assault peace officer s. 270(1)(a) *Code*

[74] This assault occurred while Ms. Carter was being transferred from her Broda Chair to her isolation cell. While an officer attempted to place cuffs on Ms. Carter she tried to swing her arms away

and towards other officers who were removing restraints. She kicked the lower part of an officer's chest as a leg restraint was removed. Other officers came to assist and Ms. Carter was then placed in the isolation cell using 5 point restraints.

E. Surrounding Circumstances to the 2009 and 2011 Predicate Assaults with a Weapon

[75] Ms. Carter has been in custody continuously since March 2009. This includes remand time at Pine Grove from March 18, 2009 until her sentence and transfer to the RPC in June 2009. She remained at the RPC as a serving prisoner until December 6, 2011 and on remand to the present. The time in custody first at Pine Grove and then at the RPC has been a very difficult for Ms. Carter and RPC staff. These years are also the most documented, at least until the summer of 2013 with respect to the Crown's documents and a somewhat earlier date for Defense documents. The timing of the trials, assessment order, Defence application for production of documents in the hands of Correctional Service Canada, as well as Ms. Carter's health, dictated the extent of the documentation filed.

[76] It has been important to look at the events, particularly in the time frame when the outstanding offences occurred, notably the assaults with a weapon on June 13, 2009 and July 17, 2011 with a view to addressing the many issues presented by counsel in these proceedings.

a) June 13, 2009 Assault with a Weapon

[77] Noted above, Ms. Carter had just been sentenced on June 8, 2009 in Regina for offences committed March 18 and 19, 2009 to 30 months' incarceration. On June 11, 2009 Ms. Carter was officially transferred to federal custody at the RPC to begin this 30 month sentence.

[78] Ms. Carter had been in the Intensive Psychiatric Care (IPC) area of the Churchill Unit of the RPC for 2 days when this assault occurred. She was allowed one hour a day outside her cell for exercise and a shower.

[79] The Defence Binder[20] includes Pine Grove Records which begin in the spring of 2009, reproduced in part to give an indication of her mental state:

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[20] Defence Binder Tab 1 - Exhibit D-1

> Log Detail Report March 25, 2009
> . . . admitted on 20-Mar-09 and placed in MSU[21] . . .
> Carter has been displaying behaviours of a bizzare nature such as repetitive praying, picking at herself and the air, rocking in a fetal position and voiding on the floor. . . Carter was escorted to the Victoria Hospital Emergency Department on the 23-Mar-09 where she was assessed by the on call psychiatrist and given medication through an injection. . . Carter was sent today to the Victoria Hospital Emergency Department where she was again assessed and returned, as she promised the psychiatrist that she would eat, drink and take her medications. . .

[80] The remaining reports in March and up to April 28, 2009 indicate that Ms. Carter was kept in MSU on 23 Hour Lockup and Red Card Status; however there were small modifications over time. At times there were problems with taking medications and proper eating. There was some improvement in April with RED CARD status continuing but 23 hour lockup having apparently been lifted and the reports contain numerous references to Marlene's positive and cooperative manner and participation in unspecified MSU programming. An MUS Placement/Release Authorization signed by the Director with the following note suggests very little time outside the cell and little interpersonal contact:[22]

> 2009-04-23 MSU on restrictions as outlined in memo regarding Marlene as per DDO office April 16, 2009. Marlene to remain on RED CARD status. Marlene to return to regular meals with FORK only. Baths will be facilitated on a daily basis. These will be staff no contact. Marlene will be allowed an extra 10 minutes corridor freedom if time permits. Outside exercise will be written by ADD Jackson and will be implemented on April 27, 2009.

[81] The Report for April 28, 2009 depicts behaviour which appears to have been a precursor to active head banging of the kind later described. On April 28th she is still breaking her fall from a kneeling position. On this date, she refused to "re-lock", I believe meaning her handcuffs. She was disciplined and on April 30th received ten days of MSU. On a modified plan, she was not offered programming which may appear to include not being offered a bath or outside exercise:[23]

> Log Detail Report April 28, 2009
> . . . Throughout the day today writer did notice Marlene was a little bit "off". She was pacing in her cell and she would get on her knees and put her hands behind her head and interlock her fingers then she would fall forward, putting out her hands at the last minute and breaking her fall.

[21] MSU – Maximum Secure Unit
[22] Defence Binder Tab 2 at page 60 - Exhibit D-1
[23] Defence Binder Tab 2 - Exhibit D-1

[82] Ms. Carter was apparently taken to the Victoria Hospital on or about May 1, 2009 but no details as were provided. Ms. Carter's behaviour deteriorated beginning on May 3rd and continuing over several days her behaviour became bizarre. She resumed 23 Hour Lockup status. The exchange with Ms. Carter on May 5, 2009 suggests a connection between misbehaviour and a wish to feel pain:[24]

> Log Detail Report May 5, 2009
> Marlene stated "You know when you come in and spray me with that shit". . . "No I want you guys to come in and hurt me; I want to feel the pain". . .

[83] Ms. Carter was again admitted to the Psychiatric Unit of Victoria Hospital on May 6, 2014. She was described as shouting and swearing to an unknown person with the impression that she was hearing voices. She returned to Pine Grove May 11th. There was another report of bizarre behaviour on May 13, 2009. Ms. Carter was apparently taken to the Prince Albert Hospital on May 16th and seems to have returned on May 19th but there was no further information about the length of her stay there. There continued to be reports in May that describe bizarre and unpredictable behaviour, being uncompliant with medication but only for a short time. She expressed frustration with lack of shower and exercise time.[25] A May 12, 2009 memo from the ADD Office of Pine Grove indicated that she was to be offered exercise and bath daily, depending on her behaviours.

[84] Ms. Carter was seen while on remand for an initial assessment by the duty Doctor at the RPC on or about June 2, 2009.[26] It is handwritten and hard to decipher all of it but indicates the following:

> *Reason for Admission*
> – Admitted today from Pine Grove. . . .
> – Self-harm behaviours – banging etc.
> – Poor compliance with meds
> – Inappropriate behaviour
> – Washing hair in toilet
> . . .
> *Mental State Examination*
> In IPC gown . . . cooperative, appropriate – acknowledges having worked with me in the past. Seems happy to be in RPC. Says she wants to be appropriate and work with staff. No hallucinations/delusions. . . Seems insightful . . .

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[24] Defence Binder Tab 2 - Exhibit D-1
[25] Further details of bizarre behaviour may be found in the Defence Binder Time line as well as the Defence Binder Chronological Index - Exhibit D-1
[26] Defence Binder Tab 2 - Exhibit D-1

She was asked to and apparently signed an agreement to cooperate with treatment.[27]

[85] Dr. Mela interviewed Ms. Carter about this incident pursuant to a Court ordered assessment concerning fitness to plead and criminal responsibility. He had this to say about the June 13, 2009 assault with a weapon:[28]

> The explanatory themes in this incident include; the opportune event of her hand released from the cuff, psychotic concerns about the safety of her children. Without evidence, she has held unshakably to the belief that something is wrong with the children. In addition to the seemingly bizarre behaviour including the bizarre eating of dirt and an unprovoked attack, it will appear that she was in a disturbed mental state. Ms. Carter however said she knew it was an attack on a person but had to do it impulsively. She felt she had to respond to her concerns about her children. These concerns have regularly been of a psychotic nature.

He discussed this incident again when giving his opinion regarding criminal responsibility:[29]

> It is therefore my opinion, of a reasonable medical certainty that on this assault, although Ms. Carter was experiencing a distorted mental state, she did not lack the requisite mental awareness that she was doing something wrong and that what she was doing was assaulting an officer.

b) July 17, 2011 Assault With a Weapon

[86] This offence also occurred while Ms. Carter was serving her 30 month sentence at the RPC. She was also charged later that month with assault on two RPC staff that she assaulted during a self-harming incident in the shower.[30] There are many incidents of self-harm, some assaults and numerous "Use of Force" Memos both before and after the assault on July 17, 2011. Of particular interest are entries contained in a CRIMP[31] report dated August 31, 2011, which includes a recording of head banging incidents both in the shower and the courtyard on the date of the assault, July 17, 2011.[32] The Defence Time Line, filed with the Court, notes many head banging incidents, some assaults, two of which did not take place during a head banging incident, all in July 2011 as follows (All of the sources are August 31, 2011 CRIMP – CSC Binder 2 of 2 Tab 172, unless otherwise noted):[33]

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[27] Ibid.
[28] Offence Binder 2 of 2 Tab 24 - Exhibit P-2
[29] Offence Binder 2 of 2 Tab 24 - Exhibit P-2
[30] The assault contrary to s. 266 *Code* took place on July 26, 2011
[31] CRIMP is an acronym for Crisis Response and Incident Management Plan
[32] Defence Binder Tab 54 page 2 of the scan - CRIMP dated August 31, 2011 - Exhibit D-1
[33] Defence Binder Time Line. See also Tab 54 page 2 of the scan - CRIMP dated August 31, 2011 - Exhibit D-1

July 3 - banged her head after exercise - placed in Broda[34]
July 4 - banged her head after shower on way to Broda
July 7 - banged her head during exercise - placed in Broda
July 9 - banged her head after shower - placed in Broda
July 12 - tried to bang her head during exercise – placed in Broda[35]
July 15 - banged her head after shower - placed in Broda
July 16 - attempted to bang her head during exercise and on way to Broda
July 17 - banged her head in shower and during exercise – placed in Broda

July 17 - threw hot water at nurse – assault with a weapon charge

July 19 - banged her head in shower – OC spray deployed, cuffed and placed in Broda
July 20 - banged her head in shower – placed in Broda
July 21 - banged her head in shower – placed in Broda
July 22 - banged her head in shower – placed in Broda
July 23 - banged her head in shower – placed in Broda
July 25 - banged her head in shower – placed in Broda

July 25 - ***attempted to hit nurse*** - Incident Report – no charge - CSC Binder 2 of 2 Tab 163

July 26 - banged her head in shower - ***stopped by 3 officers - assaulted them*** – OC spray used - Pinel 4 points restraint – no charges[36]

July 26 - banged her head in shower - obeyed orders to stop, lie on the floor and put her hands behind her back - handcuffed her hands in front - one guard let go of her arm and she hit one then another guard - OC spray used - showered with clothes on as male guards - put in Pinel restraints in her cell - Cut her clothes off with scissors while nurse maintained dignity - (see A. Raaymakers and M Niebrugge Officer Statements) Defence Binder Tab 51 – OCI - Incident Report
Charged: Information #44303351, July 26, 2011, assault on two persons, s. 266

July 27 - FSWERT deployed to remove restraints and take her to exercise - put in leg irons and handcuffs - put helmet on her - team watched her exercise for 21 minutes - took her back to cell - 5 point restraint - compliant entire time - Defence Binder Tab 52 OCI - Incident Report

July 28 - Planned use of force FSWERT - In hand cuffs and leg irons - shower under construction - head gear - exercise - return to cell placed in 5 point restraints on Pinel without incident - Defence Binder Tab 53- OCI - Incident Report

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[34] Broda is short for Broda Chair
[35] The Time Lines records the following with respect to July 12/11: to be in Broda 24 hours a day and housed in cell for counts and overnight - to write distressing thought in journal - two guards to unlock - 3 guards for shower and exercise - 3 guards if off chair but 1 guard when on chair - gets extra 30 mins out of chair if has not banged for 3 hours - commence N40 with other patients but need 3 guards when in large exercise yard - see Interdisciplinary Placement Plan - Tab 45 (located 18 pages from end of scan just below the middle of scan) - OCI - CRIMPS and Notes Apr to Aug 2011 - Multiple Harm update.pdf - Defence Binder Tab 45 - Exhibit D-1
[36] Time Line notes she was to be in the Broda Chair 23 hours/day and expresses the hope that the helmet will allow her to leave the Broda – July 26, 2011 CRIMP - CSC Binder 2 of 2 Tab 164 - Exhibit P-4 and Exhibit D-1 Time Line

July 29 - Tried to strike nurse giving meds - FSWERT to be used for shower and exercise July 28 and 29, 30, 31 and Aug 1- will be in Pinel restraints entire time - She is certified - IPC 30 minute observation – Defence Binder Tab 36 - July 29, 2011 Multiple Harm Update (51 pages from beginning of scan)

July 29 - FSWERT used to take Marlene off Pinel restraints as she attempted to hit nurse the day before - segregation in cell E20 - took her to exercise and back - CSC Binder 2 of 2 Tab 166 - Incident Report

[87] Ms. Carter was certified under *The Mental Health Services Act*, in May 2011[37] and again as of July 29, 2011.[38] Precise dates for these certifications are not known as the certificates were not filed with the Court; rather reliance has been placed on the reports filed by RPC staff. Ms. Carter was not interviewed by a psychiatrist in relation to this incident.

VI Ms. Carter's Personal Background

A. *Gladue* Report and Personal Circumstances

[88] The Court received a *Gladue* Report, prepared by Ms. Laura Matthews.[39] This report, together with other documents[40] contributed to the background information about Ms. Carter's childhood, adolescence and early adult years. Ms. Matthews wrote that Ms. Carter's "life experiences and outcomes are likely related to the intergenerational trauma associated with colonialism in Canada."

[89] Ms. Carter is a member of the Onion Lake First Nation. She spent much of her youth in the Saulteaux Cree territory in the care of her late father[41], Tony Swimmer, a member of the Saulteaux First Nation, and step-mother, Annabelle Knight. Both the Onion Lake and Saulteaux First Nation communities were profoundly affected by the Indian residential school legacy. There were two residential schools at Onion Lake and an Indian Day school at Saulteaux. Ms. Matthews quoted an Onion Lake Elder who spoke of the effect of residential schools on a community:

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[37] Defence Binder Tab 45 - Exhibit D-1 page 23 of scanned CRIMP, dated June 20, 2011 – reference to mental health certification in May 11, 2011 entry
[38] Defence Binder Tab 36 - Exhibit D-1- page 58 of pdf – RPC Multiple Self-Harmer Update – 2011-07-29 "Her status remains Certified under the Saskatchewan Mental Health Act. . ."
[39] *Gladue* Report – Defence Binder Tab 64 - Exhibit D-1
[40] Youth sentencing report dated December 15, 1988 when Ms. Cater was 17 years of age Offence Binder 1 of 2 Tab 2 - Exhibit P-1
[41] Ms. Carter's father died in 2004

> Drop a pebble in the water and its' a ripple effect . . . it wasn't just those that attended [residential school] who endured the harms, but generations to come."[42]

[90] Marlene Carter's biological mother left her at the hospital; she called her father to pick her up. Ms. Carter regards Annabelle Knight as her mother and she has been a consistent part of her life since she was three days old. Ms. Carter's mother spent a considerable time in a residential school. Ms. Carter's mother was born into a dysfunctional home and lived in 13 different foster homes.

[91] Ms. Carter lived with her father and Annabelle Knight for the first six years of her life. Ms. Carter and Annabelle reported that Tony Swimmer beat Annabelle "all the time". Tony and Annabelle were both alcoholics. Annabelle said she was beaten up by Tony every weekend. She fled when Marlene was eight. Tony Swimmer was "imprisoned for abuse of Annabelle Knight in 1977.[43]

[92] Marlene had earlier gone to live with Annabelle's aunt, Julia Knight (she also attended residential school) with whom she stayed from age seven to twelve. There she endured emotional and physical abuse and was said to have been sexually abused by three of her great uncles. Her older sister, Peggy told Ms. Matthews that "Marlene was passed around to drunk old men to perform sexual acts."

[93] In 1983 Marlene's father removed her from Julia Knight's home. In February 1984 she came to the attention of the Department of Social Services following a serious suicide attempt. She shot herself in the chest in response to her father's sexual abuser. Ms. Carter reported to Dr. Lohrasbe:[44]

> she shot herself in the chest with her father's 22 rifle. She stated simply that, "My dad was sexually abusing me and I couldn't stand it". Looking back on the incident, she regrets that she did not shoot "slightly to the left" as she later learned that she just missed her heart.

[94] Over the next two years Ms. Carter lived with her father, her step-mother and in group homes, until she was placed at Ranch Ehrlo by the Department of Indian Affairs in 1986. At Ranch Ehrlo a number of issues were identified:[45]

> Family relationships, an inability to trust adults, a troubled sexual and self-identity related to the sexual abuse and lack of problem-solving skills. Marlene tended to cope with her problems and

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[42] Page 8 of the *Gladue* Report at Tab 64 of the Defence Binder - Exhibit D-1
[43] Youth sentencing report dated December 15, 1988 – Family Background – Offence Binder 1 of 2 Tab 2 - Exhibit P-1
[44] Page 9 of Dr. Lohrasbe's Assessment - Defence Binder Tab 62 - Exhibit D-1
[45] Youth sentencing report dated December 15, 1988 – Family Background – Offence Binder 1 of 2 Tab 2 - Exhibit P-1

pain by self-mutilating, running away and withdrawing. Abuse of alcohol was an additional concern.

[95] Annabelle Knight recalled that as an adolescent, Marlene Carter struggled with gender issues and she attributed this to the sexual abuse she suffered.

[96] Marlene the author of the *Gladue* Report, that she attained grade 10, last attending Mount Royal High School in Saskatoon. A Youth pre-disposition report indicates she attained most of her grade 9 at Bedford Road School in Saskatoon.[46]

[97] Ms. Matthews wrote that it has been suspected that Ms. Carter has fetal alcohol spectrum disorder because of the rampant alcohol abuse on both sides of her parents families but no medical history is available to confirm maternal drinking when her mother was pregnant with her. Ms. Carter's mother died of cirrhosis of the liver as a result of her addiction to alcohol.

[98] Ms. Carter abused substances from an early age. One of her earliest was of "syphoning gas" when she was five and losing consciousness as a result. Her lifestyle included chronic substance abuse of alcohol, illicit and prescribed drugs. Many of her criminal convictions are linked to alcohol abuse.

[99] Ms. Carter married Lawrence Guiboche who was almost 30 years her senior.[47] They had three children together. She remained in the relationship until the oldest child was five years old. She was in and out of the lives of her children and recalled being inpatient with them, stating: "if the boys got in the way . . . I would hit them". There was some suggestion by one of Ms. Carter's sisters, Peggy, that the boys may have experienced sexual abuse as they exhibited inappropriate sexual behaviours. The boys were removed by Child Welfare for a time but eventually returned to the care of Mr. Guiboche. Ms. Carter's contact with her sons has been very limited for some time. The children are now in their late teens or early 20's and on their own and Mr. Guiboche is deceased.

[100] The Report of the Office of the Correctional Investigator: *Risky Business,* comments upon the proportion of self-injury incidents that involved Aboriginal women[48].

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[46] Ibid 21.
[47] Mr. Guiboche died at the age of 67 of a heart attack
[48] *Risky Business: An Investigation of the Treatment and Management of Chronic Self-Injury Among Federally Sentenced Women* - Final Report - September 30, 2013 at page 3 Defence Binder Tab 74 - Exhibit D-1

> Aboriginal women accounted for nearly 45% of all self-injury incidents involving the federally sentenced women offender population. Of the 264 federal offenders who self-injured in 2012–13, seventeen individuals engaged in chronic (or repetitive) self-injurious behaviour (i.e., 10 or more incidents). These 17 individuals accounted for 40% of all recorded incidents. Nine were of Aboriginal descent. Nine were women (6 of whom were Aboriginal offenders).

[101] The Report, significantly found with respect to the treatment of Aboriginal women:

> 93. There is a lack of culturally safe or appropriate responses to the problem of self- injurious behaviour among Aboriginal women. There is little evidence to suggest that staff are aware, much less apply, a *Gladue* lens to the management of Aboriginal women who self-injure.

VII Section 752.1 Dangerous Offender Assessment

[102] Dr. Lohrasbe's report focused on issues related to risk, treatability and risk management. His testimony was helpful to the Court and his evidence was compelling in many respects.

[103] Dr. Lohrasbe interviewed Ms. Carter on May 9, 2013 for 2 ½ hours. Informal comments to him from staff at the RPC were consistent:[49]

> Ms. Carter has been doing much better in recent months. . .Her aggression towards self or others has substantially declined. . . Her current medication regime was seen as a remarkable success. . . her current medication regime was seen as remarkable. . . Several of the staff members . . . have known Ms. Carter for many years. They mentioned that she has regressed on several occasions in the past following a lengthy period of improvement in mood and behaviour. They also expressed concern over the fact that her head banging continues, although much reduced in frequency and severity.

[104] Ms. Carter was placed in Administrative Segregation and Restrictive Psychiatric Intervention (RPI) three days after seeing Dr. Lohrasbe on May 12, 2013.[50] This is an indication of, among other things, just how changeable and unpredictable Ms. Carter can be. The Fifth Working Day Review document represents the total of the information provided to the Court regarding her mental health in relation to that incident. She was seen by Dr. Baziany who ordered the RPI but he was not a witness.

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[49] Defence Binder Tab 62 - Exhibit D-1
[50] CSC Binder 2 of 2 Tab 178 - Exhibit P-4

[105] Dr. Lohrasbe addressed Ms. Carter's history, noting that due to her memory deficits, he regarded her as an unreliable historian for some things. He noted her distress when described her father's abuse of her.

[106] She described some of her suicide attempts and discussed with him her head banging and he noted a strong symbolic religious theme to her accounts, tying these events as she did to be undertaken to protect her son Dallas. He observed that the ritualistic aspects of her head banging were of great significance. She was morose when discussing her children, expressing guilt about not protecting her son Dallas from abuse; however she was unable to articulate how she knew that he had been abused. She recounted head banging in 2007 and 2008 when she lived in the community crime free. The method differed from that described during her time in custody since 2009; she described banging her head against toilets or washbasins in public washrooms.

[107] She was unable to articulate the motivations for assaulting staff, but expressed feeling better of late because she had not been assaulting staff for some time.

[108] Dr. Lohrasbe initally remarked upon:

- her propensity for perseveration,
- a disconnection between acts of violence and appreciation of their potential impact on herself and others (she does not experience violence and bodily harm, emotionally and cognitively, the way that most people do)
- her rationale for head banging, to help protect her son, and her pre-occupation with her eldest son, to the exclusion of her other two boys.

A. Diagnostic Opinion

[109] Dr. Lohrasbe remarked that the ferocity of Ms. Carter's head banging is remarkable and the persistence and intensity of her attacks on staff is unusual. He regarded her case as unique, stating that neither clinical experience nor scientific literature is suffused with cases such as this. He was cautious about his opinion, stating:

> Unique cases present unique assessment challenges and the opinions that follow necessarily come with the caution that they are tentative. I offer them without the degree of confidence that accompanies more routine assessments.

[110] He reviewed Dr. Mela's diagnosis in the January 2011 report and while expressing no disagreement, chose to reconceptualise the relevant psychiatric disorders, stating that Ms. Carter's current multi-faceted psychiatric disorders can best be conceptualized as "Organic Brain Disorder"; adding that her current symptoms and behaviours are best seen as manifestations of brain damage.

[111] He went on then to explain that damage caused by inhaling toxic substances, cutting off oxygen supply to the brain or repeated concussions is based on the clinical rather than laboratory findings.[51] Dr. Lohrasbe explained the research regarding the impact of such brain damage upon impulse control:[52]

> One of the most consistent clinical outcomes from brain damage is impairment in impulse control. While there can be many sources of impulsivity, of relevance in this case is the neuro-physiological conceptualization of impulsive actions. Research on the sequence of brain activity, awareness of a cognition, and subsequent action (pioneered by physiologist Benjamin Libet in the 1970's and 1980's), demonstrated that unconscious brain activity precedes conscious awareness of the relevant mental event (thought, urge, desire, emotion). It is that awareness that allows the interruption between the mental event and action, including speech. Libel's findings have since been replicated and are now widely accepted, although the implication on the free will - determinism debate remains a source of controversy. The clinical relevance has to do with the nature of self-control and, in the context of forensic psychiatry, the control of aggressive thoughts and urges in particular. While aggressive thoughts and urges are common to us all, what distinguishes individuals who are recurrently violent is the failure to restrain or halt those mental experiences before they transform into actions. In 'normal' people, aggressive thoughts or urges (and other potentially socially disruptive mental events, such as sexual impulses) are interrupted and restrained prior to being enacted through words or action. (In philosophical circles, some claim that Libel's findings have demonstrated that 'what we may have is free won't, not free will'). It is this capacity to restrain that is impaired or undermined by various forms of mental disorder, and especially those that result from any form of brain injury. Mental events translate to action without the option for restraint that exist in people not so damaged. In clinical terms, they are impulsive, often extremely so.

[112] In testimony, Dr. Lohrasbe described it as an impaired ability to control impulses and he gave a practical illustration of Ms. Carter's difficulty:[53]

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[51] This is consistent with Dr. Mela's pursuit of tests that may measure the damage being done to Ms. Carter's brain. The reports indicated little measurable impact. See Dr. Lohrasbe's testimony at pages 654 and 657 of the transcript.
[52] Defence Binder Tab 62 - Exhibit D-1
[53] Beginning at page 628 transcript

Q Okay. So I think you said that we might become aware of an urge to do something inappropriate and that awareness allows us to interrupt the . . . mental event from becoming an action; is that right?

. . .

A Correct, or a word.
Q Or a word, . . . and you said that, like, aggressive thoughts or urges are common to all of us. It's – it's what we're dealing with is – the degree of being able to control it; is that correct?
A Correct, interrupt it.
Q And you said what distinguishes. . .the people who are recurrently violent is the failure to restrain or halt those mental experiences before they become actions?
A Yes. When we're talking about violent behaviours, but the similar principle applies in people who are verbally inappropriate, you know, particularly in people who may have brain damage or who are handicapped mentally or who have mental disorders, that same process of not interrupting the thought before it is spoken.
Q So Marlene will sometimes yell out or --
A Yes.
Q -- or say a sentence or whatever. And so she has the urge to -- to do that, but the inability to stop herself; would that be correct?
A Yes. The only -- I mean, for conveniences sake we -- we speak in sort of absolute terms. Inability, it's more like an impaired ability, it's not all the time. I -- I don't think even people with advanced brain damage, it's not like every single time that they have a thought or an urge they act on it. It's that their overall ability to restrain themselves isn't had.
Q Like right now, she's fine.
A Yes.
Q And -- and yesterday there might have been two or three times during those periods that -- that she -- she yelled out.
A Yes.
Q And so it's sort of an intermittent thing?
A Correct.

[113] Dr. Lohrasbe enumerated areas of concern that affect Ms. Carter's risk:

i) a diagnosis of Organic Brain Disorder
ii) substance abuse and dependence
iii) psychosis - a history of a few but intermittent manifestations, including auditory hallucinations, ideas of reference and likely delusional beliefs. Psychotic symptoms continue to promote self-injurious head banging, accelerating the damage to her brain.
iv) personality disorders - a secondary concern
v) obsessive compulsive behaviour and its association with both anxiety symptoms and personality dysfunction - a secondary concern – He regards her head banging as a perseverative ritualistic behaviour

[114] Upon interviewing Ms. Carter, Dr. Lohrasbe found no overt psychotic symptoms, although she described for him, psychotic symptoms that she has experienced in the past. Certainly the Court is in

receipt of psychiatric reports that indicate her experiencing psychotic symptoms, notably Dr. Mela's January 2011 report.[54] He was asked described the term psychosis:[55]

> Q . . . you referred to psychosis, why don't you describe for us what that is and what you mean in terms of when you were asking her as to time, date, place?
> A . . . Psychosis refers to the loss of contact with objective reality. So if I were to believe that I'm sitting right now in a Starbucks, I – I would have lost contact with objective reality, I would have lost contact with the fact that I'm sitting in a courtroom. If I believed that – that you were representing the devil and were asking me trick questions, I would have lost contact with reality. I would have -- I would have injected a delusional belief into what's going on right now. If I heard God speaking to me right now, that would be an auditory hallucination. Again, I've lost contact with reality. . . Now, with Ms. Carter . . psychotic symptoms emerged only when I asked her specific questions about experiences in the past, or when she was providing me with a narrative of what had prompted some of her violent actions. Psychotic symptoms emerged during the course of those descriptions. So there was no psychosis during the course of the interview, but there were psychotic symptoms in the material, in the historical material that she provided.
> Q And when you reviewed her file, and even from her own -- the interview, you make a reference there, messages from the radio or television, fair to say nothing like that occurred during the interview?
> A That's correct.
> Q And that would be consistent with psychosis, if that's what would have happened?
> A Yes.

[115] He described obsession and compulsion and in the context of Ms. Carter's behaviour:[56]

> . . . an obsession is a recurrent thought that is -- that is illogical. . . it's something that is sort of out of context, inappropriate, but keeps recurring, some idea that you have. It could be an excessive fear, it could be a realistic fear, but blown completely out of proportion. It could be a psychotic preoccupation. . . . an obsession simply means a recurrent thought that has been kind of unmoored from its context and keeps popping up. A compulsion is the action version of that. It's something you do. So the classic version of that, people who skip every fourth step, or who will avoid stepping on cracks, or who go and check that the -- the water has been shut off, even though they've just gone and checked a minute ago they'll go and check it again. So those are compulsive behaviours. Now, Ms. Carter's head banging has a compulsive quality, and it's driven by obsessions. Her -- her worry about her children, in particular her oldest son. The problem is that obsessive compulsive thinking and behaviour is a form of perseveration. In other words, something keeps persisting in your head long after its appropriate context has come and gone. And yet the fact that she bangs her head, creating brain damage, makes it more likely that she will continue to be perseverated. So that's what I mean by the tragic loop. The behaviour perpetuates the cause for the behaviour.

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[54] Offence Binder 2 of 2 Tab 24 - Exhibit P-2
[55] Page 459 transcript
[56] Page 472 transcript

[116] Dr. Lohrasbe was asked whether there's a link between the head banging and her aggressive behaviour toward others:[57]

> A I think we can separate them. I think that the head banging has some themes that she can report and explain. With the violence towards others, one of the things that makes it very difficult when we are looking ahead about managing her, is that there seems to be a total disconnect between what's going on in her and her striking out. It seems to be very impulsive, very situationally driven.

[117] He was asked, whether Ms. Carter could be managed in the community if she did not commit assaults upon others but continued to head bang:[58]

> . . . say you take away all aggression against others, the persistence and intensity of self-harm was such that I can't imagine any psychiatrist in the community not keeping her certified under the Mental Health Act until she has been clear of such incidents. I don't know what timeframe to give you, because I've never had to deal with this specific situation, but just as a guess I would say at least six months.

B. Risk Assessment

[118] Dr. Lohrasbe employed a Structured Clinical Guideline for risk assessment, known as the HCR-20 which is widely used for assessing risk among the mentally disordered. Referring to his report, the risk factors employed are set out below with his assessment as to whether the factor is present:[59]

H1. Previous Violence - clearly present – occurring in a variety of contexts, with a range of victims and at various levels of severity. It is important and directly relevant to risk
H2. Young Age at First Violent Incident - clearly present and directly relevant to risk
H3. Relationship Instability - clearly present
H4. Employment Problems - clearly present
H5. Substance Use Problems - clearly present with potential as a direct and indirect impact on risk
H6. Major Mental Illness - clearly present, important and directly relevant to risk
H7. Psychopathy – absent
H8. Early Maladjustment - clearly present
H9. Personality Disorder - clearly present but overshadowed by brain damage and psychotic symptoms

[57] Page 504 transcript
[58] Page 505 transcript
[59] Defence Binder Tab 62 - Exhibit C-2

H10. Prior Supervision Failure - clearly present and important to risk management
C1. Lack of Insight - clearly present
C2. Negative Attitudes – present but may be in the early stages of change
C3. Active Symptoms of Major Mental Illness - present and important to the "imminence" aspect of risk and the unpredictability of her symptoms. Of great concern is the idiosyncratic interpretations of innocuous events.
C4. Impulsivity – present and significant, especially related to the "imminence" facet or risk
C5. Unresponsive to Treatment - present but may be in the process of change
R1. Plans Lack Feasibility - present - lack of interest is a major impediment to risk management in the community
R2. Exposure to Destabilizers - present and includes: substance abuse, criminal peer group and ready use of objects as weapons
R3. Lack of Personal Support - present
R4. Noncompliance with Remediation Attempts - not rated
R5. Stress - present - starkly absent stress management skills

[119] Dr. Lohrasbe then employed a clinical formulation of risk, focusing on a few important risk-related issues for Ms. Carter, again referring to his report.[60]

Much can be achieved through medications, counseling, and attention to environmental/social setting, but it would be hazardous to expect Ms. Carter to function 'normally' in the foreseeable future. In particular, the tendency toward impulsivity can only be contained, not eliminated.

. . .

Impulsive reactions in her case are especially problematic due to her idiosyncratic and hence completely unpredictable interpretation of the words and gestures, and even the physical characteristics, of those around her. To put it another way, one aspect of her high risk for violence is that, unlike the majority of violent people, high risk situations cannot be readily anticipated. In addition, relatively rapid fluctuations in her mood influence her propensity to act violently.

Related to the above concerns of idiosyncratic and mood driven violence is the issue of psychosis promoting violence. Psychotic interpretations of a radio broadcast, for example, are impossible to anticipate.

An additional issue is Ms. Carter's apparent insensitivity to physical pain. This is accompanied by a detachment or indifference as to the emotional accompaniments of pain, her own and that of others. The experience of all kinds of pain, actual or anticipated, is a key factor that assists most people restrain their violent behaviors. This source of restraint appears to be largely absent with Ms. Carter. . .

[60] Defence Binder Tab 62 - Exhibit C-2

. . . She may not be actively malevolent, but her lack of felt remorse removes one of the important restraining influences that operate in many people to restrain the violent 'acting out' of unconscious and irrational mental events.

. . .

She also lacks a healthy self-concept, with its hopes, models, and motivations that promote a desire for normalcy.

. . .

Treatability

To summarize treatability: it is reasonable to anticipate that Ms. Carter, at least intermittently, will engage in and participate in treatment programs offered to her. Her mental disorders are permanent, but the variety and intensity of symptoms will fluctuate. It is not likely that treatment, which will largely serve to stabilize her cognitive, mood, personality, and behavioural dysfunctions, will have a long term effect beyond the period of time they are continually delivered.

Risk management

Her history and clinical presentation suggest that treatment benefits will not be 'portable' from one setting and situation to another. In my opinion, treatment is likely to be effective in reducing her risk for violence only insofar as it is continuously available and delivered to Ms. Carter, and it is hard to see how a supervisor in the community can apply the rigid structure and continuous oversight that is essential for reducing her potential for violence. It will, for instance, be difficult to respond quickly and safely to her head banging. It will take a much longer period and a more complete elimination of violence (to self or others) for there to be a realistic chance of managing her safely in the community.

C. Summary

[120] This summary was contained in Dr. Lohrasbe's report:[61]

> 1. Ms. Carter has a history and clinical presentation that strongly indicates the role of brain damage as the primary etiology of her current psychiatric symptoms and dysfunctions.
> 2. Collectively, these psychiatric symptoms and dysfunctions will continue to contribute to high risk for acts of violence in the foreseeable future. While the likelihood of acts of violence is very high, the nature, context, and seriousness of future violence is unknown, being directly related to Ms. Carter's idiosyncratic mental states.
> 3. Ms. Carter has a recent history of remarkably improved behavior, including a reduction in violence directed at herself or others. This improvement has occurred within a tightly structured setting, quick responses, fixed routines, and rigid environmental control.
> 4. The continuation of routine, structure, control, therapeutic input, and medications (collectively, an ongoing treatment program) will offer the greatest opportunity for continued improvement, including continued reduction in all forms of violence.

[61] Defence Binder Tab 62 - Exhibit C-2

5. At this time, it is difficult to envision how such an ongoing treatment program can be delivered to her in the community with available resources.
6. Without such an ongoing treatment program in place, the risk for violence is likely to increase rapidly.
7. These opinions are offered with the full acknowledgment that risk and its management in the community are not fixed entities and will need to be reassessed from time to time.

VIII Ms. Carter's Mental Health

[121] Ms. Carter has been admitted to the RPC seven times.[62] Dr. Mela worked with her during her admission to the RPC and as a serving prisoner in 2003/04 and more extensively from her admission in 2009 until the summer of 2011. He provided the Court with a thorough written assessment, dated in January 2011, as to fitness and criminal responsibility, expressing the opinion that with respect to a limited number of the incidents canvassed that Ms. Carter was not criminally responsible.

A. Early Diagnoses

[122] It's important to examine variable psychiatric and psychological assessments over time, notably while Ms. Carter has been at the RPC. Three early diagnoses summarized immediately below may be compared to the more current diagnoses of Drs. Mela, Adelugba and Lohrasbe set out still further below under the heading Borderline Intellectual Functioning and Deterioration over Time:[63]

i) Psychiatric assessment, dated April 7, 2001, by Dr. Marcoux and diagnosis on admission with his comments:[64]

below average I.Q.[65], Mood Disorder, depressive type with obsessive/psychotic features and Substance Abuse in early remission due to incarceration. Mixed Personality Disorder of a borderline and antisocial type

ii) Psychiatric assessment, dated September 14, 2004, by Dr. Mela and his noted diagnosis:[66]

AXIS I Anxiety Disorder due to a general medical condition
Obsessive Compulsive Disorder
Polysubstance Dependence in remission in a controlled environment

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[62] Offence Binder 2 of 2 Tab 25 - Exhibit P-2 - Dr. Adelugba's May 16, 2012 report
[63] See II Documents Filed, above for a list of reports, including psychiatric, psychological and medical.
[64] CSC Binder 1 of 2 Tab 34 - Exhibit P-3
[65] See the discussion below involving Dr. Presse and her assessment of I.Q.
[66] Offence Binder 2 of 2 Tab 20 - Exhibit P-2, beginning at page 36

AXIS II Borderline and Antisocial Personality Disorder
. . .
AXIS V GAF = 50

[123] Both Dr. Marcoux and Dr. Mela documented that Ms. Carter suffered from intrusive images of people's heads being chopped off, which she found very disturbing as they involve close family members and others.

iii) Psychiatric Discharge Summary, dated March 23, 2006, by Dr. Adelugba:[67]

AXIS I Alcohol Dependence and Polysubstance Dependence both in remission in a controlled environment
AXIS II Borderline and Antisocial Personality Disorder
AXIS V GAF 61-70

[124] Dr. Adelugba specifically noted that she denied having psychotic symptoms, i.e. hearing voices and having delusions, symptoms suggestive of Major Depressive Disorder and anxiety or thoughts of self-harm or suicide.

B. Deterioration Over Time and Borderline Intellectual Functioning

[125] This brings us then to reports evidencing deterioration over time and a reduced assessment of borderline intellectual functioning.

[126] Dr. Lohrasbe testified that Ms. Carter was of low normal intelligence, but relied it appears upon the dated testing of others:[68]

Q Dr. Lohrasbe, I think you said in your report that -- I don't know that you actually tested Marlene for intelligence during your examination. You relied on other people's testing; is that correct?
A Yes. I'm not trained to do intellectual testing.
Q . . . it was your understanding she has a low normal intelligence; is that right?
A That's my understanding, yeah.

[127] He specifically noted the assessment of Dr. L. Presse, who on August 9, 2000[69] found Ms. Carter to be low average intelligence. He noted Dr. Mela's Court ordered report of January 2011 and

[67] CSC Binder 1 of 2 Tab 59 - Exhibit P-3
[68] Page 689 transcript

his diagnosis that included borderline intellectual functioning. He did perform some rudimentary tests of her functioning, noted in the written assessment.[70] He observed that her long-term memory was impaired and on a practical level found that she was of limited assistance in recounting the details of convictions. He noted several examples of perseveration; something that he stated was common in brain-damaged individuals.

[128] Dr. Mela and Dr. Adelugba found in their respective 2011 and 2012 reports that Ms. Carter's intellectual functioning was Borderline. Dr. Mela, in his Court Ordered assessment of criminal responsibility and fitness to plead, dated in January 2011, provided the following diagnosis which included a finding that her intellectual functioning was Borderline and he gave her a GAF[71] of 35:[72]

DSM IV DIAGNOSIS

AXIS I	Anxiety Disorder due to a general medical condition (Obsessive compulsive disorder due to brain injury)
	Obsessive Compulsive Disorder with lack of insight (psychotic symptoms)
	Alcohol Dependence in remission in a controlled environment
	Poly-substance Dependence (cocaine, solvents and cannabis)
AXIS II	Borderline Intellectual Functioning
	Antisocial Personality Disorder
	Borderline Personality Disorder
	Personality Disorder NOS (OCPD and narcissistic traits)
AXIS III	Kidney Problems, Acid Reflux, Hepatitis C, Post Head Injury Complications
AXIS IV	Legal, family and poor support problems
AXIS V	GAF 35

[129] Dr. Mela was her treating psychiatrist from her admission to the RPC in June 2009 to the date of the report. He noted the sources that he relied upon in conducting his January 2011 assessment which included a second opinion from a team of experts consulted in clinical presentation and eventually in person by carrying out an in-depth interdisciplinary assessment. These assessments were conducted by the forensic mental health team from Brockville, Ontario in August 2010. He perused records of her hospitalization at the Regina General Hospital and at the RPC over the years. He remarked that prenatal alcohol exposure was suspected.

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[69] CSC Binder 1 of 2 Tab 32 - Exhibit P-3
[70] Defence Binder Tab 62 -Exhibit D-1 - Page 3 of Dr. Lohrasbe's report
[71] GAF stands for Global Assessment of Functioning and is included in the DSM IV. It is a 100 point tool rating overall psychological, social and occupational functioning of people over 18years.
[72] Offence Binder 2 of 2 Tab 24 - Exhibit P-2 at page 34 of the scan

[130] Dr. Adelugba provided this diagnosis in his May 2012 report to the Court:[73]

DSM IV DIAGNOSIS

AXIS I	Anxiety Disorder due to a general medical condition (Obsessive Compulsive Disorder due to brain injury)
	Obsessive Compulsive Disorder with lack of insight (psychotic symptoms)
	Alcohol Dependence in remission in a controlled environment
	Poly-substance Dependence (cocaine, solvents and cannabis)
AXIS II	Borderline Intellectual Functioning
	Antisocial Personality Disorder
	Borderline Personality Disorder
	Personality Disorder NOS (OCPD and narcissistic traits)
AXIS III	Kidney Problems, Acid Reflux, Hepatitis C, Post Head Injury Complications
AXIS IV	Legal, family and poor support problems
AXIS V	GAF 51 – 60

I noted that in his Discharge Summary dated March 28, 2006 that, Dr. Adelugba he did not diagnose Ms. Carter with Anxiety Disorder, Obsessive Compulsive Disorder, or Borderline Intellectual Functioning and at that time her GAF was 61 – 70.

[131] It would seem from the testing available over the years that there was a marked deterioration in Ms. Carter's intellectual functioning between the testing by Dr. Presse in 2000 and the reported functioning by Dr. Mela and Dr. Adelugba in 2011 and 2012. A Psychological Intake Assessment conducted at the Saskatchewan Penitentiary June 23, 1999 indicated that she scored in the average or normal range of functioning although there was a concern about a score indicating intellectual impairment.[74] A further Psychological Specialized assessment conducted in July of 2000 by Dr. Presse however concluded that the previous score was not a true reflection of ability and likely occurred because it was completed too quickly by Ms. Carter. Dr. Presse found that her Full Scale IQ scores fell in the low average range.[75] There are references in other documents filed with the Court indicating that other testing took place after that of Dr. Presse in 2000 and that a marked deterioration was noted, but that testing was not in the materials provided to the Court. This was noted in a Criminal Profile Report dated January 31, 2005:[76]

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[73] Offence Binder 2 of 2 Tab 25 - Exhibit P-2 beginning at page 3 of the scan
[74] CSC Binder 1 of 2 Tab 29 - Exhibit P-3
[75] CSC Binder 1 of 2 Tab 32 - Exhibit P-3
[76] CSC Binder 1 of 2 Tab 53 - Exhibit P-3 at page 4

Summary of Psychological and Psychiatric Assessments
. . . This is her second federal sentence. Testing was consistent with previous assessment results with documentation in her file suggesting possible organic brain injury. . .

[132] This reference was in Dr. Sojonky's November 5, 2010 Report to the National Parole Board:[77]

CLINICAL IMPRESSIONS/COURSE OF SESSIONS
. . . Psychiatric assessment indicates that she has most likely caused permanent frontal lobe damage. Marlene recently completed psychometric testing (WAIS IV). When compared to previous testing approximately five years ago she shows significant deterioration.

[133] A CSC Corrections Plan, dated April 19, 2011 and two CSC security level assessments, dated May 27, 2011 and November 18, 2011, disclose much of the same information, notably reference to a psychiatric assessment and psychometric testing:[78]

Psychological Concerns
Carter has many issues pertaining to mental health. She is diagnosed with Obsessive Compulsive Disorder, Deliberate Self-Harm, and Border-Line Personality Disorder. A Psychiatric Assessment dated (sic) indicates that "CARTER has most likely caused permanent frontal lobe damage as a result of repeated head blows. CARTER recently completed psychometric testing (WAIS IV). When compared to previous testing approximately five years ago she shows significant cognitive deterioration. CARTER is a High risk to re-offend".
. . .
This writer believes that due to CARTER's repeated self-injurious behaviours, it can be reasonable to assess that she is causing permanent damage to herself that may be indicative of increasing her risk areas.

C. Culpability

[134] Dr. Lohrasbe testified regarding Ms. Carter's culpability, generally:

I would have a hard time regarding her violent behaviour in the same way that I would someone who did not have all the -- the full range of mental disorders and deficits that she does have. So in terms of my perspective on her moral culpability, it would be much less than someone who is functioning normally. . .[79]

[77] CSC Binder 2 of 2 Tab 128 - Exhibit P-4
[78] CSC Binder 2 of 2 Tabs 146, 154 and 173 - Exhibit P-4
[79] Page 717 transcript

D. Suicide Attempts and Self-harming Incidents

[135] The Intake Assessment carried out in September 1999 during her first federal sentence provides background information regarding suicide attempts and self-harming to that point in time:[80]

> Carter has an extensive suicidal history; she did shoot herself in the chest around the age of twelve or thirteen, attempted drowning, hanging (x2). . . Carter has slashed her arms numerous times, and has a history of burning herself. Staff at Pinegrove Correctional Centre report that Carter would burn herself, generally on her legs, when she was experiencing stress.

[136] An Interim Program Performance Report dated October 17, 2002 reports on some specific self-harming incidents at the RPC:[81]

> A few days prior to Marlene's June 19th ward rounds, she burned her hand with boiling water as a way of distracting herself from worrying about her sons. She agreed to talk to staff and let them know if she was feeling vulnerable to self-harming thoughts. For the next week and half Marlene was noted to be reluctant to talk with staff and she appeared to be pre-occupied. . .
>
> On June 30th Marlene superficially slashed, stating she was stressed, anxious and worried about her children. . .
>
> On July 4th, Marlene was noted to be rude and impatient . . . Marlene agreed to lock in her room for a time out. . . Marlene was noted to be quiet throughout the morning . . . After the group concluded and it was time to return the sharps to the shadow board, Marlene grabbed a butcher knife and would not give it to staff. After approximately 4 hours of negotiation, Marlene stabbed herself in the abdomen with the knife.

[137] A law student prepared a summary of medical and nursing notes pertaining to admissions to the RPC September 21, 2005 to March 23 2006 and to the Regina General Hospital from January 16, to February 19, 2009, which summary provides additional background of suicide attempts or self-harm:[82]

> Banging of head since 2002 - either to ensure her boys are OK or at times this was a means to get admitted so that she would have a place to stay
>
> Suicidal ideation – attempted suicide by shooting herself in the chest when she was 12-13; dumped coffee on her face and neck, poked her abdomen with a pencil, slashed wrists in 1999 and 2000, tried to hang herself in 1998; slashed both sides of her throat with glass from a

[80] CSC Binder 1 of 2 Tab 26 - Exhibit P-3
[81] CSC Binder 1 of 2 Tab 46 - Exhibit P-3
[82] Defence Binder Tab 72 Exhibit D-1 - beginning at page 1

broken TV in 2002;[83] attempted drowning; burned hands in 2002, stabbed herself in abdomen in 2000 and 2002

[138] Dr. Adelugba's May 16, 2012 report advised the Court as to whether Ms. Carter would be able to attend Court in person. He disclosed some additional detail about suicide and self-harming events in Ms. Carter's life, at page 1.[84]

> . . . During one of her previous admissions to RPC she stabbed herself in the abdomen, slit her throat and tried to hang herself. This happened as she barricaded herself in the kitchen and the I.E.R.T. was called in to extract her from the kitchen and have her taken to the hospital. Also whilst at RPC Ms. Carter trashed her cell broke her television set and used the glass to cut her throat. She was taken to outside hospital where stables were placed in her neck. Ms. Carter then proceeded to rip the staples out and re-open the wounds.
>
> Subsequently, Ms. Carter was certified under the Mental Health Act and placed on Intensive Psychiatric Care. From December 15 to January 11, 2003 she repeatedly voiced her desire to be killed or be allowed to kill herself.

[139] Dr. Adelugba then described her assaultive and self-harming behaviour since her admission in 2009 to the RPC.

> Since Ms. Carter's current admission to RPC she has been involved in numerous incidents. The incidents involved assaults on staff, self-inflicted injuries, and assaults on other patients. . . Typically during her self-inflicted injuries she would place her hands behind her back, kneel on the floor and smash her face into the hard concrete floor. Quite often her rationale for banging her head was to ensure that her boys were safe and/or she just needed to hear her skull bones crack.

[140] He summarized the many different types of interventions tried to assist Ms. Carter over time:

> . . . These include but are not limited to placing gym mats on her cell floor, psychopharmacological therapy, counselling, electroconvulsive therapy (ECT) physical restraints in the form of broda chair and pinel board. In addition she wore helmet for a long period of time as this was the only way of minimizing injuries to her forehead.

[141] At the time of that report, Dr. Adelugba referred to a program performance report of May 10, 2012 and said that Ms. Carter could attend Court in person, rather than by CCTV and he reported that

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[83] Dr. Lohrasbe discussed the throat slashing incident with Ms. Carter, noted in his assessment report Defence Binder Tab 62 - Exhibit D-1

[84] Offence Binder Tab 25 - Exhibit P-2

Ms. Carter had greatly improved in the last three months. She had not been banging her head, she was living in a room as for regular patients, had attained off unit privileges and had been compliant with the management plan. She was involved in group programs and getting along with other patients and showing some humanity and thoughtfulness.

[142] Dr. Adelugba described Ms. Carter's progress overall since the last report in January 2011, indicating that she has had the benefit, among other things, of frequent counselling with the unit psychologist. Together they worked on areas such as emotional regulation and anger management with positive results.

E. Head Banging in Custody

[143] Ms. Madraga, RPC nursing supervisor, described the challenges of working with Ms. Carter:[85]

> A Well, her head banging, of course, is our first challenge with her. She bangs her head at every opportunity that she gets.
> . . .
> And then once the incident of head banging happens, we are concerned about neurological impairments, that sort of thing. We do checks on her all the time, followed by her injury, her wound on her head that never seems to heal, infections.
> . . .
> A Walking around, sitting as a normal you and I, she literally puts her hands behind her back and falls to the floor and hits her head straight onto the floor. Or goes onto her knees -- I've seen her do it on her knees, I've seen her do it from feet -- from standing.
> Q And from standing, like actually landing on her knees, or landing on her head?
> A No, landing on her head. I have seen her bang her head on the bars of the shower. I've seen her bang her head on the floor of her cell, leaning over the side of her bed. I have witnessed her bang her head on the table, on the window sill, on the hatch of her cell if it's been open.
> . . .
> Q Have you ever seen anything like that with any other patients you've dealt with?
> A Not to this severity, no.

[144] Medical personnel fear for Ms. Carter's life if the head banging cannot be stopped. Dr. Mela tried to impress Ms. Carter and her family with the nature of the risk to her survival and he looked for

[85] Pages 743,746 and 747 transcript

alternatives to the restraints in a helmet and padded cell:[86] According to Dr. Mela, the helmet did not work as Ms. Carter began to take it off before she engaged in head banging.[87]

[145] Ms. Madraga expressed the concern for her life this way:[88]

> Her head banging is so severe, I don't think she would -- if she was allowed to do it, I don't think she would make it.
> . . .
> Yes. Her head banging, it's hard to describe. You have to see it. But when she does head bang, it is so violent and so severe, it's very disturbing. And she -- she doesn't care to stop. She'll tell you she doesn't care to stop, and I think that she would kill herself. From a medical -- from a nursing point, a head is not meant to hit the floor like that.

[146] Ms. Madraga explained that the nurses and other staff with whom she has a connection will ask Ms. Carter to tell them before she head bangs and the will offer PRN medication which helps calm her. Once she engages in head banging the nurses will verbally intervene until the officers respond. Nurses don't respond to stop the self-harm, that's up to corrections officers.[89]

F. Progression of Head Banging and Assaults Over Time

[147] Dr. Lohrasbe's Report provided Ms. Carter's account of head banging during the years 2007 and 2008 when she was in the community in Regina:

> She had spent much of those two years with a male friend although their relationship was platonic. She desisted from criminal activities during that time. However she recalls that while in the community she banged her head very frequently, often just hard enough to see "a splash of blood ... and then I'd be happy". Head banging often dominated her day. She described going into the restrooms of hotels and restaurants, banging her head against the toilet or the washbasin, and quickly cleaning up the blood before she left. From her descriptions, these behaviours appear to be in response to communications and messages from"...my son ...he talked to me through television. He'd say, "Mom, we're coming 70 miles an hour'. I'd go, holy shit, Why are they coming? They'll be killed ...then I'd hurt myself and they did not come, so I knew it worked". She is convinced that there were many occasions when, by banging her head, she made sure that her son was safe.

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[86] Defence Binder Tab 37 - Exhibit D-1 - September 19, 2011 letter Dr. Mela to Office of the correctional Investigator seeking an exemption for the helmet at page 5 of scan. See as well at page 4 of scan "Rationale for the request to use a helmet to manage life threatening head banging, includes reference to padded room.
[87] Page 1192 transcript
[88] Page 771 transcript
[89] Page 750 transcript

[148] Having reviewed reports from the RPC and Pine Grove Correctional Centre from March to June 2009, it seems likely that head banging involving falling from a standing of kneeling position to flat on the floor developed sometime after she was sentenced federally to 30 months on June 8, 2009. The reports from Pine Grove in 2009 describe Ms. Carter while in a kneeling position with hands locked behind her head leaning forward, only to break her fall with her hands before hitting the floor.[90]

[149] The many Incident Reports detailing intense frequent and unpredictable assaultive behaviour in relation to correctional staff and fellow patients begin, according to the documentation filed in with the June 13, 2009 assault with a weapon[91]

IX Correctional Service Canada Response to Head Banging and Assaults

A. Is there a Mental Health Response to Self-harming or Assaultive Behaviour?

[150] Mr. Ouellet, Corrections Manager, discussed the direction and training given to first responder correctional officers who intervene in an incident of self-harm such as head banging.[92]

A Well, obviously, give verbal direction just to cease her actions, whatever that action might be. If it's -- if it's banging your head on the floor, walls, self-harming through slashing, I mean, first -- first option is always engaging verbal intervention.

. . .

Q And if that works, then, what would be the next step, if she's actually stopped, based on the verbal interaction, does it then move to restraint, or what's the next step?

A Yeah. The -- the officers, just for lack of a better term, would take her into custody. Dependent on what she was doing and how long it took the verbal intervention to -- to stop her actions, they may place her in handcuffs and escort her back to the chair or her cell. Others may just gain control of her through a C-clamp[93] on the elbow and escort her back to the chair or her cell.

Q And if she's got an injury I suppose that she might have to get follow-up on an injury?

A Yeah. First, I mean, obviously dependent on how bad it is, first priority would be to, I guess, secure the area that you're going to be moving her to, and then have health care come in and look at it.

. . .

Q Now, is the approach different if an assault is in process? And, again, maybe it's a distinction between assault on a fellow inmate or an assault on a staff; if there is tell me if

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[90] Defence Binder Tab 1 - Exhibit D-1

[91] CSC Binder 1 of 2 - Exhibit P-3 - beginning at Tab 66 and continuing

[92] Pages 352 – 355 transcript

[93] The Court was told that a C-clamp is taking control of the elbow to assist in walking. If the person is going to pull her arm away, potentially to run or assault, it allows the officer to sense that.

there's a distinction, but if not what's the distinction between an assault versus her self-harming behaviour, in terms of the reaction?

A The reaction, I guess, depended on what the assault is or what -- how severe the assault is, but it would be the same: verbal intervention, telling her to cease her -- her actions, if she was attacking another staff member or another inmate, stop interactions. If she engaged and stopped, then they would take her into custody. Typically with an assault they would place her in handcuffs and escort her back to her cell.

Q And let's say verbally it's not working out, in any of those scenarios verbal instruction does not work, then what happens?

A Typically she would be given direct orders along with the verbal intervention. If those did not work, then typically what would happen is they would utilize their OC spray, their pepper spray.

. . .

A . . .if it's an assault they'll be putting her in restraints and escorting her back to her cell, or to the shower to decontaminate her.

Q And I presume the OC spray works, but maybe I ought not to presume that. So is there another – another level if that doesn't work?

A If that doesn't work, then, it will go into physical handling. And they'll utilize rear wrist locks, whatever the case may be.

Q And what is a rear wrist lock?

A It's just a -- a self-defence maneuver, wrist control maneuver to assist the officers in taking somebody into control.

. . .

It would just be a manipulation of the wrist, bending it, I guess, for lack of a better term, in -- inside. . .

[151] Mr. Ouellet confirmed that the management model for response to self-harming or assault is the same across Canada for all correctional facilities. Mental illness would be a factor as the officers analyze the situation and their response, as they're required to do.[94] Mr. Ouellet was asked whether the Commissioner's Directive for Management of Security Incidents (CD 567)[95] specifically speaks to the mentally ill patient and he did not believe that it did.

[152] Mr. Ouellet advised that correctional officers receive training to deal with mentally ill patients.[96] During the assault with a weapon trial held on September 19, 2012, the complainant, Ashley Tokarchuk, advised the Court that correctional officers receive four months of core training, two days of which are devoted to working with mentally ill patients.

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[94] Beginning at page 396 transcript
[95] See Appendix F for Commissioner' Directive #567
[96] Page 400 transcript

[153] He was questioned about the Situation Management Model (SMM) and whether the process of assessing a self-harming situation and formulating a response doesn't also require a clinically driven intervention and direction that mentally ill persons are not to be punished for their behaviours associated with mental illness. On a hypothetical Mr. Ouellet expected that the response to head banging would involve the same type of intervention, whether the individual was mentally ill or not.[97]

[154] CSC leaves it up to the staff person and inmate or patient as to whether they wish lay a criminal charge for an assault. The institutional response to Ms. Carter's assaultive behaviours has sometimes, not always, been Administrative Segregation.

[155] Mr. Ouellet would not charge Ms. Carter if he was assaulted by her. He stated:[98]

> Q And -- and why wouldn't you press charges against Marlene?
> A Taking into her mental illness, it just wouldn't be something that I would do.
> Q And why -- why is her mental illness a factor?
> A Because my own interactions with her tell me that at some times she doesn't know what she's doing. And that's not based on any medical thing; it's just my interactions . . .

[156] Ms. Madraga described being assaulted by Ms. Carter, but she chose not to alert the police.[99] She added that she has never feared for her personal safety and does not rely on the guards for that; rather that her personal safety is her responsibility. It was her overall feeling that the nursing staff generally, is comfortable working there.[100]

B. Administrative Segregation or Isolation under Intensive Psychiatric Care (IPC) and Restrictive Psychiatric Intervention (RPI)

[157] Mr. James Gonzo, has worked in a number of capacities for CSC and is very familiar with the manner of reporting on CSC files as well as the collection of information for an inmate's file. He discussed the types of female CSC facilities in the Prairie Region, including the RPC, security within facilities and the basis for assessing the risk level of individual inmates. He discussed sentence management and eligibility for forms of absences and as well as parole or early release and the role of the National Parole Board. With respect to Ms. Carter, he described the intake assessment and

[97] Page 397 transcript
[98] Page 404 transcript
[99] Page 772 transcript
[100] Page 787 transcript

development of a correctional plan, her risk factors, need for interventions and security ratings, as well as the programs she has completed successfully.

[158] For four years Mr. Gonzo has been the region's segregation oversight manager. He explained what took place in February2011 concerning Ms. Carter.[101]

> Ms. Carter was placed in segregation under Corrections and Conditional Release Act, Section 31(3)(a), and says it right at the top, "For reason jeopardizing the institution or others' safety." The CCRA allows Correctional Service of Canada to -- to place inmates in segregation for three reasons: 31(3)(a) is they've acted in a manner or intends to act in a manner that threatens and jeopardizes the safety and security of the penitentiary or of any person in the penitentiary;
>
> . . . Ms. Carter, in this case here, was put in segregation under 31(3)(a) after she assaulted another patient at the RPC; . . . So, as part of the review process for segregation, within five working days a fifth working day review must be held by the segregation review board at an institution to determine: Number one, if the segregation placement was lawful at the time; number two, if it remains lawful; and number three, if it remains necessary. . . In this case here, the decision was, in fact, to release Ms. Carter from segregation, that's the final decision on page 6. . . .

[159] Mr. Gonzo continued to discuss segregation at the RPC, the availability of other options and whether there's a limit to the amount of segregation time:

> RPC as -- as a psychiatric facility does have more options than -- than might a regular institution. . . you're not going to see segregation utilized as often as you might see it at other facilities; . . . Women, typically, when they are segregated, they're segregated for much, much shorter periods of time, because there are more options that they can utilize.
>
> THE COURT: What's -- how long can a person be segregated? Is there an upper limit?
> THE WITNESS: Is there a limit, no. . .the law requires me to get involved by day 60. For females offenders I typically -- it's just the way that I manage them, but I typically get involved by day 30, to make sure that the site is, in fact, looking for options for segregation for women.

[160] Mr. Ouellet, has worked at the RPC for about thirteen years, the last ten as a correctional manager. He is responsible for operations in the units in which Ms. Carter has been kept, first the Churchill Unit and recently the Assiniboia Unit and is familiar with her. He has been part of the

[101] Beginning at page 124 transcript. CSC Binder 2 of 2 Tab 138 - Exhibit P-4. Appendix E s. 31 *Corrections and Conditional Release Act*

management team concerned with Ms. Carter. He distinguished Administration Segregation from isolation:[102]

> . . . .administrative segregation is in their own cell. . . -- can be on -- placed on admin. seg. for any number of reasons. Typically it would be safety of the institution, and that being through assaulting another staff member or another inmate. Pending an investigation into whatever actions that we would be looking into. . .

He clarified that Administrative Segregation or Isolation describes a status not a location. A patient can be on either status in the same cell. An individual can also be dual status, Administrative Segregation and Restrictive Psychiatric Intervention (RPI) or Intensive Psychiatric Care (IPC).[103]

[161] Mr. Ouellet testified that from February 2013 to the date of his testimony, Ms. Carter had been in isolation, only.[104] The records filed with the Court indicate that he was mistaken; in May, June and July 2013 she was placed on Administrative Segregation.[105]

[162] On May 13, 2013, after attacking a fellow patient, she was placed on Administrative Segregation, the issuing officer being Mr. Ouellet. She was also placed on Restrictive Psychiatric Intervention (RPI) on the order of Dr. Baziany. This decision was reviewed on a Fifth Working Day Review, May 21, 2013, Mr. Ouellet, signed the notice of the recommendation that she be released from Administrative Segregation.[106]

[163] On June 3, 2013, Ms. Carter was again placed on Administrative Segregation after an attack on another patient. This was coupled with a Restrictive Psychiatric Care (RPI) order by Dr. Baziany. The notice to Ms. Carter was also signed by Mr. Ouellet. On the Fifth Working Day Review of June 10, 2013, Ms. Carter was released and as was the case in May, it was recommended that she continue on RPI.[107]

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[102] Page 408 transcript
[103] Pages 412-3 transcript
[104] Page 405 transcript
[105] CSC Binder 2 of 2 Tabs 178, 180 and 181 - Exhibit P-4
[106] CSC Binder 2 of 2 Tab 178 - Exhibit P-4
[107] CSC Binder 2 of 2 Tab 180 - Exhibit P-4

[164] On July 18, 2013, Ms. Carter was again placed on Administrative Segregation and Restrictive Psychiatric Care (RPI) after an attack on a staff member. This was reviewed on a Fifth Working Day Review on July 25, 2013, at which time she was released.[108]

[165] In each case of Administrative Segregation, discussed above, Ms. Carter was confined to her cell in "5 point" restraints for 23 hours a day and allowed a shower and exercise for one hour each day.

[166] Ms. Madraga, supervising nurse, recalled that Ms. Carter had been on Administrative Segregation this summer and estimated the total days at perhaps 20.[109] The above noted review of the documents filed with the Court indicate four occasions when Ms. Carter was on Administrative Segregation, once in February 2011[110] and three times in the summer of 2013. The Fifth Day Working Review typically amounts to seven actual days of segregation for the patient (inmate).

[167] She advised that currently Ms. Carter was on RPI status and was asked about the difference between IPC (Intensive Psychiatric Care) and RPI (Restrictive Psychiatric Intervention) status. She explained that IPC is more intense than RPI and compared IPC to ICU in a hospital setting. [111]

[168] Ms. Madraga advised that the first two years that Ms. Carter was at the RPC, she was on IPC status but for the last couple of years, it has been RPI status.

[169] However, even if Ms. Carter is on Restricted Psychiatric Intervention (RPI) status, she may nonetheless be isolated in her cell and restrained in the Broda Chair. Ms. Madraga explained:[112]

> Q One of the things I've been struggling to understand, and I think you've explained it somewhat, but if she's in the Broda Chair, and maybe it's a seven-point restraint, why does she also need to be in her cell at the same time?
> A That's all -- the RPI order states how much time she gets out of her cell, what kind of restraint she's in. And because of the nature of her self-harm, assaulting other patients, it's all tied in together into one plan. And the doctor will gradually increase her time out, to make sure that she can be around the other patients safely, be around staff safely, keep herself safe. And at the same time, not over-stimulate her too much. We've done that, where we've just let her out full-time, and it's -- we've noticed that it's been too much for her, the over-stimulation, and has caused her to be agitated, upset, distressed and bang her head,

[108] CSC Binder 2 of 2 Tab 181 - Exhibit P-4
[109] Page 754 transcript
[110] Page 753 transcript
[111] Page 753 transcript
[112] Page 843 transcript

too. So we always do a gradual from one hour to three to six to full-time out. So this time we're just kind of in the gradual process.

[170] Ms. Madraga was asked if these decisions to isolate her were made out of concern for the mood or acceptance of Ms. Carter by the other patients:[113]

> When she was assaulting patients in the summertime, we held her back. We still took her out of her room, but she was placed in an area where she could see them through the window -- a large window in our interview room, in the kitchen. Not in their living area, so that they could choose to be away from her if they didn't feel comfortable.

C. February 2011 – Incident Reports and Administrative Segregation

[171] In February 2011 Ms. Carter was placed on Administrative Segregation and other measures were taken, including certification pursuant to s. 24 of *The Mental Health Services Act.* What follows is a summary of the events in February: the behaviour which prompted the segregation and the actions taken. As it was a very intense month for head banging, these incidents have been noted. Assaultive behaviour has been noted in bold italics.[114] Some, not all of the assaultive behaviour was during staff intervention with respect to head banging.

> ***February 1*** - head banging in her cell. Placed in Broda Chair till supper.
>
> ***February 2*** - 24 hour nursing care to document seclusion and restraint every 30 minutes and psychiatric assessment every 72 hours to review isolation and restraint. Ms. Carter requested and received medication to calm her but head banged. She agreed to be in the Broda over count times.
>
> ***February 3*** - head banging in her cell. Officers brought in and stopped. Placed in Broda.
>
> ***February 4*** - head banging in her cell. Officers brought in and stopped. Placed in Broda.
>
> ***February 5*** - Ms. Carter ***grabbed an inmate by the hair and pulled her to the floor.*** "Inmate Carter was ordered to lockup due to her role as the aggressor in the fight which did she compliantly." Certified s. 24 *The Mental Health Services Act.*
>
> ***February 6*** - head banged until ordered to stop.
>
> ***February 7 - punched inmate three times in the face.*** Was cooperative with cell placement.

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[113] Page 844 transcript
[114] Defence Binder Time Line - Exhibit D-1. CSC Binder 2 of 2 Tab 143 - Exhibit P-4

February 8 - Ms. Carter ***attacked an inmate*** in the Day Room. She grabbed her, threw her to the ground and punched her in the face and head repeatedly. It was noted that Ms. Carter was on Administrative Segregation.[115] Filed with the Court is the "Offender's Segregated Status Fifth Working Day Review,[116] dated February 16, 2011. It states that she was placed on Administrative Segregation on February 9, 2011. In the reasons given it refers to assaults on the same inmate on Feb 7th and 8th. Release from segregation was recommended.

February 8 - head banging in her cell. Placed in Broda.

February 9 - head banging in her cell. Placed in Broda.

February 10 - Met with psychiatrist and advised worried about her boys and spoke of getting a message from the radio.

February 11 - Ms. Carter was currently under certification s. 24 of *The Mental Health Services Act.* The grounds of the two doctors state, among other things: OCD, organic psychosis, severe head banging behaviour which causes continued injury to her brain which possibly leads to more severe self-injurious behaviour.[117]

February 11 - Two spontaneous and one planned Uses of Force. OC spray used each of the three incidents. FSWERT involved and she was handcuffed and put in leg irons.

February 11 - head banging in cell. Refused Broda. Refused shower and exercise. Officers intervened. ***Assaulted officer*** as removed. Would not stop head-banging.

February 15 - Ms. Carter ***kicked a nurse in the back of the leg*** while being bed panned. Staff exited the cell with no further concerns.

February 17 - Advised of her husband's death. Asked for but denied compassionate ETA.

February 17 [118] - She was taken out of the Pinel Restraint System[119] for the purpose of personal hygiene. While being placed back in the System ***she began kicking her legs at an officer, striking her in the stomach area.*** She continued to kick, additional staff was called in and the shield was utilized to protect officer but she continued to kick. A correctional manager came in and after a brief verbal intervention she agreed to be placed on the restraint system compliantly and she was.

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[115] CSC Binder 2 of 2 Tab 136 - Exhibit P-4.
[116] CSC Binder 2 of 2 Tab 138 - Exhibit P-4
[117] Defence Binder Tab 39 - Exhibit D-1 - beginning at page 32
[118] CSC Binder 2 of 2 Tab 140 - Exhibit P-4
[119] The CSC acronym for the Pinel Restraint System is PRS

February 18[120] - While being moved from her Broda Chair to her bed and leg irons were being applied, she ***attempted to kick at staff.*** No contact was made.

February 19[121] - During exercise she head banged and was OC sprayed. She ***attempted to assault staff*** by lunging and swinging at them. "She was physically restrained and guided to the floor where she ***attempted a further assault*** by kicking toward a staff person's head. O.C. spray, physical handling and restraints were used to control her.

February 22 - restrained to bed for 48 hours with no showers or exercise - had been assaulting staff and fighting while being transferred from Broda to Pinel restraint.[122]

February 28 - banged head and placed in Broda.

[172] Ms. Kim Pate, Executive Director of the Elizabeth Fry Society was asked to and visited with Ms. Carter in February or March 2011.[123] Ms. Carter advised her that she'd been in Intensive Psychiatric Care and restraints for two weeks; when in fact Ms. Pate's investigation revealed that she'd been in that situation for closer to six weeks.[124] Ms. Carter complained then of muscle deterioration; she was having trouble moving and getting around. In order to meet with Ms. Carter, Ms. Pate sat on a chair outside Ms. Carter's cell and spoke with her through the meal slot. It was very awkward as Ms. Carter was in four or five point restraints; hands and feet were restrained and they had propped up her head so that they could make eye contact through the meal slot. Ms. Pate's view of Ms. Carter was not in keeping with maintaining her dignity (looking as she was between her legs and Ms. Carter was clad in a hospital gown). According to Ms. Pate, "she was clearly in a fair bit of distress." She advised Dr. Ivan Zinger of the Officer of the Correctional Investigator of her concerns.

D. Consent to Treatment and Certification

[173] Dr. Mela was asked to explain the uses of isolation under IPC and the ability to place someone in IPC without their consent or certification under *The Mental Health Services Act*:[125]

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[120] CSC Binder 2 of 2 Tab 141 - Exhibit P-4
[121] CSC Binder 2 of 2 Tab 142 - Exhibit P-4
[122] Defence Binder Tab 42 - Exhibit D-1 - Dr. Mela's Progress Notes of February 22-23, 2011
[123] Beginning at page 918 transcript
[124] Page 927 transcript
[125] IPC is Intensive Psychiatric Care. Administrative Segregation is ordered by the institution head pursuant to s. 31(3)(a) of the *Corrections and Conditional Release Act* found in Appendix E.

A . . . according to the IPC, a psychiatrist has -- I guess, has the ability to contain the aggressive self-harming behaviour by ordering the IPC on somebody like Marlene. There may be some treatment that you may need to certify her before you actually administer that. So like medication, she would not be forced to take medication, except she is certified. But being in the cell itself, in the room, I guess, administratively restrained or restriction to her liberty, I think is allowed by the IPC order.
Q And the IPC order would be made by the psychiatrist?
A That's correct.[126]

[174] Dr. Mela was asked for the criteria for IPC:[127]

A The criteria is somebody has a mental disorder, which contributes to an increase in the risk to himself or herself or to others.

[175] He acknowledged imposing IPC to avoid an administrative segregation. [128] On February 11, 2011 while in Administrative Segregation, Ms. Carter was also certified under *The Mental Health Services Act* and released from segregation.[129]

E. Certification under *The Mental Services Health Act*

[176] Dr. Olajide Adelugba has worked as a psychiatrist at the RPC since 2000. He was involved with Ms. Carter's care at the RPC over the years and certainly in: March 2006, June 2009, May 2012.

[177] He described the certification process and its use at the RPC[130] and explained that patients attend at the RPC voluntarily.

> At the Regional Psych Centre, all the patients are there voluntarily. They are there because they want to be there. If at any point in time a patient does not want to stay at RPC, she might just ask to be discharged and she will be discharged. So for RPC, because it is a treatment facility and a psychiatric centre, if a patient is there, and the patient requires treatment, she will go through the same (inaudible) process as if she was in a community hospital.

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[126] Page 1153 transcript
[127] Page 1193 transcript
[128] Page 1203 transcript
[129] CSC Binder 2 of 2 Tab 138 -Exhibit P-4
[130] Beginning at page 1052 transcript and Defence Binder Tab 39 - Exhibit D-1 - beginning at page 32

[178] The evidence revealed that if Ms. Carter removed her consent to treatment and provided she met the criteria, she could be certified under *The Mental Health Services Act* and possibly for consecutive 21 day periods.[131]

[179] For the purposes of the Court, certification is a reflection of the level of understanding or functioning of Ms. Carter as well as her treatment. Materials filed indicate that Ms. Carter was certified in October 2010,[132] on February 5, 2011,[133] on March 29, 2011,[134] in May 2011,[135] in July 2011,[136] September 2011[137] and October 2011[138].

[180] Being certified pursuant to s. 24 of *The Mental Health Services Act* requires that two physicians, at least one of whom is a psychiatrist, examine the person within the preceding 72 hours and state that (i) the person is suffering from a mental disorder as a result of which he/she is in need of treatment or care in an in-patient facility, and that as a result of the mental disorder the person is (ii) unable to fully understand and make informed decisions regarding treatment or care and supervision, and (iii) likely to cause harm to her/himself or others or suffer substantial mental or physical deterioration if not detained in an in-patient facility. [139]

F. Cell Conditions

[181] Ms. Carter has spent the great majority of her time in her cell, whether on Administrative Segregation and/or IPC and RPI. Jennifer Balicki, a social worker at the RPC, was asked to describe the cell conditions in the IPC area of the Churchill Unit where she said Ms. Carter has been housed virtually all of the time while at the RPC:[140]

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[131] Pertinent excerpts of *The Mental Health Services Act* may be found in Appendix C
[132] Defence Binder Tab 31 -Exhibit D-1
[133] Defence Binder Tab 39 - Exhibit D-1
[134] Defence Binder Tab 39 - Exhibit D-1
[135] Defence Binder Tab 45 - Exhibit D-1 - page 23 of scanned CRIMP, dated June 20, 2011 – reference to mental health certification in May 11, 2011 entry.
[136] Defence Binder Tab 36 - Exhibit D-1 - page 58 of pdf – RPC Multiple Self-Harmer Update – 2011-07-29 "Her status remains Certified under the Saskatchewan Mental Health Act. . ."
[137] Defence Binder Tab 36 - Exhibit D-1 - RPC Multiple Self-Harmer Update 2011-09-30
[138] Defence Binder Tab 37 - Exhibit D-1
[139] Pertinent excerpts of The Mental Health Services Act may be found in Appendix C
[140] Page 300 transcript. About the time of the hearing in October 2013, her counsel was told that Ms. Carter had been moved to the Assiniboia Unit where conditions are improved.

Q And this is a description that the office of the correctional investigator relied upon. It was made by the CSC National Board of Investigation from 2009, and noted the following physical infrastructure concerns, this is with regards to the IPC unit at Churchill. It said the physical structure of Churchill Unit, especially the IPC area was not conducive to meaningful therapeutic intervention. There are three cells and a shower along a narrow hallway. The cells had no windows to outside light.[141] There was little privacy as there was no interview room capabilities in the IPC and conversation and interviews at times had to take place through the hatch in the cell door. Would you agree with that description of the IPC area?

A I would. I'd make some changes. If a patient needs to come out of their cell there was interview rooms to go into, but if for whatever reason they couldn't come out of their cell he would be speaking through the hatch to them.

[182] In response to a question from the Court about the concrete bed platform and changes in the new Assiniboia Unit, Ms. Balicki advised:[142]

> It's changed slightly. In Churchill it was the concrete floor and then there would be a raised part which would be the bed. And then they'd be given an IPC mattress, so I guess a mattress that couldn't be ripped or torn or tampered with. And they can -- and then a blanket and then baby dolls if they need. There has also been times where they've been in those cells and be – been given standard institutional mattresses, I guess, is the best way to describe them.
>
> . . .
>
> They're -- they're given something to put on top of the concrete slab. In Assiniboia there's a concrete floor, and then now it's a hard piece of plastic that is raised that they could put the IPC mattress or a regular mattress on now.

[183] Ms. Balicki was also asked to describe the "baby dolls":[143]

A Baby doll for us would be -- it's made out of a material, again, that isn't something that could be ripped to use to self-harm. They've also been modified with velcro on the shoulders and down the sides, and that has been because some patients have twisted them around their neck. . . a type of a suicide gown . . . it covers like a tank top, I guess, and then it would come down below the knees. It's kind of like a dress.

[184] Supervising nurse, Ms. Madraga, described the new cell and bed in the Assiniboia as well:[144]

A She's in a -- we're on a new unit, so she's in a brand new cell. It's -- we call it IPC. It's just an area, because it's a cameraed cell, so we can watch her for head banging. . .I have put a hospital bed in her cell. And a couple years ago, I ordered a special mattress for her, so she

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[141] Cells in the new Assiniboia Unit all have outside windows – Page 334 transcript Examination of J. Ouellet
[142] Pages 300 and 304 of the transcript
[143] Page 305 transcript
[144] Page 754 transcript

has a special pressure mattress, because she spends a lot of time in her bed. . . It helps to prevent bed sores, pressure sores. It's cleaner. I can wash it. More comfortable for her. It's a gel mattress that we special ordered for Marlene.

Q And that mattress, or that bed, allows for the same restraints that we see in the Broda Chair?

A Yes.

G. Effect of Isolation on Mental Health

[185] Dr. Lohrasbe testified generally regarding the effect of isolation:[145]

> The greater the degree of isolation for any human being the more negative the impact on mental health. And for those who may already have any kind of a suicidal tendency or history it's likely to exacerbate it.

[186] He recommended breaks from isolation which allow for interactions to counter the effects of the isolation. He was asked his opinion about the effect of isolation on Ms. Carter:[146]

> Intuitively, I would say that this is a woman who has become progressively cut off, you know, from those who've been important to her. And so she does not have the inner resources to tolerate isolation as much as someone who hasn't gone through those kinds of experiences; . . .
>
> . . .
>
> Q And to be in isolation and to hear voices, . . .what would that do to a person?
>
> A Again, not good. We -- we know for sure that isolating someone, anyone, is a bad idea, in terms of their mental health. . . . the degree of isolation matters, you know, the length of time, the particular circumstances and so on; but the more unstable the person is, the worse the effects of isolation, as a general principle.

[187] Dr. Lohrasbe discussed more humane alternatives to isolation:[147]

> . . . when I've had to deal with it I've -- I've pushed the limits of the chemical restraint as much as I can, unfortunately resources within hospital units, whether in or out of hospital, don't allow, for instance, for a one-to-one care, most of the time. Ideally, the -- the more humane, to answer your question, would be to not allow a person to be alone for lengthy periods of time, to -- to have someone, that could be anyone, an art therapist, a teacher, just a companion of some kind. Yes, that -- that would be much more humane.

[188] Dr. Mela was asked to describe the effect of isolation on Ms. Carter's mental health:[148]

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[145] Page 613 transcript
[146] Page 618 transcript
[147] Page 621 transcript

> We know the -- I know that at the time, we saw some of her behaviours as if she was feeling the impact of being alone, as if she needed people to be around. I mean, there were times where she didn't want anybody around, but there were times that I felt that the -- being alone was contributing to some of the increased behaviour that she was expressing and manifesting. Also, there was a time that -- I thought, anyway, that being on -- being in isolation was beginning to produce certain symptoms we hadn't seen before. So for instance, she would hear, at the time, a voice out of the radio that was playing in her room. I hadn't heard that before she went into isolation. Whether that is directly linked or not, I can't say, but obviously we observed her during the time.

[189] Dr. Mela described the effect of isolation on Ms. Carter's self-esteem:[149]

> Well, the room itself, is a room that is usually bare. And so, without any property, without any effects, like books or tables or clothes, you begin to see yourself as if you really have nothing. And that could affect anybody's self-esteem. But specifically in Marlene, I felt that just the ongoing behavioural difficulties, the un-abating use of those measures that were being used, was probably contributed to by the self-esteem that was lowered.

[190] Ms. Madraga, the supervising nurse, stated that all of the women on the Churchill Unit have self-esteem problems.[150]

[191] It was suggested to Dr. Mela that as Ms. Carter's psychiatrist he was in a catch-22, wanting her to have treatment without restraints but preventing the head banging and he replied that it was a matter of resources:

> Well, there was a bit of that at the time, although it was, again, my opinion at that time, maybe that we could still have been able to prevent the head banging, had we got the right resources.

[192] February 22, 2011, in Progress Notes concerning Ms. Carter, Dr. Mela noted that Ms. Carter had been restrained to her bed for 48 hours[151]. He noted that a clinical decision was to be made that day as to whether she can be released. He wrote:

> It looks likely she could be managed without continuous restraint if clinical staff is available and able to allow her some time of exercise.

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[148] Beginning at page 1151 transcript
[149] Page 1155 transcript
[150] Page 782 transcript
[151] Defense Binder Tab 42 - Exhibit D-1 - Dr. Mela Progress Note February 22/11

[193] Dr. Lohrasbe was asked whether Ms. Carter while in isolation, and craving human contact, wouldn't be creating situations for that contact by head banging:[152]

> Q . . . the theory being is that she gets to be rewarded for the head banging by getting human contact, and as well as the further sacrifice of -- of more pain and dealing with the guards. And so it acts as sort of a perverse conditioning process. Does that make any sense to you at all?
> A Yes, it does. I mean, you're describing what all parents know, that if a -- if a child isn't given adequate amounts of positive attention they will attract attention in some other way. Any attention is better than no attention for most human beings. And for those who are feeling particularly vulnerable or isolated, yes. So it's not an unreasonable theory of one factor that may be influencing that behaviour.
> Q And it's probably way more complex than that?
> A It is.

H. Pinel Restraint System (PRS)[153]

[194] Mr. Ouellet, corrections manager, described the PRS.[154] It's a completely flat stretcher with slots cut out on the side to permit carrying. There are restraints for the wrists, legs, ankles, waist and shoulders. More commonly it's used to restrain inmates to a bed.

[195] Mr. Ouellet described the different forms of the PRS have been used with Ms. Carter because she spent so much time restrained in this fashion.[155] At first they placed the PRS on top of a regular bed. The bed was then moved out and the Pinel Board was placed on top of a pad on the floor.

[196] Nursing supervisor, Ms. Madraga explained that as she has spent so much time restrained on the Pinel Board, a hospital bed was brought in:[156]

> When she first came to RPC, for the first six to eight months, we were just getting to realize that the board is just -- we use the board for temporary placements, for people that are engaging in self-harm. She was spending so much time on that, we realized that this is ongoing for her, it's

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[152] Page 698 transcript
[153] Defence Binder Tab 39 - Exhibit D-1 and see Appendix N, *Risky Business,* page 10, The Pinel Restraint System (PRS) is an approved device listed in the Security Equipment Manual intended to temporarily restrict or limit free movement. The PRS is identified in the Manual as a "medical restraining device." It is a system of restraining belts or straps that attach to a bed, chair, or stretcher that allows for incremental restraint. The seven-point Pinel Restraint System consists of up to seven different belts and/or straps (i.e., 4 limb belts, waist belt, pelvic belt and shoulder belt). According to CSC policy, the use of the PRS "is an intervention to preserve life and is not a medical treatment."
[154] Page 324 transcript
[155] I noted at paragraph 168 above that Ms. Balicki spoke of the Pinel Board being on a hard concrete surface at first.
[156] Mr. Ouellet - page 330 and Ms. Madraga – page 766 transcript

not something that's just sporadic here and there. It's all the time, all day. We needed to do something else. We started to use a bed -- a hospital bed in her cell, and then got the Broda Chair.

[197] Ms. Madraga described what it was like to rely on the Pinel Board or PRS before the Broda Chair was brought in. She begins by describing Ms. Carter's head banging behaviour:[157]

When I first started, it was the worst that I had ever seen her. We didn't have a Broda Chair back then either, so she was in her cell or on the board. That was our only options back then.

I. Broda Chair

[198] Ms. Madraga said that the hospital bed and Broda Chair were likely introduced in early 2010:[158]

. . . we realized that she was going to be banging her head a lot at every opportunity. It wasn't stopping, it wasn't going away. So we – we wanted her to be out of her cell. We didn't want to keep her isolated for hurting herself. We don't keep people isolated for hurting themselves, as much as we can, so we wanted her out of her cell with others, but still be safe.

Q And when was it that the Broda Chair, the idea to bring one of those came in?
A 2010 maybe.

[199] Mr. Ouellet described the Broda Chair.[159] It's very similar to the PRS as it allows restraint at the wrists, ankles, waist, and shoulder. He advised that since they've had the Broda Chair and in particular since February of 2013, the PRS (Pinel board) has not been needed because the Broda Chair completes the same purpose.[160]

[200] The degree to which Ms. Carter can be restrained in the Broda or in the PRS, according to Ms. Ouellet is determined on a doctor's order.[161]

[201] Nursing Supervisor, Madraga discussed the implementation of the points of restraint, explaining that Marlene is kept in three points of restraint routinely:[162]

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[157] Page 763 transcript
[158] Pages 764 and 766 transcript
[159] Page 326 transcript
[160] Page 362 transcript
[161] Page 419 transcript
[162] Page 761 transcript

A No. Nurses are only allowed to order three-point restraints if someone is engaging in self-harm. That's really a moot point for Marlene, because she's already in those.
A If she's engaging in self-harm, she's already in three-points, we would call the psychiatrist on-call to see what we could do to increase it, to stop her.

[202] Ms. Madraga was asked if there have been times when Ms. Carter has not been in restraints:[163]

A There's been various times throughout the four years, yes, where she's been in no restraints for periods of time in the day. In the daytime, no restraints for -- with restraints at nighttime only. Restraints only when she's locked. And there was a period of time where she was living as a normal offender, with no restraints, living in the day room for six months, I think.

[203] She was asked to explain "restraints only when locked", saying that the door to the cell may be the only restraint or she may be locked in her cell and also restrained for instance in her Broda Chair:[164]

When she's in her cell. Like, the inmates have locked times. They have to be locked at nighttime, and then at count, which is noon and supper. And we've done that, where we've only restrained her during that time, as being in her cell alone.

J. Medical use of the PRS and Broda Chair

[204] The Defence filed unsigned nursing evaluations with respect to the use of both the PRS and the Broda Chair for the months of February and March of 2011. These documents indicate generally speaking that pursuant to doctor's orders Ms. Carter was restrained in either the PRS or the Broda Chair with day room time as may be tolerated, provided that she was restrained when in the day room at all times. The number of points of restraint was sometimes noted, as well as the review. The documents filed indicate virtually daily attention or review of the use of restraints by medical staff.

K. Effect of Restraints on Physical and Mental Health

[205] Ms. Madraga, Supervising Nurse, explained the physical problems associated with being in restraints:[165]

[163] Page 762 transcript
[164] Page 762 transcript
[165] Page 771 transcript

From a medical nursing standpoint, it's very concerning. We don't want to have her in restraints. We don't want her muscles to deteriorate. We don't want her to have her pressure sores or her toilet concerns, or her hygiene concerns.

[206] She discussed the importance of exercise, when in restraints:[166]

Q And now, outside of her cell, you talked about one hour of the exercise time where she's handcuffed, but she walks around?

A She has free movement. That's very important for me and the nursing staff, and the psychiatrist and medical doctors, is that we provide her with at least some time of walking. Being restrained is concerning for her muscles, her bones, her body.

. . .

. . . She also gets time out of her cell in her Broda Chair with her peers. We want to provide her with a social interaction with her peers, that she -- is very important to her. She's voiced that. She likes to be around the other women.

. . .

A The psychiatrist orders for Marlene are basically her restraint, the points of restraints and her time out. The nursing staff, yes, we do work outside of that -- outside of the box for her when it comes to items that she has. If we feel that she's having a good day, and we would keep her out of her cell for longer than that designated time. Provided, we would just give him a call and let him know. There's a lot of discretion with Marlene, with nurses . . . most of the nurses that work there know her very well, and if she's having a really good day, there's no point in putting her back in her room. So she gets more time sometimes. Or if it's not going well, vice versa, they'll call the doctor and -- they'll put her back and just give him a call and say this is what's going on, and he'll say yes.

[207] Ms. Carter was referred for a medical assessment regarding complaint of back pain and weight gain, leading to problems with posture due to restraint in chair for over 8 months.[167]

L. Transfers and Removal of Restraints

[208] A high number of the incidents of head banging or assault take place during transfers from one form of restraint to another as Ms. Carter is moved or about to engage in what is intended to be routine tasks such as showers and exercise. Mr. Ouellet, corrections manager, described the process of removing and reapplying restraints before and after exercise and in the case of a shower, in the shower area. It typically involves three or four officers, depending upon her demeanour, who would move her from a bed or Broda Chair to a broda-like shower chair and back again.

[166] Pages 757 to 760 transcript
[167] Defence Binder Tab 6 - Exhibit D-1 at page 17 of the scan, letter from Dr. D. Fladland, dated December 1, 2010.

M. s. 128 of the *Canada Labour Code* and the Institutional Emergency Response Team (IERT)[168]

[209] At the RPC, the Women's IERT may be invoked by a single employee who feels that the work place is unsafe due to Ms. Carter's propensity for self-harming and assault. This may be despite the fact that the IERT approach is regarded as excessive and unnecessary by management. Mr. Ouellet, corrections manager, helped the court understand the interplay between s. 128 of the *Canada Labour Code*[169] and the IERT when he was asked about a specific incident in it as used to move Ms. Carter from the Pinel Restraint Bed to the Broda Chair on June 29, 2010.[170]

> Q -- it looks like associate executive director has personally viewed the video support -- supporting documents in this incident and stated this was not the least restrictive method, but was required as staff had lawfully invoked Section 128, compliant with the Canada Labour Code, part 2, . . . could be -- institutionally could not force staff to do the duties. The ERT was deployed via the SAMEAC. . . .
>
> Q And could you tell the Court what is meant by this reference that this was not the least restrictive method? What are the least restrictive use of force principle, could you describe that?
>
> A . . . the correctional officers on the floor – given direction to move or deal with inmate Carter, for whatever the situation might have been for this -- this particular one. Staff felt it was unsafe, based on whatever was happening prior to that, assaults on staff, but . . .128 falls under the *Canada Labour Code*, basically, safety of staff. And not being allowed to put staff in safety -- if they feel their safety is at risk, they can invoke 127, which is a first level of that process. 128 is this next step where the 127 couldn't be worked out and agreed upon. For example, if the staff said, what you want us to do -- deal with this inmate with two staff members, give us four staff members and we'll finish what you're asking us to do. Whatever this situation was they couldn't come to that, so the staff invoked 128. That brings in HRDC Human -- Human Resources Development Canada. They'll send an investigating officer, but in the meantime what you are trying to accomplish still has to get done. If that means moving her from another cell, then, the executive director can authorize the female ERT team to do that. And -- and that is because the staff are refusing to do their duties, pursuant to Section 128 of the *Canada Labour Code* (sic); is that right?
>
> A Correct.
>
> Q And I think in this case the -- could we refer to it as the team, or how -- how do you refer to it, the --
>
> A Female ERT team, female emergency response team.

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[168] IERT is a CSC acronym for Institutional Emergency Response Team. It is sometimes called FIERT or Female Institutional Emergency Response Team.

[169] s. 128 of the Canada Labour Code is contained in Appendix D

[170] Page 378 transcript and CSC Binder 1 of 2 Tab 22 - Exhibit P-3. FSW-ERT is another acronym for the same IERT for women.

Q Okay, the female emergency response team. And so they would have been brought in, because if they hadn't been brought in nobody -- nobody would have done anything further with regards to their job; is that right?
A Correct.

[210] Dr. Sojonky discussed the conflict between the goals of the clinical team and the safety concerns of some corrections officers who despite encouragement from the deputy warden would rely upon s. 128 of the *Canada Labour Code*, maintaining that it was unsafe to work with Ms. Carter without safety precautions, which included engaging the IERT. The Office of the Correctional Investigator of Canada regarded this measure as extraordinary and unnecessary, discussed below.[171]

[211] Dr. Sojonky described the appearance of IERT:[172]

> . . . utilizing a team that's trained with all sorts of devices, shields, helmets, OC spray, clubs, batons, and four of them would come dressed in full gear. . . And they would send a team of four of those officers dressed in full gear to remove Marlene from her room, in order to complete an exercise program.

[212] Mr. Ouellet also discussed the Women's IERT, adding:[173]

A I believe the number is six with a . . .including a camera person. . . And the team leader.
. . .
Q They're there to basically get the situation under control; is that right?
A Yes.
Q And the reason that there's so many of them is – is the advantage of overwhelming force; is that correct?
A No. The number, basically, is dictated by the jobs that everybody will have assigned. And, basically, it's rear guard, front guard, right side, left side. And they're each going to utilize a limb or a tactic to take that situation under control. And the team leader, by my experience, is the one that does all the verbal intervention, giving the verbal direction. And the camera person is there just strictly to operate the camera.

[213] Dr. Sojonky was inclined to praise corrections officers, especially those who went above and beyond and became involved with the patients. Nurse Madraga agreed that a lot of the guards care about the clinical treatment plan. Since Dr. Sojonky's time it would seem, they now have dedicated

[171] Defense Binder Tab 8 - Exhibit D-1 - Office of the Correctional Investigator of Canada letter from Ivan Zinger, Executive Director and General Counsel to the Minister
[172] Page 1224 transcript
[173] Page 386 transcript

guards who work in the Women's Unit. He had expressed concern about the rotation of guards from all over the RPC into the Churchill Unit.[174]

[214] Dr. Sojonky felt that Correctional Service Canada did not have enough psychologists who specialize in therapy and who have the time to work all day with patients; rather they must devote a good deal of their time to "risk assessments". Finally he acknowledged that Ms. Carter needs someone who can work with her almost every day, seven days of the week.

[215] Ms. Madraga, the supervising nurse, told the Court in October 2013 that IERT had been used once in the last year.[175]

N. When is Use of Force Reported?

[216] Mr. Ouellet was asked to explain the reporting requirements when there has been a "use of force" as he is in charge of ensuring that reports of "use of force" are completed and reviewed. He focussed on the soliciting of consent which if given is not a reportable "use of force":[176]

A Well, there are different -- different types of incidents that are reportable or -- or non-reportable, yes.
Q For example, if something is deemed to be a treatment, a medical treatment, that's not considered a reportable use of force; is that correct?
A In different circumstances, yes.
Q So, say, placing Marlene onto the Pinel board, would --- would not be considered a use of force, a reportable use of force?
A Dependent on the circumstances on that placement on the Pinel restraint system.
Q And -- and -- so what would those circumstances be?
A If she was compliant with all of the direction given to her, as far as being placed on the Pinel restraint system, and she went compliantly on the Pinel restraint system, then, that would be considered non-reportable.
Q And -- and when you're placing her on the Pinel support system, how do you get her consent for that treatment?
A Verbalizing it.
21 Q And -- and what do you mean by verbalizing? Could you describe what would be said?
A Well, if -- she'd be placed on the Pinel restraint system due to a reason. If that's banging her head on the floor or the wall, her actions, you get her to cease her actions. Immediately the nurses can authorize up to a three point Pinel placement system. So she would be

[174] Page 1229 transcript
[175] Page 829 transcript
[176] Beginning at page 369 transcript

strapped in three points of restraint. Psychiatrists or the on-call doctor can authorize up to seven points. So you would -- if -- if time permitted and I was called down there I would ask her, if not, the officers would ask her: Marlene, we've got authorization to put you on the Pinel restraint system; are you going to comply with our directions? And if she verbalized yes and during the placement there was no use of force, she did comply with all their direction, then that would be considered non-reportable.

Q And so it's not a consideration as to whether you need to -- if you have authorization you don't need her consent; is that correct?

A Well, generally -- generally speaking, the consent -- the consent is always asked for, based on trying to determine her mindset at the time, and if she is going to comply with the placement. If she answers no, she's not going to comply with the placement, that would open up the negotiation process, basically, and you would try to gain her compliance, and the reasons for that placement.

. . .

O. OC Spray Use

[217] Mr. Ouellet described the permitted use of OC spray:[177]

OC spray is more commonly referred to as pepper spray. Officers are allowed to carry it on their duty belt and utilize it where it's deemed appropriate, based on the situation management model that's issued by Correctional Service of Canada.

[218] He was asked how many times OC spray has been used in relation to Ms. Carter, and in particular if 35 sounds correct. He couldn't say but he knew it was a large number.[178]

[219] He was asked if the guards are trained to aim the OC spray for the facial area and he agreed.[179] He also agreed that it would be uncomfortable on an open sore, such as Ms. Carter often has on her forehead but he'd had no personal experience with being the subject of OC spray.[180]

[220] Mr. Ouellet went on to explain the situation management model, which is in use nationwide and is a contained in the Use of Force Commissioner's Directive.[181]Correctional Service Canada Commissioner's Directives deal with the use of force and the use of OC spray.[182]It contains directions for consultation with a health care professional before use, unless the delay would result in bodily harm

[177] Page 323 transcript
[178] Page 375 transcript
[179] Page 392 transcript
[180] Page 392 transcript
[181] CSC Commissioner's Directive concerning the Use of Force is at Appendix G
[182] CSC Commissioner's Directive concerning the Use of OC Spray is at Appendix I

or jeopardize the security of the institution. Videotaping its use is required provided time and circumstances permit. A health care professional is to examine the patient as soon as possible following use on the inmate. A Use of Force Report is required of all staff involved in the use of the OC spray. A review of the documents filed with the Court would indicate routine use of OC spray at the RPC in 2010 and 2011 during self-harming incidents involving Ms. Carter. From time to time the medical team intervened to limit its use until is ceased to be used altogether. Ms. Madraga testified that OC spray has not been used on Ms. Carter in a long time.[183]

[221] Dr. Sojonky was asked to describe the effect of the OC spray on Ms. Carter:[184]

> A I -- one recollection that's quite vivid is, after she was sprayed and showered, they let me sit with her out in the open area, because she was burning. Her face was swollen and it was red, and she couldn't stop the pain. So we sat outside and I used a towel to fan her.
> Q And how many times was OC spray used while you were on the unit?
> A . . . at one point, Marlene was sprayed seven days in a row.

P. OC Spray Effect on Mental Health

[222] Dr. Mansfield Mela who was significantly involved in the management of Ms. Carter's mental health care from 2009 to 2011 expressed concern about the use of OC spray by correctional officers to bring an end to a self-harming incident. In October 2010, Dr. Mela informed the Office of the Correctional Investigator that he certified Ms. Carter so that she would be treated as a clinical patient and the psychiatrist's orders not to use OC or with respect to restraints would be respected.[185] He also began exploring other options, such as the use of a helmet and the building of a padded cell.[186]This concern is further evidenced in his Progress Notes of February 23, 2011.[187]

> Progress Notes
> Date: 2011 February 23
> . . . During head banging she has been OC sprayed. This by suggestion that this creates more harm. It is difficult to see how the use of OC spray is going to be stopped since it is out of clinical control.

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[183] Page 825 transcript
[184] Page 1238 of the transcript
[185] Defence Binder Tab 31 - Exhibit D-1 Running Record Office of the Correctional Investigator
[186] Defence Binder Tab 37 and Defence Binder Tab 58 - Exhibit D-1
[187] Defence Binder Tab 42 - Exhibit D-1 - Dr. Mela's Progress Notes Feb 22 & 23, 2011

[223] He was asked about his concerns at the hearing.[188]

> A Well, at the time, it was used when staff were trying to stop her from banging her head. So when she starts, then I think they will call out to get her to stop, and then when she doesn't, the OC spray was being used as a way to stop her from doing it. So that's what I understood the OC spray to be used for. I was concerned at the time that it wasn't working, and of course, it has some -- it causes some difficulties in terms of how, I guess, the pain that she goes through when she's sprayed with it. But it wasn't stopping it, in terms of either immediately stopping it or subsequently preventing the self-harm. So I was just indicating -- and once the OC spray comes into being, it takes a while to get her showered, and then when she's calm, it takes longer before clinical intervention can be brought in. So I was concerned that that was kind of putting her away from what she needed, which is the clinical intervention. . .
>
> . . .
>
> Q. . . how much effort did you expend in trying to get the staff to limit their use of OC spray?
>
> A More expressing my frustration to the clinical side, because that's where it would be listened to. I mean, my understanding at the time was that this was a national policy. And I recall, during the time, discussing with some of my other colleagues around the country, on whether they've experienced OC spray in hospitals. And their view is that, no. So I think, I -- I recall having discussions with, like, the other psychiatrists, just indicating that, you know, I didn't think that it was a useful way of treating mentally ill people. But I couldn't do more – I don't recall doing more than that.
>
> Q And were you disturbed, at the time, by the use of OC spray on -- on Marlene?
>
> A My personal view is that I don't think we should have OC spray in the mental hospitals. So I don't think it was specific to Marlene, alone. I just had a general opinion about OC spray in the mental hospital.

[224] Ms. Carter's head banging, according to Ms. Madraga, has been a source of stress for the staff at the RPC; some have sought counselling.[189]

X Treatment for Ms. Carter in Correctional Service Canada

A. Remand Status

[225] In the time that Ms. Carter has been on remand (since December 6, 2011) she has not been able to participate in a correctional plan, according to Mr. Gonzo:[190] The Court was informed by Counsel for the Attorney General of Canada that while on remand status Correctional Service Canada did not feel it had the authority to transfer Ms. Carter to an outside facility, in the discussion, Brockville.

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[188] Beginning at page 1140 and continuing on page 1142 of the transcript
[189] Page 832 transcript
[190] Transcript page 140

Q And now that she would be on remand there wouldn't be a correctional plan in place, so to say?
A No, no. I mean, the only -- the only information that typically we'd be entering into the offender management system for remanded inmates would be segregation placements and reviews, memos to file, for a variety of different reasons, incident reports, and institutional charges, but we're not going to be entering correctional plans or criminal profile reports, because -- because they're not a -- serving a federal sentence at that point.

[226] However, Ms. Chopty, an institutional parole officer employed at the RPC, testified that while on remand Ms. Carter is essentially eligible for the DBT[191] program, then she said that she'd have to consult with her bosses. She would not recommend Ms. Carter for the DBT or the Intensive Healing programs because she's not stable enough.[192]

[227] It would seem, considering the discussion about DBT and the therapy offered by Dr. Sojonky, below, that the positive therapeutic relationship has been the key to Ms. Carter's successes in the past.

B. Dialectical Behaviour Therapy (DBT) and Cognitive Behaviour Therapy with Dr. Sojonky

[228] Ms. Carter was first involved with Dialectical Behaviour Therapy while serving at the Edmonton Institution for Women in 2005 and 2006[193]. In a June 17, 2005 Final Program Performance Report the author described the program:

> The Dialectical Behaviour Therapy (DBT) Skills Training Program is offered in two sections, delivered over a period of a minimum of 5 months with approximately 50 lessons. This program is based on a cognitive-behavioural approach and the goal of therapy is to restructure troubling and irrational thoughts, perceptions and beliefs. This goal is achieved through teaching participants skills which they can use and generalize to situations specific to their own lives. DBT is a therapy designed to present a variety of skills with the intention of improving the participants' quality of life as they define it. . . .

[229] With respect to her participation in DBT in 2005, the report author noted that Marlene was banging her nose on the ground, but no details regarding incidence or time frame were given; writing at page 2 under Emotion Regulation:

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[191] DBT is Dialectical Behaviour Therapy, discussed below.
[192] Transcript page 433
[193] CSC Binder 1 of 2 Tabs 54, 55 and 64 - Exhibit P-3 - document her participation in DBT in Edmonton in 2005 and 2006.

> . . . Marlene views her psychosis as "bad thoughts" and fears the positive symptoms. She has coped with her thoughts by banging her nose on the ground. She has set a DBT case conference review goal to access staff when she experiences these thoughts to talk, which she followed through with and she reported that it helped diminish the thoughts. Marlene also journals and meets regularly with the psychologist and psychiatric nurse. Marlene has sought to fit into the social activities on the unit and in general population and has at times changed her behaviour positively to be more personable.

[230] The author reported that Ms. Carter wished to be transferred to the RPC where she expected to be closer to her children and busier with programming that is more suited to her.

[231] When Ms. Carter participated in DBT at Edmonton Institution for Women again in 2006, the report was very positive in many respects:[194]

> Marlene has a very positive attitude. She was polite, patient and quiet in class.
> . . .
> On the unit she was unfailingly pleasant with staff and enjoyed casual conversations and playing cards. She also enjoyed visiting in the courtyard with a friend.
> . . .

[232] The author noted an expression of empathy by Marlene:

> On August 11 Marlene was given a charge for passing food to a friend in the courtyard. . .
>
> As well she felt empathy for this person because she said she was not getting enough to eat in her unit. The writer asked Marlene to consider some ways this person could get her share of food from her own unit and make these suggestions to her. As well as giving her suggestions on what to eat rather than breaking the rules and sharing food. This was the only time during Marlene's stay at the unit that she was given a charge.

[233] DBT has not been available on the Churchill Unit since Ms. Carter has been there until early 2013, according to Ms. Madraga.

[234] Ms. Carter was introduced to a similar likely more intense approach by Dr. Sojonky, the unit psychologist at the RPC for a six month period, from June to November 2010. The treatment, which is within his area of expertise, was employed as a means of managing Ms. Carter's self-harming. He described it as "mindfulness based cognitive behaviour therapy". He advised the Court that it is an

[194] CSC Binder 1 of 2 Tab 64 - Exhibit P-3

evidence-based treatment which is practiced throughout the corrections system in the United States and many regions of Canada, including the Regina Qu'Appelle Health Region. He described the process[195]:

> And it works in a triangle form. If you visualize it in that way, the top of the triangle is our thoughts. From that, we have feelings about our thoughts. And then in response to feelings, as human beings, we have to do some kind of behaviour to deal with the feelings that we're having.We know that the behaviour reinforces the thought. So if the thought is, I am ugly, the feeling might be sadness. The sadness might create a behaviour of self-harming. The self-harming only re-supports the distorted thought. In a day-to-day living, especially in a stressful environment, most of us aren't aware of our thoughts. It's like a clock ticking in the background that we don't hear. Mindfulness allows you to slow down in your business, to listen to what's going on. To understand what's happening in our minds, so that we can choose a different thought pattern.
>
> So mindfulness component, Marlene practiced breathing, listening to her breath. We used some songs that Marlene loved to sing in Cree, and focused on her breath, she was singing those songs. That would relax Marlene. She would be able to see the negative thought patterns, and try to choose a different response than striking out or self-harming.

[235] He described Ms. Carter's successes with passion:

> . . . it's an amazing story. When I got there, Marlene was strapped five-points to a bed in a room that I wouldn't have put my dogs in, and she hadn't moved for quite some time. And by the end of two months of treatment, for the first time in many years, Marlene ran on a football field of green grass and laughed and fell and rolled and got up and played catch with me and some of the officers, and had a wonderful time.[196]
> . . .
> . . . So for Marlene, at one point, we went two months without any self-harm, and two weeks without any incidents of violence, because the intrinsic motivation for her was to go to the sweat lodge. She was able to walk to the sweat lodge and be a helper to the elder, which was a great honor for her. That intrinsic motivation, when negative thought comes, can be used to replace the negative thought, and say to Marlene, we're working towards something you love, which is going to a sweat lodge. So therefore, we should choose something different than striking out at an officer or a nurse, which she did. . .[197]

[236] He described the goals of this treatment regime[198]:

> The objective was to minimize, as much as possible, any violent behaviour. As well, and primarily the self-harm that Marlene was doing to herself. And the hope was, if we could

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[195] Transcript page 1212
[196] Beginning at page 1215 of the transcript
[197] Beginning at page 1220 of the transcript
[198] Beginning at page 1216 of the transcript

minimize that to a level that was manageable, that Marlene could perhaps live somewhere that was more humane and would allow her some freedom to actually enjoy the outdoors, to participate in sweat ceremonies and her culture, which is very, very important to her as a First Nations woman.

[237] Dr. Sojonky gave the Court a very positive example of the potential to limit head banging by Ms. Carter:[199]

Q . . .when you dealt with her, was she expressive, flat or what was her mannerisms in your interaction?
A She would be the same as you and I might be if we were having fun somewhere, or doing therapy. She joked, she laughed, she told me stories of her children. She told me about boyfriends that she loved. She told me about going to the sweat lodge. We talked freely to the point where Marlene taught us a Cree song and every day when we got successful exercise, she stood in the sunshine and sang her Cree song very beautifully, to all of Corrections Canada, I think. They videoed it and sent it across the country.
Q And did that help with her treatment?
A Yes. Again, it's positive intrinsic motivation. It increases self-esteem. It goes to a system of behaviour that this can go on. Life could actually be more manageable, even there, to be able to go outside. To be able to sweat, to be able to sing. But in order to do that, we have to minimize violent outbreaks. We have to minimize banging of the head.

[238] Extended walks were used as an incentive to avoid self-harm in the showers. Dr. Sojonky reported at the time that as of July 8, 2010, Ms. Carter had approximately six showers without self-harm and she walked in the courtyard with Dr. Sojonky or, Audrey Hobbman, Native Liaison, approximately nine times for periods of 15 to 30 minutes, without restraints or the presence of corrections officers. Dr. Sojonky told the Court:[200]

> As part of the treatment program . . . showers, if successful, were rewarded with extended walks. One of the challenges was, often Marlene would use the shower to self-harm. And it made the officers very vulnerable physically, and herself at risk, physically, because that's very difficult. So we set up this program that she would be rewarded with good -- if she had a -- in the past, she would have exercised, then a shower and bang. So we tried to reverse it, so she would have a good shower, then we would do the walk. A bit of reward behaviour strategy.

[199] Beginning at page 1227 of the transcript
[200] Page 1242 of the transcript and the report in CSC Binder 2 of 2 Tab 110 - Exhibit P-4

[239] Finally, he spoke of her progress which allowed her to leave the Churchill unit of the RPC to enjoy a variety of activities including: walking to the gym and lifting weights, walking to the library and selecting books, and walking to the field where she played soccer, football and baseball:[201]

[240] Dr. Sojonky was asked to discuss obstacles that he encountered with the treatment regime. He felt that there were two key obstacles: Ms. Carter's cognitive impairment and the correctional environment. He described repeatedly waiting for correctional officers to be available so that he could carry out his programming with Ms. Carter. He expressed frustration with the degree of security required for simple exercises and gave an example:[202]

> . . . we had a small grass area, quite tiny, that the ladies could go outside for a little bit of time.And part of it was Marlene, in her program, was allowing her to walk in that grass area for 15 minutes. And quite often, it required, by their regulations, four officers with OC spray, with handcuffs, gloves, all sorts of apparatus to release her from that chair, where she would happily leave and go do her exercise. And on occasion, we were prevented from doing that.

[241] Dr. Lohrasbe noted, together with other indicators, Dr. Sojonky's work with Ms. Carter and found it to be indicative of her having the capacity for therapeutic engagement; that she is capable of being motivated to work with a therapist to reduce destructive behaviour.[203] Those other indicators included: Dr. Adelugba's May 16, 2012 report indicating improvement and a greatly reduced incidence of violence toward other persons, Dr. Presse's 2000 assessment of intellect in the low average range, Ms. Carter's positive completion and performance in the DBT programming at the Edmonton Institution in 2005 and 2006, and an apparently positive response to adjusted medications in 2012/13. He contrasted that with the sustained deterioration in Ms. Carter's behaviour seen in 2011.

C. Exploration of Alternative Medical Approaches at the RPC

[242] In the roughly two continuous years that Dr. Mela worked with Ms. Carter he referred her to specialists to determine the extent and nature of any neurological damage and explored possible surgical remedies. He opposed the use of OC spray. He and others sought to influence the approach taken by corrections in response to incidents of self-harm in a positive way, including suggesting that a dedicated team of guards be assigned to the Churchill Unit of the RPC; this latter suggestion has since

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[201] Page 1244 of the transcript
[202] Beginning at page 1219 of the transcript
[203] Defence Binder Tab 62 - Exhibit D-1 -Dr. Loharasbe's June 20, 2013 report

been implemented. Dr. Mela and his team sought remedies which were designed to limit further damage to her brain as a result of head banging, including: fitting Ms. Carter with a protective helmet and building a padded cell. Finally, Dr. Mela and the team in charge of Ms. Carter's mental health management sought her transfer from the RPC to Brockville, a mental health facility which has provided care to federally sentenced prisoners in a structure where first responders are not correctional officers, but trained mental health professionals.

XI Office of the Correctional Investigator

[243] The Office of the Correctional Investigator has focussed upon the CSC response to the head banging or self-injury.

A. Recommended Move to a Hospital Setting

[244] A number of alternatives to Ms. Carter's current placement were considered at the hearing. The most viable option appears to be the Hospital in Brockville which has received placements from Correctional Service Canada of persons with mental health concerns. The institutional parole officer from the RPC, Ms. Chopty, testified that patients have gone to Brockville as a condition of parole.[204] Of late, there has been discussion about a contract to secure beds with a view to direct transfers from Correctional Service Canada institutions.

[245] In September 2011, Commissioner Don Head, Correctional Service Canada, indicated that Brockville Hospital was willing to accept Ms. Carter as a patient and the Correctional Service was amenable to placing her there.[205]

> Further to your recommendation that Ms. Carter be transferred to Brockville, Ms. Carter was reviewed and assessed by a treatment team from Brockville in the fall of 2010. At that time they were unwilling to admit her. Following this assessment however, several recommendations for treatment options were discussed and followed up with by the attending psychiatrist and Ms. Carter's treatment team at RPC. Brockville has recently indicated that they would now be willing to consider her acceptance to their facility.

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[204] Page 435 transcript

[205] Defence Binder Tab 55 - Exhibit D-1 -letter from Commissioner Don Head, CSC to Ivan Zinger, Executive Director and General Counsel, Office of the correctional Investigator

[246] Mr. Head went on to note that despite Brockville's willingness to consider Ms. Carter for admission, Ms. Carter has been remanded to the RPC until April 2, 2012 and concludes:

> The attending psychiatrist for Ms. Carter has advised that should the current efforts at stabilization prove unsuccessful and the courts impose a lengthier sentence, RPC will explore the possibility of a transfer to Brockville.

At that time, Ms. Carter was still serving a Federal sentence to December 6, 2011.

[247] Dr. Mela was involved in inviting a team from Brockville Hospital to assess Ms. Carter with a view to her being transferred to that facility.[206]

> Q And what was the thinking behind -- behind that, inviting the team to assess her?
> A At the time, although we had received a number of kind of second opinions, we still felt we needed, I guess, more input. The second reason at the time was that we were considering -- or at least the administration had agreed with, which was that would a change of environment be instrumental in assisting Marlene. And that change of environment, I guess, was debated between the kind of environment we had with correctional officers, and an environment where there are no correctional officers. . .
> . . .
> Q And . . .why, at the time, did you think it would be better for Marlene to be exposed to that environment, where the officers weren't the first responders?
> A . . . But also, clinically, we thought that most of the manifestations of which she was going through, had some clinical basis. And so if it was responded -- responded to clinically, would we get a different outcome. . .
> . . .
> Q . . . what was the clinical advantage of having the nurses as first responders?
> A I guess, philosophically speaking, you can estimate that if, for instance, there was an incident that was provoked by Marlene -- I mean, obviously, safety always comes first. But when the approach is one of discussion, de-escalation and trying to develop an approach that you can rely on later on, not just deal with the incident and forget it. I think it is likely that she would have benefited from that. . .

[248] Dr. Mela illustrated how a different approach may work and there was some discussion why it would not be possible to have nurses as the first responders at the RPC:[207]

> Yeah, so if you think about even the tone of voice that you use to prevent somebody from self-harming, the tone is one of caring, one of -- I guess at the same level with the person. Not loud or commanding. I suspect, and I think that we can reasonably expect a better

[206] Pages 1144 to 1146 transcript
[207] Page 1147 transcript

response to that, than one that could aggravate the person if it's loud, commanding and, I guess, forceful.

Q And did you talk about the possibility of making nurses the first responders on the Churchill unit?

A Yes.

Q And did that get beyond the discussion level?

. . .

A No.

[249] By letter dated August 11, 2011, Mr. Ivan Zinger, Executive Director and General Counsel of the Office of the Correctional Investigator of Canada[208] wrote the Associate Senior Deputy Commissioner of Correctional Service Canada expressing concerns about the management of Ms. Carter's mental health at the RPC and recommended that she be placed in an outside psychiatric facility. He gave several reasons, including that the response of the correctional staff to incidents of self-harming behaviour is to apply physical restraints for lengthy periods. He also commented upon the use of the women's IERT to escort Ms. Carter to and from her exercise in the courtyard, which he regarded as an extraordinary and inappropriate measure:[209]

> Ms. Carter is a 40 year Aboriginal woman who has a long history of self-harming behaviour. Since her arrival at RPC in June 2009, Ms. Carter has frequently engaged in serious self-harming behaviour (head-banging) and in assaultive behaviour towards staff. To mitigate against the risk from this behaviour, she has been placed in physical restraints for long periods of time (Pinel Restraint System and Broda Chair) and, in an exemption to CSC policy, she has also been fitted with a protective helmet. Ms. Carter is presently certified under the provincial Mental Health Act.
>
> As you can appreciate, our Office has been monitoring Ms. Carter's progress for some time. On July 29, 2011, it was noted in the daily SITREP[210] that the IERT[211] was used to escort Ms. Carter from her living unit to the exercise yard for exercise, and then escort her back. . . In the days leading up to the decision to use IERT, Ms. Carter's pattern of assaulting staff had increased, and the assaults were more serious . . .
>
> It is our understanding that both the Executive Director and the Clinical Director of RPC believed that given Ms. Carter's frequent placement in restraints, it is important that she be provided with the opportunity for fresh air exercise, in accordance with law and policy. In order

[208] *Corrections and Conditional Release Act* - Office of the Correctional Investigator -- Function - s.167. (1) It is the function of the Correctional Investigator to conduct investigations into the problems of offenders related to decisions, recommendations, acts or omissions of the Commissioner or any person under the control and management of, or performing services for or on behalf of, the Commissioner that affect offenders either individually or as a group.

[209] Defense Binder Tab 8 - Exhibit D-1 - Office of the Correctional Investigator of Canada letter from Ivan Zinger, Executive Director and General Counsel to the Minister

[210] SITREP is an acronym for Situation Report

[211] IERT is an acronym for Institutional emergency Response Team

to facilitate this while protecting staff, the decision was taken to use the RPC women's IERT for a period of three days, after which the transition was made to have Ms. Carter escorted and supervised by unit staff.

. . . our Office views the use of the IERT in this fashion to be an extraordinary and inappropriate measure – one that is beyond even the security regime used for male offenders in the Special Handling Unit.

Given the significant mental health issues that Ms. Carter suffers with, the fact that the current approach to managing Ms. Carter within a federal correctional institution has not shown any progress, and that the regime of keeping her in near constant restraints for long periods of time is inconsistent with effective and human treatment, it is recommended that the Service undertake to transfer Ms. Carter to an outside psychiatric facility as soon as possible.

[250] By letter dated, December 3, 2012, Mr. Howard Sapers, correctional investigator, wrote the Minister of Public Safety Canada providing six case summaries of federally sentenced offenders to support the assertion that some sentenced offenders cannot be properly managed in a federal penitentiary, stating:[212]

These offenders were subject to intervention by my Office recommending their transfer to an external psychiatric treatment facility. Considered together, these cases provide tangible evidence to support findings and recommendations concerning the need for the Correctional Service of Canada (CSC) to more seriously and urgently engage alternative mental health service delivery arrangement with external healthcare providers.

. . .

. . . Most have incurred dozens of uses of force interventions to prevent or interrupt patterns of repetitive self-harming. It is not uncommon that additional institutional charges and convictions related to prison self-injurious behaviours results in a further term of incarceration beyond the original sentence. These offenders are often managed in maximum security segregation units or observation cells, where the conditions of confinement, lack of external stimuli and limited association can result in further deterioration in mental health functioning, leading to an escalation in the frequency and seriousness of self-injury. . . The known protective/preventive factors for self-injury in prisons - less time locked in a cell; employment; meaningful association with others; engaging in correctional programs; regular and quality contacts with family- appear to conflict with security and incident-driven responses that, in chronic cases, are reduced to simply keeping an offender alive.

. . .

On some level, each of the case summaries raises disturbing parallels to Ashley Smith's preventable death. Like Ashley, these offenders have mental health care needs well beyond the resources or capacity of the Service to safely manage. . .

. . . Outside psychiatric hospitals provide a therapeutic environment where interventions are initiated by a team of health care professionals. This is not the case in federal penitentiaries, not

[212] Defence Binder Tab 60 - Exhibit D-1

even in the Regional Treatment Centers, where first responders are typically correctional officers. Segregation, pepper spray and restraints are not treatment for mentally ill individuals.

B. *Risky Business*, Report of the Office of the Correctional Investigator

[251] Ms. Carter was one of eight women in Correctional Service Canada who exhibited self-harming behaviour that became the subject of an investigation and September 30, 2013 report by the Office of the Correctional Investigator Canada, *Risky Business, An investigation of the Treatment and Management of Chronic Self-Injury Among Federally Sentenced Women*[213]. The report decried the routine use of force, segregation and restraints by correctional, not mental health staff, to address self-injurious behaviours[214].

> 2. In a series of Annual Reports, the Office has repeatedly raised concerns regarding the capacity of the Correctional Service of Canada (CSC) to appropriately manage chronic self-injury in federal penitentiaries:
> - over-reliance on use of force and control measures, such as physical restraints, and restrictions on movement and association to manage self-injurious offenders;
> - non-compliance with voluntary and informed consent to treatment protocols;
> - limited access to services for federally sentenced women offenders with complex mental health needs;
> - inadequate physical infrastructure, staffing complements, resources and capacity to meet complex mental health needs; and
> - inappropriate monitoring and inadequate oversight in the use of physical restraints.

[252] The Report discussed the use of OC spray and the Pinel Restraint System (PRS) and the "least restrictive principle"[215]:

> 34. Since the death of Ashley Smith in October 2007; there have been clear indications that a security-driven culture among correctional staff has resulted in a risk-averse reflex to control and/or contain self-injurious incidents. A security response is one in which incidents are characterized and treated as compliance issues – i.e., ordering women to comply with an order to cease their self-injury. If the inmate does not comply with verbal negotiations or with orders to stop self-injuring, then staff typically respond with Oleoresin Capsicum spray (commonly referred to as OC or pepper spray) and/or physical handling to control the woman (which may not be the least restrictive intervention available).
>
> 35. . .Resistive or assaultive behaviour most often occurs only after correctional staff intervene

[213] Defense Binder Tab 74 - Exhibit D-1 - *Risky Business*, Also attached as Appendix N.
[214] Appendix N, *Risky Business*, Introduction
[215] Appendix N, *Risky Business*, page 13

and is most frequently observed in the context of mandatory strip searching as part of a segregation or observation cell placement following a self-injury incident.

. . .

37. . . In most cases, these measures simply contain or reduce the immediate risk of self-injury; they are not intended to deal with the underlying reasons or symptoms of mental illness manifested in self-injurious behaviour.

38. Based on Office interviews, as well as documentation from the incidents, the Pinel Restraint System (PRS)[216] appears to be a primary intervention measure to manage self-injurious behaviour, particularly at the RPC. Pinel restraints were used in over half of the incidents to manage self-injurious behaviours. RPC staff informed the Office that the Pinel restraint table is prepared immediately when a self-injury incident occurs. Two women were responsible for a disproportionate number of the incidents in which the Pinel restraints were applied; one of these women spent a period of some months restrained either in a Pinel bed or a Broda Chair[217] for up to 23 hours a day. . .

[253] *Risky Business* commented upon the physical structure of the IPC area of the Churchill Unit of the RPC,[218] where Ms. Carter was housed until renovations resulted in a move to the Assiniboia Unit about the time of this hearing October 2013:

> 28. There is no stand-alone specialized facility to treat chronic self-injurious women offenders in federal corrections. Some of the most challenging and complex cases are managed in the Churchill Unit, a recently expanded 20-bed female wing co-located at the otherwise male Regional Psychiatric Centre (RPC Prairies) in Saskatoon.10 It has been common for the women housed at RPC to be kept in clinical seclusion, otherwise known as Intensive Psychiatric Care (IPC) or Restrictive Psychiatric (RPI) status (the latter affording women restricted movement and privileges out of their cell). A CSC National Board of Investigation from 2009 noted the following physical infrastructure concerns:
>
> > The physical structure of Churchill Unit and especially the IPC area was not conducive to meaningful therapeutic interventions. There were three cells and a shower along a narrow hallway. The cells had no windows to outside light ...[T]here was little privacy, as there were no interview room capabilities in the IPC, and conversation and interviews, at times, had to take place through the hatch on the cell door.[219]

[254] The Report discussed the use of segregation and clinical seclusion:

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[216] Appendix N, *Risky Business*, page 10, The Pinel Restraint System (PRS) is an approved device listed in the Security Equipment Manual intended to temporarily restrict or limit free movement. The PRS is identified in the Manual as a "medical restraining device." It is a system of restraining belts or straps that attach to a bed, chair, or stretcher that allows for incremental restraint. The seven-point Pinel Restraint System consists of up to seven different belts and/or straps (i.e., 4 limb belts, waist belt, pelvic belt and shoulder belt). According to CSC policy, the use of the PRS "is an intervention to preserve life and is not a medical treatment."

[217] Appendix N, *Risky Business*, paragraph 13 – A Broda Chair is a specialized repositioning wheelchair equipped with safety pads and restraint belts.

[218] Appendix N, *Risky Business*, page 11.

[219] National Board of Investigation, 1410-2-09-39, p. 119.

> 43 . . . Security personnel consistently informed the Office that segregation was necessary to respond to self-injury incidents in order to prevent further harm, or to "preserve life." While segregation is not supposed to be used to manage this kind of behaviour or as a punishment, CSC often relies on this measure to ensure personal safety and maintain the security of the institution. This is concerning, particularly given that a disproportionate number of prison self-injury incidents occur in segregation or observation cells.
>
> . . .
>
> 47. Clinical seclusion[220] remains a controversial intervention even in psychiatric settings. This practice is in place at Brockville Mental Health Centre, Institut Philippe-Pinel in Montréal, the CSC Regional Psychiatric Centre and as a management tool at the former Complex Needs Program, RTC Pacific. . .
>
> 48. However, staff at both community psychiatric facilities stressed that the use of clinical seclusion as an intervention strategy for self-injurious behaviour is based on an assessment of the individualized needs of each patient; it is not relied upon as a blanket response to all self-injury incidents. In addition, decisions regarding a patient's placement in seclusion are made exclusively by mental health staff following an assessment of the patient. . .

[255] The *Risky Business* Report contrasted the approach taken by Correctional Service Canada and external health providers' in the management of self-injury incidents:

> 59. . . In community psychiatric care settings, the staff that deal with the identification, assessment and management of self-injurious behaviour are nearly always health care professionals. During the review period, four women received some treatment at community psychiatric hospitals at different times. While in CSC facilities, these women spent long periods of time in either clinical seclusion or segregation due to their self-injurious behaviour. In contrast, while at the community psychiatric hospitals, the women often attended work, program or therapy as part of their daily routines; staff treated them as "patients" in a program-enriched environment.

XII Discussion of the Law Pertaining to the Issues

A. List of cases cited in alphabetical order:

R. v. Adamo, 2013 MBQB 225
R. v. Bellusci, 2012 SCC 44
R. v. Casemore, 2009 SKQB 306
R. v. Daniels, 2013 SKQB 324
R. v. C.J.D., 2012 SKQB 101, aka *Downs*
R. v. D.B., 2008 SCC 25

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[220] Appendix N, *Risky Business*, page 19, Clinical seclusion is the involuntary confinement alone in a cell/room of a seriously disordered inmate/patient who presents an imminent risk of physical harm to self or others. The expert consensus is that seclusion should be used as a last resort and discontinued at the earliest time possible.

R. v. Ewenin, 2013 SKCA 50
R. v. Gladue, [1999] 1 S.C.R. 688
R. v. Hill, 2012 ONSC 5050
R. v. Ipeelee, 2012 SCC 13
R. v. Jewitt, [1985] 2 S.C.R. 128
R. v. Knife, 2013 SKQB 197
R. v. Lemaigre, 2014 SKPC 108
R. v. Natomagan, 2010 SKPC 7
R. v. Neve, 1999 ABCA 206, aka *R. v. N.(L.)*
R. v. O'Connor, [1995] 4 S.C.R. 411
R. v. Papequash, 2013 SKQB 369
R. v. Pike, 2010 BCCA 401
R. v. Standingwater, 2013 SKCA 78
R. v. Summers, 2014 SCC 26
R. v. Szostak, 2014 ONCA 15
R. v. Warawa, 2011 ABCA 294
R. v. Wright, 2008 SKQB 268

[256] The onus in dangerous offender proceedings rests with the Crown; it must prove all necessary elements, beyond a reasonable doubt[221]. Section 753(1.1) of the *Code* imposes a presumption and consequently an onus on the offender; however, the Crown is not relying upon it.[222] I note in passing the decision of *R. v. Hill,*[223]which held that s. 753(1.1) infringed the principles of fundamental justice guaranteed by s. 7 of the *Charter*. This issue is canvassed somewhat further below.

B. Application of *Criminal Code* Sentencing Principles and *Gladue* Factors and Alternatives

[257] The sentencing provisions of the *Criminal Code* which address the purpose and principles of sentencing apply.[224] Importantly, *Gladue* factors and alternatives also apply. Section. 718.2(e) of the *Code,* is set out below:

> *Other sentencing principles -- s. 718.2*
> 718.2 A court that imposes a sentence shall also take into consideration the following principles:
> . . .
> (e) all available sanctions other than imprisonment that are reasonable in the circumstances should be considered for all offenders, with particular attention to the circumstances of aboriginal offenders.

[221] *R. v. Pike*, 2010 BCCA 401 at paragraph 29 and *R. v. Natomagan,* 2010 SKPC 07 paragraph 56
[222] Brief of the Attorney General of Saskatchewan dated march 14, 2014, page 2.
[223] 2012 ONSC 5050
[224] See Appendix B for applicable sentencing provisions in the *Criminal Code.*

[258] Section 718.2(e) has been interpreted by the Supreme Court of Canada in *R. v. Gladue*[225] and *R. v. Ipeelee.*[226] I noted the recent discussion regarding application to dangerous offender proceedings by Saskatchewan's Court of Appeal in *R. v. Standingwater*[227] at paragraph 44:

> 44 The Supreme Court of Canada made it clear in *R. v. Ipeelee* (at para. 59) that s. 718.2(e) "is a remedial provision designed to ameliorate the serious problem of overrepresentation of Aboriginal people in Canadian prisons, and to encourage sentencing judges to have recourse to a restorative approach to sentencing". Furthermore, the Court said that s. 718.2(e) "calls upon judges to use a different method of analysis in determining a fit sentence for Aboriginal offenders". In sum, the section "directs sentencing judges to pay particular attention to the circumstances of Aboriginal offenders because those circumstances are unique and different from those of non-Aboriginal offenders".

In the paragraphs that follow, the Court clarifies that s. 718.2(e) applies to all sentencing decisions, including those involving serious violent offenders.

[259] *R. v. Ewenin,*[228] is a decision based on the dangerous offender provisions that existed before the 2008 amendment; the remarks of Chief Justice Richards at paragraph 28 continue to apply:

> 28 This line of analysis takes on special significance in light of the Supreme Court of Canada's decision in *R. v. Gladue*, [1999] 1 S.C.R. 688, as confirmed and elaborated upon (subsequent to the trial judge's decision) in *R. v. Ipeelee*, 2012 SCC 13, [2012] 1 S.C.R. 433. As a result of those Supreme Court decisions, it is now particularly important that, when dealing with a dangerous offender proceeding involving an Aboriginal person, a trial judge has the benefit of evidence which explores not only the programming, services and controls available in relation to offenders generally but which also explains the programming, services and controls available in relation to Aboriginal offenders in particular. Counsel must put the judge in a position where he or she can consider both the programming and services within the prison environment and the programming and other risk management measures available in the community where the offender resides or will reside on his or her release.

[260] The Defence filed a *Gladue* Report that covered a great deal of otherwise unknown information about Ms. Carter's background and connection to her First Nation communities: Onion Lake First Nation and Saulteaux First Nation.

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[225] [1999] 1 S.C.R. 688
[226] 2012 SCC 13
[227] 2013 SKCA 78
[228] 2013 SKCA 50

C. Judicial Interpretation of the Dangerous and Long-Term Offender Provisions

[261] The pertinent portions of *Charter* and *Criminal Code* are set out in Appendix B. For my purposes now, I am setting out the following provisions concerning this application:

> *Application for finding that an offender is a dangerous offender -- s. 753(1)*
> 753. (1) On application made under this Part after an assessment report is filed under subsection 752.1(2), the court shall find the offender to be a dangerous offender if it is satisfied
> (a) that the offence for which the offender has been convicted is a serious personal injury offence described in paragraph (a) of the definition of that expression in section 752 and the offender constitutes a threat to the life, safety or physical or mental well-being of other persons on the basis of evidence establishing
> (i) a pattern of repetitive behaviour by the offender, of which the offence for which he or she has been convicted forms a part, showing a failure to restrain his or her behaviour and a likelihood of causing death or injury to other persons, or inflicting severe psychological damage on other persons, through failure in the future to restrain his or her behaviour,
> (ii) a pattern of persistent aggressive behaviour by the offender, of which the offence for which he or she has been convicted forms a part, showing a substantial degree of indifference on the part of the offender respecting the reasonably foreseeable consequences to other persons of his or her behaviour, or . . .
>
> *Presumption -- s. 753(1.1)*
> (1.1) If the court is satisfied that the offence for which the offender is convicted is a primary designated offence for which it would be appropriate to impose a sentence of imprisonment of two years or more and that the offender was convicted previously at least twice of a primary designated offence and was sentenced to at least two years of imprisonment for each of those convictions, the conditions in paragraph (1)(a) or (b), as the case may be, are presumed to have been met unless the contrary is proved on a balance of probabilities.
>
> *Sentence for dangerous offender -- s. 753(4)*
> (4) If the court finds an offender to be a dangerous offender, it shall
> (a) impose a sentence of detention in a penitentiary for an indeterminate period;
> (b) impose a sentence for the offence for which the offender has been convicted—which must be a minimum punishment of imprisonment for a term of two years—and order that the offender be subject to long-term supervision for a period that does not exceed 10 years; or
> (c) impose a sentence for the offence for which the offender has been convicted.
>
> *Sentence of indeterminate detention -- s. 753(4.1)*
> (4.1) The court shall impose a sentence of detention in a penitentiary for an indeterminate period unless it is satisfied by the evidence adduced during the hearing of the application that there is a reasonable expectation that a lesser measure under paragraph (4)(b) or (c) will adequately protect the public against the commission by the offender of murder or a serious personal injury offence.
>
> *If offender not found to be dangerous offender -- s. 753(5)*
> (5) If the court does not find an offender to be a dangerous offender,

(a) the court may treat the application as an application to find the offender to be a long-term offender, section 753.1 applies to the application and the court may either find that the offender is a long-term offender or hold another hearing for that purpose; or
(b) the court may impose sentence for the offence for which the offender has been convicted.

[262] These provisions, amended in 2008, have been judicially interpreted, concluding that once the offender has been found to be a dangerous offender, an indeterminate sentence is presumptive. In *R. v. Szostak,* the Ontario Court of Appeal wrote:[229]

The 2008 Legislation

[52] In my view, any doubt that intractability is not a necessary element to find a person to be a dangerous offender has been removed by the 2008 amendments. This legislation removes the discretion that existed under the 1997 legislation not to find a person to be a dangerous offender even though the person came within the definition in s. 753(1). That discretion has been replaced by a highly structured discretion in s. 753(4) and (4.1). Those provisions are as follows:

(4) If the court finds an offender to be a dangerous offender, it shall
(a) impose a sentence of detention in a penitentiary for an indeterminate period;
(b) impose a sentence for the offence for which the offender has been convicted – which must be a minimum punishment of imprisonment for a term of two years – and order that the offender be subject to long-term supervision for a period that does not exceed 10 years; or
(c) impose a sentence for the offence for which the offender has been convicted.

(4.1) The court shall impose a sentence of detention in a penitentiary for an indeterminate period unless it is satisfied by the evidence adduced during the hearing of the application that there is a reasonable expectation that a lesser measure under paragraph (4)(b) or (c) will adequately protect the public against the commission by the offender of murder or a serious personal injury offence.

[53] Thus, the legislation contemplates that a person could be declared a dangerous offender because they meet the definition but nevertheless be given a disposition including a long-term supervision order or a conventional sentence. However, these two options are only available if an indeterminate sentence is not required to protect the public from the commission of murder or a serious personal injury offence. If a person, to be declared a dangerous offender, had to not only meet the statutory definition but display a pattern of conduct that was pathologically intractable, that person could, it seems to me, rarely, if ever, be eligible for a long-term supervision order or a conventional sentence.

[54] Further, while I agree that the legislation must be interpreted in the spirit of *Lyons* and bearing in mind the sentencing principles and objectives in ss. 718, 718.1 and 718.2, it is apparent that Parliament intended a broader group of offenders be declared dangerous offenders than was envisaged in *Lyons* where the court spoke of "a very small group of offenders". While the legislation is still narrowly targeted to a small group of offenders, that Parliament intended to broaden the group of persons to be labelled as dangerous offenders is apparent from the

[229] 224 2014 ONCA 15

legislative reversal of the principle in *Johnson* referred to earlier that no sentencing objective is advanced by declaring an offender dangerous and imposing a determinate sentence. I point out that there has been no constitutional challenge to the 2008 regime in this case.

See also *R. v. C.J.D.*[230] and *R. v. Warawa,*[231]

D. Sentencing

a. Pursuant to s. 753(1)(a), are either/both of the s. 267(a) offenses of assault with a weapon "serious personal injury offenses" pursuant to s. 752(a) of the *Code*?

[263] Section 752(a) defines "serious personal injury offence" to include an indictable offence, involving the use of violence against another person. I find that the two offences of assault with a weapon, the occurring on June 13, 2009 and July 17, 2011 meet the definition of a "serious personal injury offence" as it is defined. There is no ability, as Mr. Bains maintained, to add a qualitative analysis to that definition and no purpose to embarking upon a discussion of whether in fact these two offences, apart from the meaning proscribed, are serious personal injury offences; they meet the technical definition.

b) Has the Crown Established a Pattern

i. Pursuant to s. 753(1)(a)(i) does the evidence establish a pattern of repetitive behaviour, of which the offence for which she has been convicted forms a part, showing a failure to restrain her behaviour and is there a likelihood of her causing death or injury to other persons, or inflicting severe psychological damage to others by failing in future to restrain her behaviour, or

ii. Pursuant to s. 753(1)(a)(ii) does the evidence establish a pattern of persistent aggressive behaviour, of which the offence for which she has been convicted forms a part, showing a substantial degree of indifference respecting the reasonably foreseeable consequences to others?

[264] It is useful to set out s. 753(1)(a) in its entirety:

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[230] 2012 SKQB 101
[231] 2011 ABCA 294

Application for finding that an offender is a dangerous offender -- s. 753(1)

753. (1) On application made under this Part after an assessment report is filed under subsection 752.1(2), the court shall find the offender to be a dangerous offender if it is satisfied

(a) that the offence for which the offender has been convicted is a serious personal injury offence described in paragraph (a) of the definition of that expression in section 752 and the offender constitutes a threat to the life, safety or physical or mental well-being of other persons on the basis of evidence establishing

(i) a pattern of repetitive behaviour by the offender, of which the offence for which he or she has been convicted forms a part, showing a failure to restrain his or her behaviour and a likelihood of causing death or injury to other persons, or inflicting severe psychological damage on other persons, through failure in the future to restrain his or her behaviour,

(ii) a pattern of persistent aggressive behaviour by the offender, of which the offence for which he or she has been convicted forms a part, showing a substantial degree of indifference on the part of the offender respecting the reasonably foreseeable consequences to other persons of his or her behaviour, or . . .

[265] In *R. v. N.(L.)*[232], decided prior to the 2008 amendments to the dangerous offender provisions, the Court discussed the evidence which may be relied upon in considering whether a "pattern" was established:

106] The starting point for the threat evaluation therefore is past conduct. Only two of the three thresholds under s. 753(a), that is ss. (i) and (ii), have any possible application to this case. In general, both require a pattern of behaviour (described differently in each) in respect of which the predicate offence must form a part. Both set out in precise detail the criteria which must be met if the Crown is to establish that the offender's conduct falls within one of the proscribed patterns of past behaviour.

107] What does it take for the Crown to prove the required patterns of behaviour under ss. 753(a)(i) and (ii)? While "pattern" is not defined in the Code, what is defined in each of ss. 753(a)(i) and (ii) are the various components instrumental in creating the pattern. If the Crown fails to prove one or more of the required elements, then the proscribed pattern has not been made out. Under s. 753(a)(i), the elements are the following:

1. A pattern of repetitive behaviour;
2. The predicate offence must form part of that pattern;
3. That pattern must show a failure by the offender to restrain his or her behaviour in the past; and
4. That pattern must show a likelihood of death, injury or severe psychological damage to other persons through failure to restrain his or her behaviour in the future.

108] Under s. 753(a)(ii), the required elements are these:

[232] 1999 ABCA 206 at paragraph 151, aka *Neve*

1. A pattern of persistent aggressive behaviour;
2. The predicate offence must form part of that pattern; and
3. That pattern must show a substantial degree of indifference by the offender respecting the reasonably foreseeable consequences of his or her behaviour. . .

[266] In *R. v. C.J.D.*[233], in determining the application of s. 753(1)(a)(i), Justice Mills was unable to find that a pattern existed and in so doing referred to *R. v. N.(L.)*[234] and this discussion about the quality of the past behaviour:[235]

> 110 This takes us to the second point: the quality of the past behaviour. Does all criminal behaviour form part of the pattern? In our view, it does not. We read s. 753(a) as requiring that the court be satisfied on two points: (a) that the predicate offence is part of a pattern of behaviour which has involved violent, aggressive or brutal conduct; and (b) that it is likely that this pattern of conduct will continue and will lead to conduct endangering the life, safety or physical well-being of others: see *Lyons, supra*. . .
>
> 111. . . The first is where there are similarities in terms of the kind of offences; the second where the offences themselves are not similar in kind, but in result, in terms of the degree of violence or aggression inflicted on the victims. Either will do. Thus, the mere fact that an offender commits a variety of crimes does not mean that no pattern exists. There is no requirement that the past criminal actions all be of the same or similar form, order or arrangement; though if this has occurred, it may well suffice.
>
> . . .
>
> 113 . . . We do not suggest that the offences must be of the same kind, that is, for example, a number of robberies. Similarity, as noted, can be found not only in the types of offences but also in the degree of violence or aggression threatened or inflicted on the victims. This explains why the requirement for similarity in terms of kinds of offences is not crucial when the incidents of serious violence and aggression are more numerous
>
> . . .
>
> 123 Generally, there are three areas of evidence which will be considered in determining whether there is a pattern of conduct falling within the threshold requirements under s. 753:
>
> 1. the offender's past criminal acts and criminal record;
> 2. extrinsic evidence relevant to those past acts and the circumstances surrounding them; and
> 3. psychiatric reports opining as to that conduct.

[267] In *R. v. C.J.D., supra*, Justice Mills considered whether a pattern had been established in the context of sexual assault, stating:

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[233] 2012 SKQB 101
[234] *R. v. N.(L.)*, 1999 ABCA 206, also known as *R. v. Neve*
[235] The wording leading up to subsection (a) has changed with the 2008 amendments(making the word mandatory) but the wording in (a)(i) and (ii) remain the same.

> 47 . . . It is not appropriate to simply say that since four sexual assaults have occurred, a pattern has been established. All sexual assaults are serious, and their effects on the individual involved should not be minimized. At the same time, the Courts have recognized that some sexual assaults are more serious than others by the degree of physical violence or sexual interference. .

[268] At paragraphs 47 to 50 inclusive, he considered the following criteria:

- the characteristics of the victims,
- were the victim and offender known to each other or was there a relationship,
- was the offender was intoxicated on each occasion,
- the presence or absence of a significant degree of psychological and/or physical trauma,
- the proximity of the offences to each other in time,
- the conduct of the accused in perpetrating the assaults,
- was there was an escalation or de-escalation in the degree of violence,
- the degree of planning, if any, and
- the presence of anger or animosity toward the victim.

[269] With respect to the criteria enunciated in *R. v. N.(L.), supra,*[236] and elaborated upon in *R. v. C.J.D.,*[237] *supra,* two additional criteria might be added:

- the environment in which the offence was committed
- the moral blameworthiness of the offender

[270] The Alberta Court of Appeal in *R. v. N.(L.), supra,* discussed the evaluation of moral blameworthiness and culpability and the difference between the two at paragraphs 256 to 258:[238] This discussion was in the context of the Court retaining residual discretion, once the statutory prerequisites had been met; a discretion that has been removed with the 2008 amendments to the dangerous offender provisions of the *Code*.

[271] Nevertheless, consideration of moral blameworthiness comes within the ambit of s. 718.1 of the Criminal Code. The sentencing principle of proportionality applies with respect to the gravity of the offence and the degree of responsibility of the offender. Reduced moral blameworthiness has also been acknowledged in the context of young persons, ages 12 up to 18 years of age, whose criminal actions

[236] *R. v. N.(L.),* 1999 ABCA 206
[237] 2012 SKQB 101
[238] 1999 ABCA 206

are governed by *The Youth Criminal Justice Act.*[239] The principle may be applied to individuals whose mental illness or cognitive impairment is such that their acts are viewed in a different light.

[272] This principle was applied in *R. v. Adamo*,[240] a case in which the mandatory minimum sentence provided for in s. 95(2)(i) of the *Code* was found to be grossly disproportionate and precluded consideration of the offender's reduced moral blameworthiness and as such contravened sections 7 and 12 of the *Charter*. In that case the offender challenged the constitutionality of the section pursuant to s. 52 of the *Constitution Act, 1982*. No such challenge is before this Court.

[273] Consideration of the moral blameworthiness may be appropriate at one step or another in the decision-making process pursuant to the dangerous offender provisions, given its general application as a principle of sentencing.

[274] In *R. v. Casemore*,[241] Ottenbreit J. (as he then was) wrote this caution regarding pattern:

> [9] A "pattern" does not need to equate to similar fact evidence; general similarity is sufficient. There need not be a lengthy history of violence or aggression for a pattern to be found, so long as there are sufficient elements of similarity in the offender's behaviour. . .

This excerpt was cited with apparent approval in the decision of *R. v. Daniels.*[242]

[275] In *R. v. Pike*,[243] the British Columbia Court of Appeal wrote this about "pattern":

> 80 The "threat" under s. (a) is to be determined "on the basis of evidence" of a pattern of behaviour under ss. (i) or (ii). That pattern, in turn, must be linked to the predicate offence.
>
> 81 Breaking any of these connections - between the predicate offence, the pattern analysis or the threat assessment - distorts the careful balance of the provisions, and risks serious injustice. This is revealed more clearly when one considers the provisions broadly.
>
> 82 The predicate offence is not a meaningless, statutory trigger. It is a "last straw", described by Marshall J.A. in R. v. Newman (1994), 115 Nfld. & P.E.I.R. 197 at para. 69 (Nfld. C.A.) as a "one last act of serious personal violence to anchor the offender's pattern of pre-existing unrestrained or uninhibited behaviour". It takes its significance, in part, from the fact that it

[239] See *R. v. D.B.*, 2008 SCC 25
[240] 2013 MBQB 225
[241] 2009 SKQB 306
[242] 2013 SKQB 324
[243] 2010 BCCA 401

demonstrates that the relevant pattern of behaviour continues. As Marshall J.A. explains, it serves an important purpose: "[i]t guards against visiting one of the most serious criminal sanctions upon someone who has essentially abandoned a past pattern of intensely serious violence on the basis of a relapse of relatively less grave proportions" (at para. 72). This explains why the pattern and predicate offence must be related. It would be inconsistent and unfair if the ultimate threat determination were to be made on the basis of a perceived threat unrelated to either the predicate offence or the pattern of behaviour it reveals as still persisting.

[276] I also noted that *R. v. Szostak,*[244] the Ontario Court of Appeal discussed pattern:

> [56] In *R. v. Hogg*, 2011 ONCA 840 (CanLII), 2011 ONCA 840, this court considered the meaning of the phrase "a pattern of repetitive behaviour" in s. 753(1)(a)(i). Despite the date of this court's judgment, given the dates of the offences, it would seem that the case was decided under the 1997 legislation. The court referred with approval to decisions of the British Columbia Court of Appeal and the Newfoundland Court of Appeal in *R. v. Dow*, 1999 BCCA 177 (CanLII), 1999 BCCA 177, 134 C.C.C. (3d) 323; *R. v. Pike*, 2010 BCCA 401 (CanLII), 2010 BCCA 401; and *R. v. Newman* 1994 CanLII 9717 (NL CA), (1994), 115 Nfld. & P.E.I.R. 197, and concluded as follows at paras. 40 and 43:
>
> > To summarize, the pattern of repetitive behaviour that includes the predicate offence has to contain enough of the same elements of unrestrained dangerous conduct to be able to predict that the offender will likely offend in the same way in the future. This will ensure that the level of gravity of the behaviour is the same, so that the concern raised by Marshall J.A. [in Newman] – that the last straw could be a much more minor infraction – could not result in a dangerous offender designation. However, the offences need not be the same in every detail; that would unduly restrict the application of the section.
> >
> > . . .
> >
> > Although the pattern differed in the detail of how the offences were carried out, the predicate and past offenses still represented a pattern of repetitive violent behaviour that made it likely that the appellant would continue to commit similar acts of violence in order to have sexual gratification in the future. . .

[277] I noted the decisions of *R. v. Knife*[245] and *R. v. Papequash,*[246] of our Court of Queen's Bench, which decisions were based on findings that the Crown had not established a pattern. I understand are both under appeal.

[278] The Mr. Bains referred the Court to *R. v. Standingwater*, at paragraph 21, which states:[247]

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[244] 2014 ONCA 15
[245] 2013 SKQB 197
[246] 2013 SKQB 369
[247] 2013 SKCA 78

> . . .Moreover, other than under s. 753(1)(a)(iii), the measures set forth in the *Criminal Code* for determining whether an offender is a dangerous offender do not mandate any qualitative comparison of the brutality of a predicate offence with the brutality of like offences committed by those offenders who have been designated dangerous offenders. A predicate offence does not have to meet a defined level of brutality before a dangerous offender designation is warranted; rather, any offender may be designated a dangerous offender if the evidence establishes, to the satisfaction of the court, that any of the three alternative measures set forth in s. 753(1)(a) has been met.

I note that the Court in *Standingwater, supra*, was not considering the question of pattern, having made no reference to that question or the interpretation of that aspect of ss. 753(1)(a)(i) and (ii) which has been discussed herein.

[279] The discussion about "pattern" having regard to s. 753(1)(a)(i) continues to have application to s. 753(1)(a)(ii). In *R. v. Lemaigre*,[248] Ebert, J. recently discussed the meaning of "a pattern of persistent behaviour" and a "substantial degree of indifference" in the context of s. 753(1)(a)(ii):

> 142 Although not necessary in view of my findings under s. 753(1)(a)(i), I will address this provision briefly. In *R. v. Yanoshewski* (1996), 104 C.C.C. (3d) 512, the Saskatchewan Court of Appeal, defining a pattern of persistent behaviour, says the term "persistent" means enduring or constantly repeated and in that case says that the behaviour of the appellant was persistent in view of the fact that he had committed offences for a substantial period of time without any significant breaks. This was followed in *R. v. Bunn*, 2012 SKQB 397.
>
> 143 In *R. v. George* (1998), 126 C.C.C. (3d) 384, the British Columbia Court of Appeal, in defining a substantial degree of indifference, says the Court cannot look only at the offender's actions at the time of the offence but other offences as well in making this determination and says at p. 394-5 that if the offender has a conscious but uncaring awareness of causing harm to others and this has occurred over a long period of time involving frequent acts with significant consequences, this is sufficient to establish a substantial degree of indifference. George was followed in *R. v. Dow*, 1999 BCCA 177 and *R. v. Bunn*, 2012 SKQB 397.

iii. What is Ms. Carter's Pattern?

[280] Justice Mills' analysis in *R. v. C.J.D., supra*,[249] has been particularly helpful in determining whether the Crown has established a pattern of which the predicate assault offences form a part, as proscribed in s. 753(1)(a), whether it is pursuant to ss. (i) or (ii). I suggested above that two more criteria might be appropriate in determining whether a pattern exists: the environment in which the

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[248] 2014 SKPC 108
[249] 2012 SKQB 101

offences are committed and the moral blameworthiness of the offender. In light of the foregoing review, I have found that there is a break in the pattern; that the offences before me differ in a significant way from previous offending behaviour, based on the following analysis:

1. A number of Ms. Carter's earlier significant offences of violence as a young person and as an adult are separated by large gaps in time. There is a 10 year gap between the robbery in 1989 and the aggravated assault in 1999 and forcible confinement and assault with a weapon in 2000. These latter offences occurred in a correctional setting.
2. The offences in 2004 involving assaults on inmates and guards more closely resemble the current behaviour and take place in a custodial setting. They are less serious than the preceding offences but nevertheless attracted a significant period of incarceration.[250]
3. Next was an aggressive common assault committed on a stranger in March 18, 2009. It is the second of two offences of significant violence (the 1989 robbery being the first) that occurred in the community. It is coupled with assaults committed upon persons who are guarding her in a custodial setting.
4. There are two significant gaps in the record, 7 years from 1992 to 1999 and 2 years following her release in 2006 to the assaults in 2009.
5. Examining the record as a whole, with closer consideration for the offences that have occurred in a custodial setting; there is a sharp distinction between the offences that occurred prior to and including the spring of 2009 for which Ms. Carter has previously been sentenced and the predicate assaults for sentencing at this time. This has to do with Ms. Carter's moral blameworthiness and the environment in which the offences were committed. These distinctions are evident:
   A. The circumstances in the weeks surrounding these offences, especially the assaults with a weapon indicate that Ms. Carter was under extreme stress from a mental health perspective.
   B. Ms. Carter's head banging, as it was observed at the RPC, by all accounts, developed in its current intensity, falling face first from a standing or kneeling position, without breaking her fall, on or about June of 2009. In April 2009 she was seen to be working toward this at Pine Grove, when she would break her fall at the last minute. This is significant as it pertains to further brain damage and deterioration in functioning.

[250] In discussing the seriousness of these offences, the Court is aware that this alone does not signify a break from a "pattern".

C. Ms. Carter's mental health as well as her cognitive ability deteriorated such that investigations were launched with a view to measuring the deterioration, likely connected to the head banging and she was downgraded from being low average intelligence to borderline cognitive functioning. She was diagnosed with organic brain disorder.

D. A new and different pattern of assaultive behaviour began in 2009 and was likely at its most intense in the spring and summer of 2009 and a large portion of 2011 and following; involving very impulsive unpredictable behavior in a backdrop of isolation, restraint and frequent self-harming events and directly tied to her reduced mental health. More so than earlier assaults, these assaults have an obsessive compulsive quality that has been linked to her brain damage.

c) What is the significance of the presumption in s. 753(1.1)?

[281] The Crown advised that it does not rely on s. 753 (1.1). Had that not been the case, I would have declined to find as this section requires, that the appropriate sentence for any of the predicate assaults is two years or more.

d) When the offender is not found to be dangerous offender s. 753(5)

[282] Sections 753(5) and 753.1(1) provide:

If offender not found to be dangerous offender -- s. 753(5)
(5) If the court does not find an offender to be a dangerous offender,
(a) the court may treat the application as an application to find the offender to be a long-term offender, section 753.1 applies to the application and the court may either find that the offender is a long-term offender or hold another hearing for that purpose; or
(b) the court may impose sentence for the offence for which the offender has been convicted.

Application for finding that an offender is a long-term offender -- s. 753.1(1)
753.1 (1) The court may, on application made under this Part following the filing of an assessment report under subsection 752.1(2), find an offender to be a long-term offender if it is satisfied that
(a) it would be appropriate to impose a sentence of imprisonment of two years or more for the offence for which the offender has been convicted;
(b) there is a substantial risk that the offender will reoffend; and
(c) there is a reasonable possibility of eventual control of the risk in the community.

[283] Having regard to the foregoing, I find that it would not be appropriate to find Ms. Carter to be a long-term offender having regard to the criteria in s. 753.1(1):

(a) I have determined that no single offence for which she has been convicted merits a sentence of two years or more.
(b) Having regard to the evidence, notably Dr. Lohrasbe's assessment as to risk, I find that there is a substantial risk that Ms. Carter will reoffend.
(c) While I have considered that Ms. Carter may be managed in the community, albeit in a mental health facility, there is insufficient evidence at this time to conclude that there is a reasonable possibility of eventual control in the community. Should she be transferred to Brockville Hospital and should that foster an improvement and some prospect of long-term residency in a hospital or mental health facility, it may be possible to so conclude.

[284] In light of the foregoing, I have concluded that I may, pursuant to s. 753(5)(b) impose sentences for the 19 offences for which Ms. Carter has been convicted.

E. *Charter* Issues and Remedies

[285] A discussion of the available remedies is appropriate. The Applicant has variously invoked sections 7, 12 and 15 of the *Charter* and in seeking relief has raised four issues of remedy. This Court has been asked to make orders:

a) Declaring ss. 753(1.1) and 753(4.1) to be of no force and effect
b) Finding that the treatment that Ms. Carter has received while in custody at the RPC violates the Charter
c) Granting a stay of proceedings for the outstanding charges identified in the Agreed Statement of Facts for which guilty pleas have been entered
d) Granting a constitutional exemption or other remedy pursuant to s. 24(1) of the Charter, including a structural injunction

[286] Each of these remedies is discussed below. The pertinent *Code* and *Charter* provisions have been reproduced in Appendix B to this decision.

a) Declaring ss. 753(1.1) and 753(4.1) to be of no force and effect

[287] Section 753(1.1) provides:

> *Presumption -- s. 753(1.1)*
> (1.1) If the court is satisfied that the offence for which the offender is convicted is a primary designated offence for which it would be appropriate to impose a sentence of imprisonment of two years or more and that the offender was convicted previously at least twice of a primary designated offence and was sentenced to at least two years of imprisonment for each of those convictions, the conditions in paragraph (1)(a) or (b), as the case may be, are presumed to have been met unless the contrary is proved on a balance of probabilities.

[288] Noted at the outset of this discussion, *R. v. Hill, supra*,[251] held that s. 753(1.1) infringes the principles of fundamental justice guaranteed by s. 7 of the *Charter* and it was declared of no force and effect. In that case notice pursuant to s. 52 of *The Constitution Act* had been given.[252]

[289] As the Attorney General of Saskatchewan has advised the Court that it does not rely upon s. 753(1.1) of the dangerous offender provisions, and notice pursuant to s. 52 *The Constitution Act* has not been given, no further discussion is required.

[290] The Applicant also sought a declaration that s. 753(4.1) is of no force and effect. Sections 753(4) and (4.1) provide:

> *Sentence for dangerous offender -- s. 753(4)*
> (4) If the court finds an offender to be a dangerous offender, it shall
> (a) impose a sentence of detention in a penitentiary for an indeterminate period;
> (b) impose a sentence for the offence for which the offender has been convicted—which must be a minimum punishment of imprisonment for a term of two years—and order that the offender be subject to long-term supervision for a period that does not exceed 10 years; or
> (c) impose a sentence for the offence for which the offender has been convicted.
>
> Sentence of indeterminate detention -- s. 753(4.1)
> (4.1) The court shall impose a sentence of detention in a penitentiary for an indeterminate period unless it is satisfied by the evidence adduced during the hearing of the application that there is a reasonable expectation that a lesser measure under paragraph (4)(b) or (c) will adequately protect the public against the commission by the offender of murder or a serious personal injury offence.

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[251] 2012 ONSC 5050
[252] 2012 ONSC 5050 at paragraph 4

[291] I agree with the argument of the Attorney General for the Province of Saskatchewan, Constitutional Branch, that s. 753(4.1) is not in issue in these proceedings as the Applicant has not brought an application pursuant to s. 52 of *The Constitution Act*. A discussion on the merits of the Applicant's position is not required in the absence of an evidentiary basis which accompanies an application pursuant to s.52 of the *Act*.

b) Finding that the treatment that Ms. Carter has received while in custody at the RPC violates the *Charter*

c) Granting a stay of proceedings for the outstanding charges identified in the Agreed Statement of Facts for which guilty pleas have been entered

[292] With respect to these latter issues, the remedial question is the same; whether this Court should grant a stay of proceedings pursuant to s. 24(1) of the *Charter*. *R. v. Jewitt*[253] is the leading case. The Supreme Court of Canada adopted this test set out by the Ontario Court of Appeal in *R. v. Young*:[254]

> . . . there is a residual discretion in a trial court judge to stay proceedings where compelling an accused to stand trial would violate those fundamental principles of justice which underlie the community's sense of fair play and decency and to prevent the abuse of a court's process through oppressive or vexatious proceedings. It is a power, however, of special application which can be exercised only in the clearest of cases.

As discussed in *R. v. O'Connor*,[255] the Supreme Court has repeatedly found that a stay of proceedings is to be granted in the "clearest of cases".

[293] The Court is required to consider the appropriateness of alternative remedies. The Supreme Court of Canada in *R. v. Bellusci*[256] recently considered the appropriateness of a stay of proceedings being granted in a case involving an inmate in and a guard in a prison setting. The Court held:

> The trial judge in this case carefully and correctly considered all the relevant principles. He assessed the gravity of the prejudice and explained why he thought alternative remedies were inadequate. He did not misdirect himself on the applicable law or commit a reviewable error of fact. His exercise of discretion to grant a stay of proceedings was not so clearly wrong as to amount to an injustice. It is clear from his analysis that he felt that the *Charter* breach in issue

[253] [1985] 2 S.C.R. 128
[254] (1984), 40 C.R. (3d) 289
[255] [1995] 4 S.C.R. 411
[256] 2012 SCC 44

here fell within the "residual" and "exceptional" category of cases where the misconduct was so egregious that the mere fact of going forward in the light of it will be offensive. Having found that B had been provoked and subjected by a state actor to intolerable physical and psychological abuse, it was open to the trial judge to stay the proceedings against him. Appellate intervention in these circumstances was therefore unwarranted.

[294] I am unable to agree in the circumstances that this is the clearest of cases such that this remedy should be granted and I note that there are alternative remedies available, including a reduction of sentence that might otherwise be appropriate.

d) Granting a constitutional exemption or other remedy pursuant to s. 24(1) of the *Charter:* including a structural injunction.

[295] I agree with the arguments of Counsel for the Attorney General of Saskatchewan, Constitutional Branch and for the Attorney General of Canada on these points with respect to structural injunction:

i. This Applicant must seek a prerogative relief in relation to CSC before the Federal Court of Canada or alternatively a writ of *habeas corpus* before the Court of Queen's Bench of this province. The Provincial Court does not exercise supervisory jurisdiction over federal correctional facilities.
ii. A structural injunction is a civil remedy and should not be entertained in the context of criminal proceedings.
iii. There is an insufficient evidentiary record with respect to the actions of the CSC to support the relief sought.

[296] With respect to the relief of a constitutional exemption, I agree that it should not be granted when the underlying statute has not been appropriately challenged pursuant to s. 52 of *The Constitution Act* and that there is an insufficient evidentiary record to support granting such relief.

e) s. 12 of the *Charter* – cruel and unusual treatment

[297] In summary, with respect to the *Charter* applications of the Applicant, I am unable to grant the relief requested, for jurisdictional and evidentiary reasons. As well with the evidence before me and the focus of these proceedings, there are necessarily many more questions than answers. In the result, in many instances I have endeavoured to outline the issues and provide some of the most compelling pertinent information.

[298] However, while the Correctional Service Canada is not a party to these proceedings and I am constrained in my ability to grant *Charter* relief, I may nonetheless, where confident in the reliability of the information received, take treatment into account in sentencing. I focussed upon the following complaints:

i. Use of OC spray during self-harming incidents upon a mentally ill patient
ii. Use of the Pinel Board – especially during the time prior to that the Broda Chair was made available to Ms. Carter and the use of it when the Broda Chair was preferred
iii. Overuse of isolation and restraint – when it was not done for medical reasons but for other reasons including as punishment

[299] I am confident that an informed public would be shocked regarding the use of the OC spray and the Pinel Board. The evidence is that OC spray was used many times on Ms. Carter, perhaps as many as 35 times, to arrest self-harming behaviour and that it merely served to increase distress. As well I am confident that the use of the Pinel Board especially when it was used in its most unpleasant form, when she was strapped to a hard board over extended periods of time, was inhumane. While the Pinel Board was subsequently replaced by a hospital bed with the Pinel Restraint System attached and a gel mattress was obtained to alleviate bed sores, there was an obvious alternative to its use, especially during the day; the Broda Chair should have been brought in much sooner.

[300] I noted that s. 68 of the *Corrections and Conditional Release Act* prohibits the use of restraint as a means of punishment. The allegations with respect to the use of isolation and restraint are very serious and warrant closer examination than this forum permitted, focussed as it was on the dangerous offender application. As I endeavoured to sort through the reports provided, it was difficult to know with precision, when and whether the treating psychiatrist ordered the use of restraint or if it was imposed by correctional officers. Often the terminology used was unclear, for instance "placed in the Broda Chair and the Pinel Restraint System (PRS) was applied."[257] As well, an Incident Report may refer to removing Ms. Carter from the PRS and then returning her to it, without identification of the reason for being in the PRS initially. Further, it was difficult to know when isolation was used, the duration and surrounding circumstances. I viewed reports that suggested that isolation and restraint would be alleviated after a couple or at most a few hours. Even Dr. Mela's Progress Note, dated

[257] Defence Binder Tab 50 - Exhibit D-1

February 22, 2011, as compelling as it appears, did not attribute responsibility for Ms. Carter being in restraint for 48 hours.[258]

[301] Where concern has been expressed about mistreatment so far as the Court was made aware, there have also been some substantial changes. OC spray as a means of stopping Ms. Carter's head banging was discontinued. The Pinel Board, in its most troubling form was replaced with a hospital bed and a gel mattress. The Broda Chair replaced the use of the Pinel Board in large part and the Broda chair allows Ms. Carter during the daytime greater freedom to leave her cell and socialize and yet be restrained from hurting herself. When Administrative Segregation was employed more recently, it was coupled with Intensive Psychiatric Care (IPC) or most often Restrictive Psychiatric Intervention (RPI) so that the degree of restraint and isolation from others was carefully monitored and alleviated after a few hours rather than many hours or days.

[302] My concerns regarding the mistreatment, particularly as it pertains to the use of the OC spray and Pinel Board may be reflected in my assessment of the remand credit and the length of the sentence to be imposed.

F. Remand Credit

[303] Pursuant to s. 719(3.1) of the *Criminal Code* and having regard to the reasoning of the Supreme Court of Canada in *R. v. Summers*[259] I find that Ms. Carter is entitled to an enhanced ratio of 1.5 to each day spent in presentence custody. Ms. Carter's remand time has been most onerous, certainly more onerous than for most in presentence custody. Further she has been unable to access programming and the prospect of being transferred to a mental health facility such as Brockville has been on hold pending sentence. She has been on remand for 2 years and 230 days or 960 days, which after a credit of 1.5 for each of the 960 days, puts her enhanced remand credit at 1440 days or 48 months or 4 years.

G. The Appropriate Sentence

[304] Ms. Carter is being sentenced for 19 offences under the *Criminal Code*. The Crown proceeded on all charges by indictment:

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[258] Defense Binder Tab 42 - Exhibit D-1 - Dr. Mela Progress Note February 22/11.
[259] 2014 SCC 26

- 2 assaults with a weapon contrary to s. 267(a), punishable by a max of 10 years' incarceration,
- 7 assaults peace officer, contrary to s. 270(1)(a), punishable by a maximum of 5 years, and
- 10 common assaults contrary to s. 266, also punishable by a maximum of 5 years' incarceration.

[305] Seven of the offences are assault on peace officers contrary to s. 270(1)(a). Section 718.02 of the *Criminal Code* requires that in sentencing for that specific offence, a Court must give primary consideration to the objectives of denunciation and deterrence. The 2 assaults with a weapon were committed in relation to correctional officers. I am mindful that a number of the common assaults were committed on correctional officers. With the exception of the assaults with a weapon, the injury, if any in relation to the assaults on peace officers would likely not have elevated these offences above a common assault. I am also mindful of the background circumstances of these assaults, notably that she was often in a form of isolation or under restraint and some of the assaults occurred in the backdrop of her being transferred from one form of restraint to another or during a "use of force" by correctional officers. One of these assaults clearly occurred during a self-harming incident. Some of the background information was scant such that it was difficult to express confidence in knowing the full background to the offence.

[306] The assaults most troubling to the Court, even giving consideration to Ms. Carter's reduced moral blameworthiness, are those involving an attack on an unprotected fellow patient, an attack with a weapon and those which involved either repeated blows or significant physical handling. These offences warrant the greater sanctions generally. I believe this speaks to the principle of sentencing which is to acknowledge the harm to victims.

[307] In arriving at the appropriate sentence, I have considered the purpose and principles of sentencing provided for in s. 718 of the *Criminal Code*. In light of Ms. Carter's record for violence and Ms. Carter's mental health status, and mindful of the fundamental purpose of sentencing: to contribute, along with crime prevention initiatives, to respect for the law and the maintenance of a just, peaceful and safe society the dominant sentencing objectives are:

- Denunciation,
- Deterrence,
- Separation from society,
- Rehabilitation,
- Acknowledgement of the harm to the victims,

- Proportionality having regard to the gravity of the offence and the degree of responsibility of the offender,
- A sentence should be similar to sentences imposed on similar offenders for similar offences committed in similar circumstances;
- Where consecutive sentences are imposed, the combined sentence should not be unduly long or harsh;
- An offender should not be deprived of liberty, if less restrictive sanctions may be appropriate in the circumstances; and
- All available sanctions other than imprisonment that are reasonable in the circumstances should be considered for all offenders, with particular attention to the circumstances of aboriginal offenders.

[308] Deterrence is a difficult principle to apply to someone who is mentally ill, especially someone who behaves as impulsively and compulsively as does Ms. Carter. In this regard, I note again R. *v. Adamo, supra*, at paragraph 31:[260]

> 31 Absent public safety concerns, then, mental illness is usually a mitigating factor. Punishment and specific and general deterrence are of little use when dealing with a person who has offended, at least in part, because of mental illness. As described by Clayton C. Ruby et al., Sentencing, 7th ed. (Lex-isNexis Canada Inc., 2008), a consensus has developed that "general deterrence should be given very little, if any, weight in a case where an offender is suffering from a mental disorder because such an offender is not an appropriate medium for making an example to others" (s.5.251, pp. 293-94).

[309] In light of public safety concerns and given Ms. Carter's propensity for frequent violence in unpredictable ways, she must be separated from society and in a highly structured setting. As Dr. Lohrasbe advised, Ms. Carter presents as a very high risk to reoffend.

[310] With respect to Rehabilitation, having heard from Dr. Sojonky about his progress in working with Ms. Carter and importantly the improved quality of life that she experienced in a short 6 months; there remains hope that Ms. Carter can be rehabilitated, at least to the extent that in a highly controlled setting, her self-harming and aggressive behaviour may be greatly reduced and she may enjoy a much greater quality of life. I noted that Dr. Lohrasbe did not dismiss the possibility of rehabilitation and that Dr. Mela observed that it's a question of the proper resources being available for her treatment. It is puzzling and disappointing that DBT or a similar therapy has not been made available to Ms. Carter for a very long time and not since she's been on remand.

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[260] 2013 MBQB 225

[311] I have given consideration to the principle of proportionality and notably not only the gravity of the offence but the degree of responsibility of the offender. Ms. Carter's moral blameworthiness is reduced greatly by her mental health, specifically, her obsessive/compulsive diagnosis and reduced cognitive capacity. As noted in *R. v. Adamo*, *supra*, at paragraph 34:[261]

> 34 Hand-in-hand with the mitigating aspect of mental illness in sentencing is the reduced moral culpability of offenders who are mentally ill. Since 1996, proportionality has been the primary sentencing objective in the Code, and was part of the law in Canada prior thereto. Punishment must be proportion-ate to the moral blameworthiness of the offender. An offender impelled to commit a crime by mental illness is not a free actor; his or her moral blameworthiness is necessarily lesser than that of a person who freely chooses to commit a crime.

[312] Ms. Carter is a First Nations member and while the information provided clearly supports a finding that she has been disadvantaged in countless ways by virtue of her background; there is not a realistic alternative offered for her to reside in the community at this time, given her very challenging mental health condition. Many available community-based resources do not offer the high level of structure required for Ms. Carter's as endorsed by Dr. Lohrasbe.

XIII Sentencing Decision

[313] No one of the offences is deserving of a sentence of 2 years or more. Taken as a whole and having regard to the individual circumstances of the 19 assaults, a total sentence of 6 years, which after credit of the equivalent of 4 years of remand leaves a remainder of 2 years to be served in a federal correctional facility. Where the sentences refer to time served, it is intended to include actual time served as adjusted for a ratio of 1.5 to each day actually served. With respect to the matters before me the following sentences are imposed, identified by Information #s:

i) #44658836, June 13, 2009, assault with a weapon, handcuffs, s. 267(a) - 6 months consecutive, time served

ii) #39985092, July 17, 2011, assault with a weapon, hot water, s. 267(a) - 6 months consecutive, time served

iii) #44802893, June 26, 2009, assault, s. 266 - 3 months concurrent, time served

iv) #44659235, November 5, 2009, assault, s. 266 - 3 months concurrent, time served

[261] 2013 MBQB 225

v) #43986724, February 28, 2010, assault peace officer, s. 270(1)(a) - 3 months concurrent, time served

vi) #43266417, June 20, 2010, assault peace officer, s. 270(1)(a) - 3 months concurrent, time served

vii) #44330447, October 7, 2010, assault peace officer, s. 270(1)(a) - 3 months concurrent, time served

viii) #46420419, between February 7 and 8, 2011, assault, s. 266 – 1 year consecutive time served

ix) #42799178, February 11, 2011, assault, s. 266 - 3 months concurrent, time served

x) #37290766, May 26, 2011, assault, s. 266 - 3 months concurrent, time served

xi) #36653086, June 6, 2011, assault, s. 266 – 1 year consecutive

xii) #44303351, July 26, 2011, assault on two persons, s. 266 – 1 year consecutive, time served

xiii) #44303524, August 8, 2011, assault peace officer, s. 270(1)(a) – 3 months concurrent time served

xiv) #36654811, October 22, 2012, assault, s. 266 – 1 year consecutive, time served

xv) #44332045, January 17, 2013, assault peace officer, s. 270(1)(a) - 3 months concurrent, time served

xvi) #33303772, May 12, 2013, assault, s. 266 – 1 year consecutive

xvii) #38468315, June 29, 2013, assault, s. 266 - 3 months concurrent, time served

xviii) #44664085, July 12, 2013, assault peace officer, s. 270(1)(a) - 3 months concurrent, time served

xix) #44664475, August 20, 2013, assault peace officer, s. 270(1)(a) - 3 months concurrent, time served

[314] The following Ancillary Orders are made:

(a) Ms. Carter is prohibited for life from possessing any firearms, weapon or ammunition as defined in s. 109 *Criminal Code,*

(b) She is directed to provide bodily substances samples to the appropriate authority be for the purpose of analysis and deposit into the DNA databank, pursuant to s. 487.051 of the *Criminal Code,*

(c) A copy of all exhibits and a transcript of testimony given by the witnesses together with the written reasons of this Honourable Court shall be forwarded to the Correctional Service of Canada in accordance with s. 760 of the *Criminal Code,* and

(d) Victim surcharges are waived as they would create an undue hardship.

Whelan, J

XIX List of Appendices Attached

A. Criminal Record
B. *Charter* and *Criminal Code* provisions
C. Mental Health - Federal and Provincial Legislation
D. *Canada Labour Code* s. 128
E. Administrative Segregation - Corrections and Conditional Release Act, Regulations and Commissioner's Directive #709-1
F. Management of Security Incidents - Commissioner's Directive #567
G. Use of Force - Commissioner's Directive #567-1
H. Use of Restraint Equipment for Security Purposes - Commissioner's Directive #567-3
I. OC Spray Use - Commissioner's Directive #567-4
J. Management of Inmate Self-Injurious and Suicidal Behaviour - Commissioner's Directive #843
K. Physical Restraints for Medical Purposes - Commissioner's Directive #800-2
L. Psychological Services - Commissioner's Directive #840
M. Punishment, Treatment, Living conditions & Visits - *Corrections and Conditional Release Act* and Regulations
N. *Risky Business* - OCI's Final Report - September 2013, not reproduced, it may be found at: *Risky Business*: www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20130930-eng.pdf

MARLENE JANE CARTER

OFFENCE INDEX

1. 1988-10-20 North Battleford, SK (Youth Court)	Possession of Property Obtained by Crime Over $1000 s. 313(a) CCC	6 Months Probation
2. 1988-12-15 Swift Current, SK (Youth Court)	Break Enter & Theft s. 306(1)(b) CCC (16 chgs)	1 yr Open Custody on Each Chg Conc
3. 1989-01-24 Saskatoon, SK (Youth Court)	Theft Over $1000 s. 294 (a) CCC	3 Months Open Custody Conc to Stc Serving
4. 1989-05-16 Saskatoon, SK (Youth Court)	Robbery with Violence s. 343(b)-344 CCC	16 Months Secure Custody Consec to Stc Serving
5. 1990-03-08 Saskatoon, SK (Youth Court)	Saskatoon Provincial Director Review s. 94(1) YCJA	Stc Varied on Review from Secure Custody to be Changed to Open Custody
6. 1990-09-05 Noth Battleford, SK (Youth Court)	Assault a Peace Officer s. 270(1)(a) CCC	21 Days Conc to Stc Serving
7. 1990-09-10 North Battleford, SK (Youth Court)	Unlawfully at Large s. 145(1)(b) CCC	30 Days Consec to Stc Serving] Not on CPIC.
8. 1990-10-25 Saskatoon, SK (Youth Court)	Theft Over s. 334(a) CCC	3 Months Consec to Stc Serving] Not on CPIC.
9. 1991-05-16 North Battleford, SK	BE & Theft s. 348(1)(b) CCC	7 Months Jail
10. 1992-04-27 Prince Albert, SK	Mischief Over $1000 s. 430(3) CCC	Time Served & 1 yr Probation
11. 1999-01-28 Saskatoon, SK	(1) Poss of Property Obtained by Crime Over $5000 s. 355(a) CCC	(1) 9 Months & 9 Months Probation

		(2) Fail to Comply with Recognizance s. 145(3) CCC **(5 Chgs)** (3) Driving with More Than 80 Mgs on Alcohol in Blood s. 253(b) CCC	(2-3) 1 Month on Each Chg Conc & 9 Months Probation on Each Chg
		(4) Poss of Property Obtained by Crime Over $5000 s. 354(a) CCC	(4) 9 Months Conc & 9 Probation
		(5) Driving with More Than 80 Mgs on Alcohol in Blood s. 253(b) CCC (6) Fail to Attend Court s. 145(2)(a) CCC	(5-6) 1 Month on Each Chg Conc & Conc
12.	1999-04-23 Prince Albert, SK	Aggravated Assault s. 268 CCC	2 Years Conc to Ste Serving
13.	2000-07-12 Prince Albert, SK	(1) Forcible Confinement s. 279(2) CCC (2) Assault with a Weapon s. 267(a) CCC (3) Mischief Under $5000 s. 430(4) CCC	(1-3) 2 Years on Each Chg Conc but Consec to Ste Srvn
14.	2003-04-29 North Battleford, SK	Uttering Threats s. 264.1(1) CCC	45 Days
15.	2003-10-14 Edmonton, AB	Assault s. 266 CCC **(2 Chgs)**	1 Day & 9 Months Probation Conc on Each Chg Conc
16.	2004-01-09 Saskatoon, SK	(1) Theft Under $5000 s. 334(b) CCC (2) Fail to Comply with Recognizance s. 145(3) CCC **(3 Chgs)** (3) Fail to Attend Court s. 145(2)(b) CCC (4) Fail to Attend Court s. 145(2)(a) CCC (5) Fail to Comply with Probation Order s. 733.1(1) CCC	(1-5) 35 Days