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The Spanish Influenza and Canada's Criminal
Justice System: Lessons for Pandemic Planners

Volume II: The Courts, Police and Corrections

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Mr. Fred Burch was the SIPP 2006-2007 Government of Saskatchewan Senior Fellow. *The Courts, Police and Corrections* is the second and final volume in Mr. Burch's two-volume publication. Additional copies of both volumes can be downloaded for free from SIPP's website at www.uregina.ca/sipp. Mr. Burch gave a public presentation at SIPP on his research, on November 22, 2007.

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THE SPANISH INFLUENZA AND CANADA'S CRIMINAL
JUSTICE SYSTEM: LESSONS FOR PANDEMIC PLANNERS

VOLUME II: THE COURTS, POLICE AND CORRECTIONS

Mr. Fred Burch
SIPP Government of Saskatchewan Senior Fellow
2006-2007

INTRODUCTION

Intuitively, current day Canadian criminal justice system (CJS) employees would suspect that the Spanish Influenza had an impact on their respective 1918 counterparts, but confirmation exists in municipal, provincial or federal archives and in annual reports — accessible in theory, much less so, in practice. And, although publicly accessible Canadian health sector pandemic plans¹ each mention the Spanish Influenza of 1918, the event is generally dismissed as an anomaly.

Differences in the socio-political environment, communication infrastructure, population demographics, and significant advances in medicine and health care, combined with the overwhelming influence of World War I, foster a widely held belief that the extreme morbidity and mortality rates associated with the Spanish Influenza are unlikely to reoccur. Further, in relation to the criminal justice system theme of this report, it could be argued that applying the term “system” to the criminal justice components that existed in Canada in 1918-19 is questionable. What could we possibly learn by reviewing the impact of an extreme early twentieth century event on an antiquated criminal justice system in a country still in its infancy?

Volume I of this report reviewed the community component of the criminal justice system in 1918-19. Volume II includes a brief section on the court component, but focuses on police services and correctional agencies, with an emphasis on October and November 1918, the most devastating period of the Spanish Influenza in Saskatchewan and most of Canada.

1. A comprehensive list is available at <<http://www.safecanada.ca>>.

I. COURTS

Primary source documentation on Saskatchewan's courts in 1918 was difficult to locate; documentation mentioning the Spanish Influenza was even more so. The apparent scarcity of archived files and annual reports was, perhaps, a function of the structure of the judiciary in Saskatchewan during that era. Morris (2001) notes, for example, the *Magistrates Act, 1906* (Sask.) c. 19 and the *Police Magistrates Act, 1907* (Sask.) c. 14 resulted in a judicial system quite different from current day:

The early magistrates intermeshed judicial, executive and police functions and were a far cry from the model of an independent, professional judiciary, separate and distinct from executives, the police, the prosecutor, and the municipal administration. (p. 2)

Changes to the courts that occurred in the spring of 1918 may have affected records-keeping due to the “growing pains” typically associated with significant organizational change. For example,

On the 1st of March, 1918, The Court of Appeal Act and The King's Bench Act abolished the Supreme Court of Saskatchewan and created two new courts: the Saskatchewan Court of King's Bench and the Saskatchewan Court of Appeal. The Court of King's Bench performed the trial function, and the Court of Appeal assumed the appellate jurisdiction. (Vancise, 2003, p. 3)

Antiquated processes, significant legislative change, new organizational structures, and an apparent lack of archived information, support the belief that any lessons learned from the Spanish Influenza would be difficult to uncover and of questionable value to CJS administrators. However, the police role as “Magistrate,” and the changes in the higher courts, are facts that shed light on other trends, such as increasing inmate counts and fluctuating, but uninterrupted, admissions to provincial correctional facilities during the peak period of the Spanish Influenza. For example,

newspapers reported that certain sittings of King's Bench (now Queen's Bench) ceased due to the Spanish Influenza:

The postponement of the criminal sittings of the Court of King's Bench at Regina, Moose Jaw and Saskatoon will mean the postponement of some big trials, including the Bromley murder trial at Moose Jaw. (Criminal Court Sittings Have Been Postponed, 1918, October 22, p. 9)

As a result, there were lengthier stays in provincial facilities for those awaiting trial for offences that likely would result in a federal sentence. Further, a review of the Regina Jail's Admission and Discharge logbooks (Saskatchewan Archives Board (hereafter SAB), Department of Justice, 1918) shows that although admissions fluctuated, they did not stop. The use of police magistrates could partially explain this trend. The continuation of first appearances and the acceptance of guilty pleas were likely possible because these hearings would involve only small numbers of personnel, perhaps a single police magistrate and one (jail) escort officer.

One of the other few sources that mention the Spanish Influenza was the *Canadian Law Times (CLT)*, the predecessor to the *Canadian Bar Review*, which mentions the influenza not in articles, case reviews or editorial sections but in the obituaries. Death from Spanish Influenza was first referred to in the November 1918 issue. Prior to November, these obituaries would report on court registrars, lawyers and judges, who, when age was noted, were often between 60 and 85. In the November 1918 issue this changed; the majority of the obituaries referred to deaths in the 30 to 40 age group, the group that experienced the highest mortality rate overall. Cause of death, regardless of age, was not always included in these obituaries except when it was the result of the conflict in Europe. Most of the obituaries that mention younger ages do, however, specifically refer to Spanish Influenza.

These "youthful" obituaries are of limited value in extracting any lessons learned from the impact of the Spanish Influenza on the court system but do present fascinating anecdotal accounts of the human pathos associated with the Spanish Influenza particularly in combination with other events of that era. The obituary of a District Court Registrar from Manitoba is one such example. Having experienced the horrors of the Battle of Paschendale, the

Registrar returned to Canada unscathed. He also managed to survive the Spanish Influenza. But in the spring of 1919, while on his honeymoon at Clear Water Lake, Manitoba, he drowned in a canoeing accident (*CLT*, 1919, p. 535).

In sum, the apparent lack of primary and secondary source documentation on the court system in Saskatchewan during the Spanish Influenza era makes it difficult to offer anything but general and/or somewhat speculative observations. In a few districts the higher courts did not sit for over a year, therefore provincial facilities were forced to maintain control of inmates charged with the most serious offences for longer periods of time. Admissions from the lower courts decreased for a short period but did not stop entirely. These fluctuations were probably related to illness amongst police personnel but the use of single police magistrates, rather than a full sitting of a provincial court, would have helped in the processing of new admissions throughout the peak period of infection.

II. THE POLICE²

As the court system was undergoing change and growth in the early 1900s, so too were police organizations. Massive population increases due to immigration prior to 1914 had resulted in the need for more police personnel across Saskatchewan. In addition to the Royal North West Mounted Police (RNWMP), a few provinces, Saskatchewan included, had a provincial police service.³ The number of police work sites across Saskatchewan combined with Regina's designation as the training headquarters for the RNWMP (which resulted in the constant arrival and departure of large groups of new recruits) makes it difficult to accurately determine the number of police officers active in the fall of 1918 (the number of police being one half of the equation needed to determine mortality rates for this specific CJS component). As noted below, estimates of police strength and the number who died from Spanish Influenza requires multiple qualifiers; attempting to do this for a specific time period adds a further level of complexity.

2. Few Canadian social science textbooks that focus on the police mention the Spanish Influenza. Conversely, few academic articles reviewing the Spanish Influenza mention the police. Two exceptions include Lux (1996, pp. 350-351) and McGinnes (1977, pp. 460-463) who cite Canadian archive documents describing RNWMP interactions with Indian Agents and on-reserve leaders during disease outbreaks.

3. The Royal North West Mounted Police (RNWMP) was an established service in the territories when Saskatchewan became incorporated as a province in 1905. Saskatchewan retained the services of 250 members of the RNWMP under contractual agreement with the federal government. Disputes between the federal and provincial governments over priorities — with the federal government emphasizing protection of international boundaries and the provincial government favouring enforcement of provincial liquor laws — resulted in termination of the contract in 1917 and the creation of the Saskatchewan Provincial Police (SPP). When the SPP was formed, the RNWMP still maintained responsibility for federal law enforcement (which included jurisdiction over Indian reserves) in Alberta, Saskatchewan and the Territories (RCMP, 2006).

The RNWMP annual report for the year ending September 30, 1918 (published in 1919), lists 483 personnel. The majority (322⁴) were stationed in Saskatchewan. The numbers at the end of each month could easily vary by hundreds due to the nature of Regina's training depot designation and sudden large changes in the "authorized strength" of the force.⁵ The same annual report (1919) attributes seven officer deaths to Spanish Influenza, noting five of the seven deaths occurring within a special World War I cavalry contingent. It does not appear that these officers performed regular duties during the peak influenza time period as the annual report notes the special contingent was transferred to the Canadian Expeditionary Force on October 1, 1918. In the same report, however, the Commissioner states that most of the force sailed from Vancouver on November 17, 1918, therefore, it was likely that the five Spanish Influenza deaths in the special contingent probably occurred in Regina sometime after October 6, 1918 (the date of the first known Spanish Influenza death in Saskatchewan).

The 1920 annual report (year-end September 30, 1919) lists 1600 RNWMP members, with 968 stationed in Saskatchewan⁶ and, coincidentally, again documents seven officer deaths due to Spanish Influenza. The 1921 annual report records "the death of two officers and eleven other ranks" (p. 31) but without any explanation. All of the deaths noted in the 1920 and 1921 annual reports are under the heading "Health." The October 10, 1918, *Regina Morning Leader (RML)* reported that the Spanish Influenza had infected 17 RNWMP officers at the "Barracks" and indicated a number were from "B" Squadron destined for Siberia. The next day an additional 13 RNWMP influenza cases were reported in the *RML*.

In 1918, 1919 and 1920, the RNWMP annual reports have a year-end of September 30. Most reports are signed in November of each year and each

4. The 322 figure is the combined total of all Saskatchewan detachments noted in the "Recapitulation Table" on page 21 of the Annual Report of the RNWMP (Privy Council, 1919).

5. For example, from an actual strength of 483 (Privy Council, 1919, p.21), to 1200 authorized in December 1918 and then to 2500 authorized in July 1919 (Privy Council, 1920, p. 7).

6. The Annual Report of the RNWMP (Privy Council, 1920) notes that one officer and 148 "other ranks" of the 968 were to transfer to Manitoba and an additional 258 were to transfer to Vancouver and Macleod by November 1919 (footnote at p. 9).

includes descriptions of events that occurred up to 45 days after the official year-end. Therefore, all seven deaths reported in the annual report labeled year-end September 30, 1918, likely occurred in October or November 1918.

The news reports and deaths in the RNWMP annual reports under “Health,” combined with a review of the *Canadian Police and Peace Officers Memorial Honour Roll*⁷ — which does not record any 1918 to 1919 deaths within the ranks of the RNWMP due to violence — suggests most, if not all, of the “unexplained” deaths were related to the Spanish Influenza. In sum, while it is difficult to determine with certainty the number of RNWMP Spanish Influenza deaths in specific time periods, a reasonable estimate during the peak period of October and November 1918 is seven or, assuming there is no double counting, as high as 27 if we use the same 18-month period covered in the Saskatchewan Bureau of Public Health annual report of 1921.

As the Saskatchewan Provincial Police (SPP) was a considerably smaller force than the RNWMP, the numbers are a little easier to estimate. The “Guide to the Records of the Saskatchewan Provincial Police” (SAB, Summary of the history of the SPP, 1918) notes that by December 31, 1918, there were 106 men (p. 5). As the SPP did not have a training facility, with large numbers arriving and departing, the figure of 106 is a reliable estimate of the number of SPP officers in Saskatchewan in the fall of 1918. A review of archived SPP divisional reports reveals that at least two SPP members died from the Spanish Influenza (SAB, Department of Attorney General, 1918).

There were seven cities with municipal police forces in Saskatchewan in 1918. Estimated staffing levels were determined for Regina (31), Saskatoon (20), Moose Jaw (20) and Prince Albert (6).⁸ These numbers were used to extrapolate police complements in the three remaining cities (Swift Current, North Battlefords and Weyburn). The result is a total of 105 municipal police officers (an average of 15 per city). While the Regina City Police

7. Retrieved June 2, 2006, from <<http://www.cacp.ca/english/memoriam/english/default.htm>>.

8. The Regina figure was relayed via e-mail courtesy of J. Thompson, Regina City Police (RCP) quoting from the RCP 1918 annual report; Saskatoon figure was received via e-mail from Sgt. S. Grant of the Saskatoon City Police quoting from a November 23, 1917, internal report. The Prince Albert figure was received via e-mail from S. May (Prince Albert Police and Corrections Museum) quoting from Firth (1986); the Moose Jaw figure is courtesy of Terry Coleman, Chief of Police, who cautioned that the figure of 20 staff was derived from a 1920 photograph.

(RCP) Department's 1918 annual report does not indicate if any officers were ill or died from the outbreak, there was reference to the Spanish Influenza as a problem in city police cells and offices: "Conditions are not improving and the recent epidemic has proven that it is not only a menace for prisoners who are compelled to occupy the cells but for those who have to occupy such offices" (RCP, Annual Report, 1918).

The 1918 RCP annual report also alludes to the difficulties of providing service with an already depleted staff complement:

The police force in 1918 consisted of 31 officers and constables. This is 12 less than the original strength of the Department. Under ordinary conditions this is entirely inadequate but in view of the war time economy which has been strictly observed by the Police Department, we have endeavoured to get along by working officers long hours and by depriving members of the Department of the time off which all working men should reasonably expect. (RCP, Annual Report, 1918)

The municipal archives of the seven cities were not searched (with the exception of the City of Regina archives). Representatives from the city police services who were contacted indicated that on-site files or annual reports for the 1918 period were difficult to locate or may not exist. In sum, it was impossible to establish how many, if any, city (municipal) police officers in Saskatchewan's seven cities died from the Spanish Influenza.

In addition to RNWMP, SPP, and municipal police officers, a number of smaller communities had one or more town constables. The number of town police in Saskatchewan in 1918 fluctuated with population increases and decreases. A report from the Saskatchewan Department of Justice (undated) notes that since 1909, municipalities required a population of at least 500 before they could be incorporated as a town, and "in the early years, towns and cities had no choice but to have their own police forces." There are 70 towns listed in the Saskatchewan Department of Municipal Affairs *Annual Report 1918-1919* (1920). Of those towns, 35 show populations between 700 and 4400; the other 35 report populations of between 300 and 650. Comparing Municipal Affairs annual reports from previous years suggests that towns with populations of 700 had broken the "500" milestone for at least a full year, which is sufficient time to make it

probable that they had at least one town constable during the peak influenza period, adding a total of 35 to the overall number of police in Saskatchewan.

Morbidity estimates are contained in the narratives provided in RNWMP and SPP annual reports. The estimates ranged from 30% (a figure frequently offered as an estimate of infection in the general population) to 100% (a reflection of small detachment sizes). Newspaper accounts suggest that during specific periods 50% of the officers at Regina's RNWMP Barracks were infected (Infection at Barracks, 1918, October 26).

Morbidity rates for the *total* population due to past droplet/air borne diseases, especially those that involve influenza-like illnesses, are problematic; records exist only for those who report infections. Mortality rates, however, should be reliable if the cause of death is accurately recorded. Ironically, it is suggested that the reverse may be true for the occupation "police." In 1918-19, detachment complements (and municipal police services) were small and units were para-military. Administrators would have reported the exact numbers who had called in sick, therefore, the reported percentage of those sick should be reasonably accurate. Concerning police mortality rates, however, the difficulty in establishing the total number of officers in Saskatchewan erodes the ability to confidently estimate the overall number of deaths as a rate for that occupation group.

A table entitled "Occupation of Deceased from Epidemic Influenza, 1918, 1919, 1920" appears in the 1921 Annual Report of the Saskatchewan Bureau of Public Health (SBPH) and under the heading "Policeman" estimates nine deaths, which the SBPH derived from official death certificates. It is possible that this would include deaths from all police services in Saskatchewan (town police, municipal, provincial police and RNWMP). Whether any members became infected as a result of contacts made in the performance of their duties is unknown.

Having noted the limitations in determining police numbers, a reasonable estimate of the total number of police officers in Saskatchewan in the fall of 1918 is 568. This figure is based on: RNWMP — 322; SPP — 106; Municipal Police — 105; and town police — 35. Based on the SBPH report, this estimate would result in a mortality rate of 16 per 1000 police officers in Saskatchewan if the nine deaths occurred in the fall of 1918.

This police mortality rate is significantly higher than the overall provincial rate of 6.4 per 1000 as noted in the SBPH Annual Report (1921).

Support for a police specific mortality rate much higher than the provincial rate may be derived by working the mortality rate equation backwards. If the number of deaths (nine) is relatively accurate and the overall provincial mortality rate of 6.4 per 1000 is applied, using nine deaths in the equation would require 1400 police officers, a number that appears to be improbable.

The difficulties noted above in determining the actual number of police officers (with the exception of the SPP), and the number of police deaths, clearly suggests caution is needed when applying any significance to the mortality rate of 16 officer deaths per 1000. Nonetheless, it is suggested that the rate is probably on the low end as the number of RNWMP Spanish Influenza deaths, possibly as high as 27, was not added to the figure of “nine” reported by the SBPH. With this in mind, if a similar illness afflicted Saskatchewan, or Canada, how many deaths in the police community would the general or the chosen police specific mortality rate generate using current police complements?

For the year 2006, Statistics Canada records 2030 police officers in Saskatchewan and 62,458 for all of Canada (Statistics Canada, 2006, p. 24). These figures include personnel from RCMP headquarters and the training academy. The 1918 estimate of 568 police officers in Saskatchewan also includes RNWMP in training in Regina. If a pandemic similar in virulence to the 1918-19 Spanish Influenza had occurred in 2006, and infectivity and other conditions were similar, there could have been 13 police officer deaths in Saskatchewan using the overall provincial mortality rate of 6.4 per 1000. If the higher, police specific, mortality rate of 16 per 1000 is used, 32 police officer deaths could have occurred in Saskatchewan.

By applying the two rates (6.4 and 16) to the total number of police officers across Canada in 2006, the number of deaths could have been between 400 and 1000. Either rate would have had a significant impact on the ability of police agencies to conduct their regular duties and any new tasks resulting from a pandemic. If the virulence of a future contagious disease is similar to the Spanish Influenza, over 50% of the fatalities would occur within one to two months. As traumatic as the deaths may be, morbidity rates of 30 to 100% within specific work units would pose the greatest dilemma for police administrators as it appears that in 1918 the officers in specific work sites became ill at the same time.

Table 1. Estimated Police Mortality (Spanish Influenza) 1918 - 2006

(A) Time Period	(B) Estimated or Actual Number Of Police	(C) Estimated Fatalities using Saskatchewan's 1918 Provincial Mortality Rate of 6.4 / 1000	(D) Estimated Fatalities using Saskatchewan's 1918 Police Specific Mortality Rate of 16/1000
In Sask. Fall 1918	568(estimate)	N/A	9
In Sask. 2006	2030 (actual)	13	32
In Canada 2006	62,458 (actual)	400	999

* The 1918 figure is a compilation of reported and estimated figures as noted in the preceding pages. It includes an unknown number of trainees and RNWMP troops destined for service overseas; the 2006 figure also includes RCMP trainees. The 2006 figures are from Statistics Canada. (2006). *Police Resources in Canada*, Cat No. 85-225-XIE.

The police specific morbidity and mortality rates shown in Table 1 are based on deaths that occurred during what is acknowledged as one of the most devastating pandemics since the Black Death.⁹ The 20 to 40 age group suffered the most during the 1918-19 pandemic, and it seems reasonable to assume most police officers in 1918 would have been in this category. In the fall of 1918, the age of police officers may have been correlated with mortality, but it is difficult to determine if the occupation itself was related to the rate. Was there something different about the interactions between police officers and civilians during the pandemic that might suggest a correlation? Was there anything different about policing duties in general in the fall of 1918 compared to other time periods?

Pettigrew (1983) provides multiple anecdotal examples of police officers across Canada in 1918, particularly in the north, travelling to small communities and reserves to assist by bringing survivors, often orphans, to larger communities or helping to bury the dead. As noted in Lux (1996, pp. 348-351), the RNWMP were dispatched to reserves to enforce quarantines but often found themselves engaged in relief work as the Indian agents in certain regions were afraid of infection and refused to assist.

9. One estimate indicates the Black Death of the 14th Century killed 25% of Europe's population (Diamond, 1997, p. 202).

The Superintendent of the Prince Albert Division of the Saskatchewan Provincial Police noted that,

all members suffered with the Spanish Influenza ...[This] caused the High Courts to be adjourned from time to time, in fact Prince Albert has not had a court of King's Bench since April. (It) will be held in Prince Albert on April 15th 1919 when there will be a large docket as some of the prisoners have been in jail since June last. (SAB, Department of Attorney General, Prince Albert Divisional Report, 1918)

The Saskatoon Division of the SPP noted similar problems and commented on a new workload increase caused by the outbreak, stating that Spanish Influenza

swept the district ... Medical Practitioners worked night and day ... [V]olunteers no doubt saved many lives... [The] epidemic increased workload related to careful inventory of all property of deceased persons with no relatives in the district. (SAB, Department of Attorney General, Saskatoon Divisional Report, 1918)

The Regina SPP Division reported that "Only five members suffered from mild attacks of the Spanish Influenza...(and) recovered entirely" (SAB, Department of Attorney General, Regina Divisional Report, 1918). Swift Current, however, recorded one of the two SPP deaths attributable to the epidemic (SAB, Department of Attorney General, Swift Current Divisional Report, 1918). The Superintendent of the Swift Current SPP noted that during the period of the Spanish Influenza, one constable

lost his life, and through which nearly every member of the division was incapacitated for a considerable time, tying up the Police work of the Division in general and causing adjournments of the higher Courts, thereby causing much delay and inconvenience in connection with the Administration of Justice.

This Superintendent also inadvertently reports on a possible role of the police in spreading the disease, noting that

we were very fortunate in only having one death, as several of the Constables, although suffering from the disease, could not be induced to take the necessary steps to take care of themselves and regardless of danger, kept on attending to their duties. (SAB, Department of Attorney General, Swift Current Divisional Report, 1918)

As noted earlier, a role of the police in 1918 was to assist with quarantine. The October 10, 1918, Saskatchewan Provincial Order in Council and the Regulations approved on October 16, 1918, resulted in a number of mayors believing they had authority to close town access.¹⁰ Multiple communities set up blockades and refused to allow anyone other than medical personnel into their town and village limits.¹¹ The Saskatchewan Provincial Police originally assisted with such “blockades.” Lux (2001, pp.182-185) points to an ironic situation created by ruling class interpretations of the concept of quarantine and the use of blockades. At the turn of the century, local doctors routinely imposed quarantines on reserves in an attempt to contain infectious diseases, such as measles and smallpox; RNWMP officers enforced such quarantines. In contrast, during the Spanish Influenza, the province’s Medical Health Officer (MHO) also sought assistance from the police, not to enforce the local quarantine efforts but to stop it, as quarantine was “contrary to the approved methods of combating the disease” (Lux, 1996, p. 100). On November 5, 1918, Saskatchewan’s Provincial MHO wrote to the SPP insisting that they disregard such “laws” enacted without legal authority (*Ibid*). The SPP were still facing image and acceptance problems having just recently taken over from the

10. Refer to the Section on “Quarantine and Isolation” in Volume I of this report.

11. Similar incidents occurred in Alberta (e.g. Lethbridge, Taber and Pincher Creek). The Alberta Provincial Police assisted with the closure of railway stations and highways (McGinnis, 1977, p. 451).

RNWMP.¹² This combined with policing shortages caused by the influenza and the apparent fear level in the community suggests the SPP may have been unwilling or unable to step into the middle of the dispute between community leaders and the provincial MHO. Railways did recommence selling passenger tickets in late November, but it is possible that this related more to the ebb of the infection rate than the direct involvement of the SPP in counteracting “blockade” efforts.

Given the paucity of primary source documents, it is difficult to construct a clear picture of the impact of the Spanish Influenza on police services in 1918. Whether police officers intuitively engaged in “social distancing,” entered households more cautiously, or attempted to use provided (or makeshift) personal protective equipment, or if police administrators even attempted to disseminate reasonable guidelines, is simply unknown. In the absence of evidence to the contrary, officers were likely no better informed or protected than the general population. Exposure to those recently deceased and securing their property without personal protective equipment may have been causal. The question then becomes, are police agencies today any better prepared? Are there pandemic plans that provide guidelines or practical assistance to current police services? And, are mechanisms in place to provide timely and accurate information to police officers when a pandemic is approaching and or has arrived?

Policing and Current Pandemic Plans

Current municipal and provincial health sector pandemic plans generally acknowledge that they complement the Canadian pandemic plan and all make frequent reference to the need for other government departments, regions or groups to use these plans as a guideline. As they are health agency generated plans, there is no specific intent to provide guidelines for other sectors. Reference to police agencies is generally limited

12. In a notation dated December 21, 1918, Inspector Sullivan of the Prince Albert SPP noted “foreigners pay very little attention to our uniform” although they are “gradually beginning to realize the SPP force is the same as the Mounted police” (SAB, Department of Attorney General, 1918, C Divisional Report for Prince Albert SPP).

to listing expectations or additional work load duties.¹³ For example, most plans mention that assistance from police agencies will be required to enforce quarantine or isolation, secure anti-virals and/or vaccines, provide security for the transportation of these items, and assist with criminal record checks (due to an expected increase in volunteers).

A number of police agencies¹⁴ across Canada are actively developing (or have completed first drafts of) emergency plans related to the impact of an infectious disease outbreak. In addition to the overall goal of assisting public health agencies with control efforts, police administrators will have to do so while dealing with issues that will face any organization, including depleted staffing levels, requests for personal protective equipment, and isolation or quarantine (for police officers who wish to avoid returning home at the end of a shift), as well as related issues such as salary if isolation or quarantine is required or voluntary.

A number of tasks that need to be considered by police agencies are not merely implied or expected by other agencies; they are legally mandated. Bill C-12, the new *Quarantine Act* (S.C., 2005, c. 20) received Royal Assent on May 13, 2005, and came into force on December 12, 2006. Section 52 of the new *Quarantine Act* states: “A peace officer shall provide any assistance that an officer [Quarantine or Environmental Health Officer] acting under this Act may request for the purpose of administering or enforcing this Act.” Although the *Quarantine Act* primarily affects the RCMP (its main application is to air and seaports), police services in all major centres will need to be aware of the various powers and restrictions in the Act. For example, there are specific provisions for arrest without warrant (section 18) and prohibitions related to the use of force must be specified in a search warrant issued by a provincial judge authorizing entry into a dwelling (section 48.3).

13. The BCPIP (2005) contains a generic checklist for police agencies on pages 124-25. The Calgary Health Region Plan (CHRP, 2005, p. 56) notes that planning for the region is not to assume that the police will be available for vaccine transportation and other related security functions. Of all Canadian pandemic plans, Toronto’s plan (TPIP, 2006) contains the most police specific information and guidelines.

14. The officer responsible for the Regina City Police plan indicates, for example, that as of June 2007, Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Saskatoon, Toronto and Ottawa city police services, and the RCMP have, or are developing, plans.

Saskatchewan provincial legislation also refers to a health role for the police and shapes this role in terms of discretionary powers. Section 55 (1) of the *Public Health Act 1994* (c. P-37.1, am'd 2004), for example, notes that police officers “may” render assistance to public health officers “conducting an inspection, investigation, inquiry or search” as outlined in previous sections of the Act (e.g. section 38-2) and detain civilians who refuse to comply. The use of the word “may” could cause reluctance by police officers to assist if requests are made during the initial stages of a pandemic when confusion is likely to be high. If police officers do not believe they have adequate personal protection, or do not have clear pre-determined locations to take these individuals (or well-equipped police cells), their reluctance to assist may be greater.

The attempt in this section to establish mortality rates and to extrapolate the rate to current police numbers — especially given the noted qualifiers — may at best catch the readers’ attention, but the figure is of limited value from a policy perspective. Morbidity rates, however, especially for those who manage small work units, should demand serious attention as infection rates of 30 to 50% will pose more serious problems in these units. Further, if there is an expectation of a large and sudden list of volunteers requiring security clearances, planning to accommodate this needs to occur. And, although there are other points to be considered, will officers have access to appropriate personal protective equipment (PPE) and the ability to quarantine themselves if their duties result in confirmed exposure?

III. CORRECTIONS

Crosby (2003, p. 19) suggests that prisons and military institutions should provide fertile ground for research on the impact of the Spanish Influenza as these institutions are generally required to maintain detailed records of those in their charge. Offender “tombstone data,” combined with overall admissions, daily counts and available bed-spaces could reveal valid and reliable morbidity and mortality rates, allowing comparison between and across facility types. If records describing preventative measures enacted in correctional facilities in 1918 were available, success or failure of such measures could provide insight for CJS administrators and the community in general.

But, Crosby (2003) focused his research on United States military records and civilian infections in major American cities, making only limited reference to correctional data. Military organizations may have been more meticulous in their record keeping than quasi-military organizations (such as prisons). In Saskatchewan, archived prison records from the Spanish Influenza era (in particular from the fall of 1918 to the end of 1919) present a curious collection of detailed expenditures and receipts with occasional incident reports but few files containing policies or data on health and security, or inmate, employee and management working relationships. It is unknown whether this is a result of the Spanish Influenza, a function of the war (paper and other items were in short supply), a lack of literacy skills, a different “documentation” ethic, or a reflection of the assigned department (Public Works).

Although the amount and type of material uncovered in Saskatchewan and federal archives was not as voluminous as had been hoped, sufficient primary source documents exist to present a modest glimpse of what happened in corrections during the Spanish Influenza pandemic. To put the review of this material into perspective, a “snapshot” comparison of the number of offenders in custody in Canada in 1918 versus a more recent tally appears on the following page.

The 1918 figures in Table 2 include those offenders labelled “criminally insane” who were maintained on each correctional facility’s (federal and provincial) daily counts; the 2004-2005 data includes inmates held in

federal Regional Psychiatric Centres. The number of “young offender equivalents” housed in Children’s Aid Society facilities in 1918 is not included under the “Reformatories” headings. Further, youth remanded in custody are not included in the 2004-2005 youth statistics. In spite of these and other comparison problems, Table 2 still provides a modest appreciation for the scale of the difference between the two time periods.

Table 2. Institutional Counts 1918 and 2004-05

(A) Facility Type	(B) Count September, 30 1918	(C) Average Daily Count FY 2004-2005
Penitentiaries	1,643	12,301
Reformatories (Boys)	1,195	---
Reformatories (Girls)	311	---
Youth (Secure and Open Custody)	---	1,299
Adult Jails (Provincial)	2,052	19,816
TOTAL	5,201	33,416

Source: Column B - Dominion Bureau of Statistics, 1919, Table 7; Column C - Statistics Canada, Youth custody and community services in Canada, 2004/2005, Cat No. 85-002, Vol. 27, no. 2. p. 18, and, Adult Correctional Services in Canada, 2004/2005, Cat No. 85-002, Vol. 26, no. 5. p. 3.

Adult Provincial Facilities: Saskatchewan

Correctional facilities usually have an official or rated capacity (the number of cells and/or beds) that may be tied to budget allocations. Unable to post “No Vacancy” signs however, capacity fluctuates with inmate count and security needs and can change quickly and significantly with additions, renovations, use of other space (e.g. hallways or gymnasiums), or double bunking. The capacity and count at the time of any serious air-borne or droplet contagious disease outbreak likely will be correlated with morbidity and mortality.

The architectural drawings (SAB, Van Egmond and Storey fonds, 1912) for the “new” Regina Gaol built in 1913-14 on 640 acres shows 126 single occupancy cells on three levels (21 per side on each of three levels) plus 14 cells in the basement or ground level for a total capacity of 140 inmates. The basement cells,¹⁵ reflecting social issues and philosophies of the 1918 era,

15. In 2007, this area is referred to as “East G.” The 14 cells were restructured over the decades to create a total of 17 cells.

were labelled on the blueprints as “Lunatic,” “Padded,” “Punishment” or “Condemned.”

The “new” 1913 Regina Gaol, similar to the provincial facility in Prince Albert, engaged inmates in husbandry and food production activities intended to aid in prisoner reformation and contribute to institutional self sufficiency (Skinner et al., 1980, pp. 37-41). It was not uncommon in Canada for prisons to have poultry and swine operations (as well as cattle and horses) in addition to a variety of crops. This mixed farming concept, also prevalent in homesteads across North America in 1918, is somewhat similar to that which occurs on a large scale in Asia today — various types of poultry and livestock in relatively close proximity to congested human living quarters surrounded by large crop fields.

The common method of dressing poultry during that era (common in prisons and the community) was by hand. The *RML* classifieds, during the fall of 1918, routinely contain advertisements for “Feather Pickers,” tasks not only completed by hand but probably without the benefit of any personal protective equipment. What is now referred to as Zoonosis — “any disease and/or infection which is naturally ‘transmissible from vertebrate animals to man’” (World Health Organization, 2007, p. 1) — has been known by medical science for centuries, but it is not necessarily knowledge that has been widely translated into practice. Indigent Asian farmers, often the subject of current (2005 to 2007) news articles on Avian Flu outbreaks, were (until recently) no more aware of the possible serious consequences of uncontrolled mixed farming than the struggling homesteaders in Saskatchewan (and Canada) during the era of the Spanish Influenza. There does not appear to be any direct evidence that the presence of swine and poultry, potentially rich environments for “re-assortment,”¹⁶ was related to influenza outbreaks in correctional facilities. However, the facility with the highest mortality rate did have both, and reported a “hog cholera” outbreak that resulted in the entire “piggery” being destroyed.¹⁷

16. The CPIP (2004) notes, “It is thought that new influenza viruses capable of causing pandemics in human populations arise through genetic mixing (re-assortment) between human and avian influenza viruses. Pigs, which can be infected with both human and avian influenza viruses, may act as vehicles for such re-assortment events” (p.17).

17. St. Vincent de Paul Penitentiary notes in the 1921 annual report that its entire swine operation had to be destroyed due to “hog cholera” (now labelled swine influenza). A time period is not given but the reference is in a post-Spanish Influenza annual report.

In 1918, the staff complement at the Regina Gaol was 22. The “jailer” lived in the City of Regina while the keeper, instructors, surgeon and a number of the “turnkeys” resided in “cottages” located approximately 100 metres from the actual Gaol.¹⁸ The title “jailer” was later changed to “warden” in the early 1920s and decades later to the current title of “director.” In 1918, the “gaoler” (warden) and “chief keeper” (deputy director)¹⁹ occupied offices virtually unchanged and still in use in 2007.

The average daily count for the Regina Gaol for 1918-19 was 122. A review and manual calculation of the daily entries in the Regina Gaol Admission logbook for 1918 shows, however, that the count during the peak period of the Spanish influenza (October 1 to November 31, 1918) was approximately 85 (SAB, Department of Justice, 1918). The low count (relative to the year-end average count) was, in part, a function of fewer daily admissions coinciding with the onset of the Spanish Influenza in the community.

From October 6 to October 15, 1918, there was a noticeable increase in admissions (ten more than in any other nine-day period that calendar year), but in the last two weeks of October admissions decreased to 12, less than 25% of the admissions for all other two-week periods from September to December 1918 (or any two-week period in all of 1919). The initial increase was possibly a function of police agencies with “holding cells” that arranged to transfer inmates more quickly than usual in *anticipation* of reduced staffing levels or fear of contagion; the later sudden drop in admissions was possibly related to *actual* reduced policing levels as infection spread. That is, the increases occurred during circumstances similar to what the World Health Organization describes as Phase 4 — “evidence of increased human to human transmission,” and Phase 5 — “evidence of significant human to human transmission.” The decrease in admissions corresponded with Phase

18. The 22 staff were: nine turnkeys, five escort officers, two instructors, a surgeon, a storekeeper, the gaoler, a chief keeper and two assistant keepers — numbers were compiled from correspondence in SAB, Saskatchewan Department of Public Works [hereafter SDPW], 1918.

19. It should be noted there is little consistency in terminology or spelling of basic terms such as jail, gaol, prison, warden, jailer, keeper, turnkey or guard, etc. in the annual reports or in archived documents, with the author of each document often apparently selecting whichever word or spelling they believed to be appropriate.

6 — “efficient and sustained human to human transmission.”²⁰ This suggests that current CJS administrators should interpret, with caution, common statements in all Canadian pandemic plans that planners will have 30 to 90 days before the peak period to operationalize contingencies once a pandemic emerges. At the Regina Gaol, the infection arrived and ended in a 30-day period. In a number of prisons in Canada, it appears that the time between onset of the infection and cessation of infection was 21 to 45 days.

The Saskatchewan Bureau of Public Health (SBPH) annual report for 1921 translated all mortality figures for the province, cities, towns and villages into rates per 1000 population. Using an estimated average population in Regina over the three-year period of 40,250 and a final death toll of 330, the SBPH documented a mortality rate of 8.2 per 1000 Regina citizens.²¹ Morbidity rates may be subject to questions of validity and reliability as cases may go unreported by those choosing not to contact a clinic or doctor, or be misdiagnosed, particularly in the early stages of the outbreak. Further, in 1918, if civilians chose to contact a medical professional, influenza was not a reportable disease under provincial health legislation until the pandemic became entrenched; hence, morbidity and mortality records were incomplete. In correctional facilities in 1918, it does not appear that administrators kept detailed records of the type of staff illnesses, but, similar to police agencies, the number of employees was relatively small. Therefore, a warden or “jailer” who reported illness percentages probably was presenting a fairly accurate figure.

The 1919 annual report for the Regina Gaol notes that “Like all other institutions we were visited by the epidemic of Spanish Influenza which for a time was most serious as practically all attendants and inmates were affected at about the same time” (SAB, SDPW, 1919, p. 35). The stated morbidity rate for the Regina Gaol, apparently close to 100%, was high

20. Refer to WHO *Six Phases of Alert* at http://www.who.int/csr/disease/avian_influenza/phase/en/. Retrieved November 29, 2006.

21. The Dominion of Canada Census, however, lists Regina’s population as 30,213 in 1911 and 34,432 in 1921. Although it is possible that Regina’s population rose to 40,250 during the period of the Spanish Influenza, it is just as likely that the estimate of 40,250 in the SBPH report was excessive and inadvertently skewed the mortality rate. Adding the 330 deaths to the 1921 Census population for Regina (creating a population of 34,762) would result in a mortality rate of 9.5 per 1000 population.

compared to estimates of 30 to 50% for most civilian communities. With three inmate deaths due to Spanish Influenza on October 25, 26 and November 1, 1918 and an estimated count of 85 inmates, the inmate mortality rate for the Regina Gaol compared to the community was also high — 35 per 1000 — but the value of a rate based on such a small sample is questionable. With this caution in mind, during October and November 2006, the average count at the Regina Provincial Correctional Centre (Regina PCC) was 425. If the 1918 Regina Gaol inmate mortality rate is applied to the 2006 (two-month) count at Regina PCC, 15 deaths would be expected.

Shortly after the City of Regina recorded its first Spanish Influenza death on October 6, 1918, operational issues related to infection surfaced at the Regina Gaol. A letter dated October 11, 1918, from the Deputy Minister of Public Works to an employee, whose duties included admission and discharge functions at the Regina Gaol, begins with “in reference to not wanting to work in the position of Turnkey at the Regina Jail under the present conditions...” (SAB, SDPW, 1918 A). The response notes that there was nothing under the existing rules and regulations that addressed employee absenteeism due to fear of disease, therefore the employee was advised, in writing, that he had to report for work or his position would be filled. Ironically, two of the three Regina Gaol inmates who succumbed to Spanish Influenza were recorded in the “Admitting and Discharge Book” by the same employee who had written to the Deputy Minister, suggesting the employee had in fact come into some form of contact with individuals who later succumbed to the infection. This specific employee’s name appears in archival records into the late 1920s, which indicates he survived.

The “keeper” of the Regina Gaol did not fare as well, suffering a serious bout of Spanish Influenza that required two months recovery time (SAB, SBPW, 1919). Although the keeper did return to work at the Gaol in 1919, he apparently never fully recovered and died from an unrelated illness in 1921. Prior to the keeper’s bout with Spanish Influenza, his spouse died from Spanish Influenza (the keeper and his family lived in an on-site cottage at the Regina Gaol). Adding to an already stressful time for the keeper (and all employees), two inmates escaped by sawing through bars the same evening the keeper’s spouse died (both events were reported in the *Regina Morning Leader*, 1918, October 22, p. 9, 10). Whether or not employee illness, or possible reduced staffing levels, played a role in the escape is

unknown. The incident does, however, serve as a reminder to prison personnel that due diligence towards normal operational activities is still required during periods of calamity.

Just prior to the third and final Regina Gaol inmate Spanish Influenza death, a letter from the office of the sheriff, Judicial District of Swift Current, dated October 29, 1918, was received by the keeper's office referring to three Regina inmates who had been escorted to that region for court. The three inmates, plus the single Regina Gaol escort employee, became ill on arrival in Swift Current and were subsequently placed in "quarantine" by the local MHO — who also became seriously ill. The sheriff notes that the Regina Gaol's escort employee had to be taken to hospital due to influenza as did the civilian initially hired to oversee the inmates and a second civilian who provided nightshift coverage. When the three inmates had fully recovered the sheriff believed he could not take them off quarantine until authority had been received from the local MHO, who, unfortunately, was still incapacitated by the disease. The concern that concluded his letter did not focus on health, staffing requirements, or safety issues but rather, "who will pay for the inmate meals?" An invoice was attached (SAB, SDPW, 1918 B).

Within the walls of the Regina Gaol the effects of the Spanish Influenza appeared to be waning by November 9, 1918, but in the community, infections and deaths continued to escalate until the end of the month. On November 9 the Deputy Minister of Public Works received a telegram from a Regina Gaol escort staff noting that the railway would not issue transportation as the destination town (Melville) was quarantined (SAB, SDPW, 1918 C).

Similar to 1918, current offender transportation to court locations may be problematic. Courtroom structures that have remand units attached, or are in close proximity, may fare better (for example the current Winnipeg Remand Centre is connected by walkways to the court house). Although correctional facilities with a direct physical link to the courts may experience fewer problems than those that have to transport by vehicle, those facilities with a "video court" system may experience the fewest disruptions. Most video courts, however, only address first appearances; actual trials require a physical presence. If, in fact, a future pandemic has an affect on inmate court movement, the cancellation of first appearances could have a significant impact on inmate counts.

Without considerable planning, video courts may not provide a sustainable solution. Video courts are generally attached to Admission and Discharge Units and the process and equipment requires special expertise. It is likely that only a small number of employees, those with the specialized training, would need to become ill before a video court system would collapse.

The Regina Gaol was not the only Saskatchewan correctional facility experiencing problems. The surgeon for the Prince Albert Jail reported,

seven deaths have occurred during the year and one execution. Five deaths are due to the outbreak of influenza disease among the prisoners in November last. One death to paralysis and one morphine fiend died of haemorrhage. (SDPW, 1919, p. 39)

Unlike the Regina Gaol, Prince Albert's average daily count and the number of admissions during the peak Spanish Influenza period did not change significantly once the infection became established in the community. The year-end average daily count was 76. From October to December, the average daily count was 78 (66 males and 12 females). The five inmate deaths were males in the 20 to 40 age high risk category common in the community, and occurred between October 24 and November 24, 1918 (SAB, Department of Social Services, 1919).

The mortality rate for the Prince Albert Jail, male and female inmates combined, was 64 per 1000 (5 of 78) compared to the Regina Gaol's rate of 35 per 1000 (3 of 85); none of the deaths in the Prince Albert Jail were female. If the mortality rate is limited to the male inmate population — a base of 66 — the rate for the Prince Albert Jail was 75 per 1000. The Saskatchewan Bureau of Public Health used a population of 8500 for Prince Albert to calculate mortality for that city. With 74 recorded Spanish Influenza deaths in Prince Albert, the rate was 8.7 per 1000 population (SBPH, 1921, p. 132).

It should be noted that when comparing the mortality rates of the cities to the adjacent provincial jails, different time periods are being used — an 18-month period for the cities, a two-month period for the jails. Technically, the jail deaths represent all jail deaths for the same 18-month period but all occurred in two specific months within the longer time frame. The average jail population at risk during the two-month period was considerably smaller

than what the average count would have been for the total 18-month period (counts began to rise after the war). The two-month calculation is the figure prison administrators probably should find more interesting along with the fact that although most prisons were infected quickly and extensively, there were no reported Spanish Influenza deaths after the two-month peak period. In the community death continued on a downward slope with secondary, and in some regions third, waves for the next 16 months.

Compared to the Regina Gaol in October 1918 (85 inmates and 126 single cells), the Prince Albert Jail was over-crowded. Prior to Saskatchewan's incorporation as a province under the *Saskatchewan Act* (1905, 4-5 Edw. VII, c. 42), the facility in Prince Albert was considered a territorial jail under the jurisdiction of the inspector of penitentiaries in Ottawa. In his 1904 annual report, the Prince Albert Jailer notes they had 20 cells and had just received approval "to erect a new cell wing giving accommodation for 24 prisoners, a ward for insane persons, 2 dark cells and a work room" (Minister of Justice, 1904). A completely new facility was constructed in Prince Albert and received its first inmates on March 7, 1923 (SDPW, Annual Report, 1923, p. 51). The jail that existed during the peak months of the Spanish Influenza, however, had approximately 44 cells and housed an average of 78 inmates. Depending on the existence of alternate space within that facility, which possibly could have been converted to dormitories, it appears likely the Prince Albert Jail had little choice but to house inmates in close proximity to one another.

Current pandemic plans (for example, BCPIP, 2005, p. 170; CPIP, 2006, p. 5) make frequent reference to "social distancing" or "spatial separation," generally citing "one meter" as a guideline for ordinary conversation (increased if coughing is involved). The CPIP (2004, p. 177) cites an article from a 1998 *Journal of the American Medical Association* issue as evidence that overcrowding (in general) is a causal factor. Congestion, therefore, may have been a factor in the higher mortality rate experienced by the Prince Albert Jail compared to the Regina Gaol or to the City of Prince Albert.

Annual reports from other western Canadian provincial governments generally included comments on morbidity and mortality due to Spanish Influenza in their respective "Gaols." The Lethbridge Provincial Gaol (Alberta) reported an average inmate count of 100 and one fatality. The Fort Saskatchewan Gaol (Alberta), with a yearly average count of 76, reported "over fifty prisoners down with the disease and one fatality" (Alberta

Department of Public Works, 1918-19 A).²³ Concerning a facility in Winnipeg, the *Manitoba Free Press (MFP)* reported that “Flu conditions at the provincial jail are greatly improving,” noting that 20 inmates had been infected but by November 6, 1918, only 10 remained in the jail hospital. The jail doctor was quoted as stating, “no patients in the city were better looked after than the inmates of the hospital ward of the jail. This, he claimed, resulted in the rapid decrease in the spread of the disease in that building” (Better at Jail, 1918, November 6).

Issues faced by Saskatchewan adult corrections in 1918 were likely similar to those in other provincial (and federal) facilities, and could well reappear during a future outbreak. While only one reference to an employee not wishing to work in the infected environment was uncovered, it is likely a larger number of employees will express significant occupational health and safety concerns unless adequate planning has taken place. Issues related to inmate transportation and court appearances are tied to other CJS components and may be beyond the control of correctional administrators. If inmate court movement ceases due to court closures or escorting issues, the impact on provincial corrections may be substantial as remand counts can grow dramatically in a short period of time without the equalizing effect of remand discharges.

But traditional jails were not the only facilities that housed adult offenders. In Saskatchewan, and in other provinces, mental health facilities were often designated to receive those labelled “criminally insane.”

Adult “Criminally Insane” Offenders

The Saskatchewan Hospital in North Battleford (SHNB)

is the province’s only facility dedicated specifically for intensive rehabilitation of people with mental illness [and also] provides a 25-bed Forensic Unit for remand assessment, treatment and special disposition under the Criminal Code for persons found

23. As the inmate registries for the Alberta institutions were not reviewed, it is unknown if the counts for these institutions during the peak Spanish Influenza (SI) period were higher or lower than the yearly average count.

“Not Criminally Responsible”. Admissions for the Forensic Unit are by referral through the justice system. (Saskatchewan Health, 2007, p.1)

Originally referred to as the Provincial Hospital for the Insane at Battleford (SDPW, 1915, p. 62) the words “Asylum,” “Lunatic,” or “Mental,” appear in the title alternately until the 1923 annual report when the “The Battlefords Mental Hospital” became the favoured title for decades after.

In the fall of 1918, the facility housed a mixture of civilians and returning soldiers suffering from various mental health problems but also accepted those labelled “criminally insane.” Considerably larger than the capacity of the Regina and Prince Albert provincial jails and the Saskatchewan federal penitentiary combined, the SHNB was built to accommodate 800 patients. The facility opened in February 1914 with 230 male and 116 female patients — Saskatchewan residents who were transferred from the Hospital for the Insane in Brandon (SDPW, 1915, p. 62). Newspaper accounts indicate the SHNB was over capacity during the peak Spanish Influenza period (Saskatchewan Provincial Hospital at Full Capacity, 1918, November 7, p.11), but the news article cites a count of 1000 which included all employees and their families.

Including the SHNB in a section on corrections requires an explanation. The percentage of patients housed at SHNB convicted of a crime is unknown, as is the extent of the segregation of suspected offenders. Further, the mandate of the SHNP was not the same as facilities built specifically for offenders. SHNB, however, has been included in this review for three reasons. First, the controversy over appropriate housing for criminal law violators with mental health problems still exists. Second, in 1918, provincial and federal facilities across Canada all report sending inmates to similar facilities. And, third, a Forensic Unit at the SHNB still provides much needed psychological services for individuals with suspected or diagnosed mental health problems convicted of, or remanded on, criminal code offences.

At present, with federal Regional Psychiatric Centres located across Canada and on-site or contracted services available at regular penitentiaries, the Correctional Service of Canada (CSC) has created an environment for offenders with mental health problems far more hospitable than that which existed in 1918. The final report of the Standing Senate Committee on

Social Affairs, Science and Technology *Out of the Shadows* released in May 2006 however, recommends a substantial review of existing CSC facilities and programs (p. 360). In sum, the basic issue — where best to house offenders with mental health problem — still exists. In provincial facilities the problem is perhaps more acute as access to existing secure mental health facilities is difficult unless it is court ordered. Facilities for offenders with mental health problems often operate at full, or over, capacity.

In 1917-18 and 1918-19, the Regina and Prince Albert provincial jails sent a combined total of 191 inmates to SHNB (SDPW, Annual Reports, 1918, 1919). In the federal system, the Saskatchewan Penitentiary (in Prince Albert) and St. Vincent de Paul Penitentiary (in Quebec) note that on any given day in 1918-19 an average of six inmates were maintained on their inmate counts but were actually housed in provincial hospitals for the “insane” or “insane asylums” (Minister of Justice, 1919, p. 18, 21).

The SHNB reported 55 and 58 deaths in 1916-17 and 1917-18 respectively but saw a significant increase in 1918-19 when 47 Spanish Influenza deaths brought the official death toll up to 115. In the next fiscal year (1919-20), there were 85 deaths but only seven deaths (five females and two males) were specifically attributed to Spanish Influenza. Unlike “traditional” correctional facilities, the SHNB experienced employee deaths as well as patient fatalities — three SHNB employees died as a direct result of Spanish Influenza. There does not appear to be any record of employees of traditional provincial or federal adult correctional facilities succumbing to the Spanish Influenza.²⁴

Using a figure of 47 and a patient population of 800,²⁵ the Spanish Influenza mortality rate at the SHNB for 1918-19 was 59 per 1000. The City of North Battleford, with 25 fatalities, had a rate of 5.5 per 1000 (SBPH, Annual Report, 1921, p. 132).

24. This statement is based on a review of all provincial government annual reports (sessional papers) for the departments responsible for provincial corrections and public health as well as a review of federal Justice annual reports and a search of SAB files in Saskatoon and Regina, and LAC archives in Ottawa.

25. Dates for each SHNB Spanish Influenza death could not be located but clearly they spanned two fiscal years. Indications are the hospital operated at full capacity during the 18-month period of the influenza, therefore, the calculated mortality rate more closely models community calculations.

The Saskatchewan provincial hospital was not the only facility of its type in Canada, nor was it alone in experiencing Spanish Influenza fatalities. By November 30, 1918, the Hospital for the Insane at Selkirk, Manitoba, reported nine deaths attributed to Spanish Influenza (Manitoba Minister of Public Works, 1918). The Hospital for the Insane at Ponoka, Alberta, recorded 31 deaths, including two attendants, due to Spanish Influenza (Alberta Department of Public Works, 1918-19).

Mental health hospitals held individuals who were physically as well as mentally ill. The existence of co-morbidities during an influenza outbreak increases mortality risk; therefore, higher death rates at the SHNB could be expected. Regardless, it appears that the SHNB was ill-equipped to handle a serious contagious disease outbreak. Shortly after opening in 1914, the superintendent notes in his first annual report they were fortunate a case of typhoid did not spread as their isolation facilities were poor (SDPW, Annual Report, 1915, p. 64). In 1914-15, when typhoid made an appearance, the SHNB patient and “inmate” count was low compared to the space available; in the fall of 1918, operating at maximum capacity, patients and employees were not as fortunate.

Young Offenders: Saskatchewan

Information from a modest number of Children’s Aid Societies has been included in this report, but with reservations similar to those expressed in the previous section on “criminally insane offenders.” The percentage of children housed in Children’s Aid Society facilities for criminal code violations in relation to the overall count is unknown. Further, the mandate of Children’s Aid Society facilities was different from that of correctional facilities. In spite of these concerns, discussion of Spanish Influenza statistics from Children’s Aid Societies has been included as, combined with juvenile detention centres (also known as reformatories), the two groups represent the closest comparison to current youth criminal justice offender populations.

Although there was a provincial boys detention centre in Saskatchewan in 1918, a separate facility for female children did not exist. Female youth in conflict with the law could be housed in Children’s Aid Society facilities in Regina but, if they were unmanageable, they were transferred to Winnipeg or Calgary female detention homes. In Saskatchewan, Children’s Aid Societies were established under provisions of the *Act for the better Protection*

of *Neglected and Dependent Children*, cited as the *Children's Protection Act (1908)*. A percentage of all male and female children who allegedly violated any provincial or federal legislation could be held in facilities operated by Children's Aid Societies along with "neglected and dependent" children placed there for other reasons.

The creation of juvenile detention centres (often referred to as reformatories) and the use of Children's Aid Society facilities reflected a significant change in the way children were viewed and treated between the 1850s and the inception of the *Juvenile Delinquents Act* (S.C. 1908 c. 40). Smandych (2001) notes that "The underlying principles of the JDA reflected the belief that the state had a major role to play in intervening in the affairs of any family in which there was a child who was defined to be either 'delinquent' or in need of protection" (p. 16).

Children under 16 years of age appear (rarely) in the 1918 admission logs for the Prince Albert and Regina provincial adult gaols, but the practice (pre-1908) of placing children as young as 12 with adult offenders had all but ceased by the time of the Spanish Influenza.²⁶ The report of Regina's Juvenile Court Judge included in the annual report of the Superintendent of Neglected and Dependent Children (hereafter SNDC) for 1918-19, notes:

It was soon found that neglected children and delinquent children were so closely related that it was not possible to separate them, hence in all the well established juvenile courts today, the neglected child comes into the juvenile court as well as the delinquent child. (Saskatchewan Department of Welfare (SNDC), 1919, p.18)

In the decades prior to the Spanish Influenza, philosophical changes may have resulted in more appropriate treatment of children. The accompanying "nurturing" approach may explain in part why employee deaths occurred in youth but not in traditional adult jails. Employees in juvenile facilities in 1918 *may* have had closer physical contact with the children they were responsible for compared to the contact between employees and inmates in adult facilities.

26. The Prince Albert Jail admission logbook for 1918 shows at least one entry of a 12-year-old-male (SAB, Department of Social Services, 1918).

In 1918-19, the average daily count at the Regina Boys Detention Home was 29 (SDPW, Annual Report, 1919, p. 61). Although there is no mention of employee infections, the Boys Detention Home, located outside of Regina, reported that all of the children became sick (22 at the same time), but there were no reported fatalities. The Children's Aid Society equivalents in Alberta did not fare as well. The annual report of the Matron of the Children's Shelter in Calgary (Alberta Department of Attorney General, 1919) noted that "nearly every member of the shelter suffered from its visitation," and although none of the children succumbed, the Matron of the facility died (p 64). In the same report, the Edmonton Children's Shelter noted 27 infections and two deaths amongst the children (p. 63). At the conclusion of 1918-19, the Children's Aid Society in Alberta reported two female matrons and the shelter's "first lady probation officer" had succumbed to the disease. Those responsible for the children's shelters in Alberta reported that, "Quite a large number of children from affected homes, or children who were in danger of exposure to the disease were thrown upon our hands" (p. 57).

Congestion, reducing the ability to keep an adequate social distance (one to two meters is suggested for ordinary conversation), may have been a factor in the spread of infection in youth facilities as well as in certain adult correctional facilities. Employees of Children's Aid Societies in 1918 may have been more inclined to violate the "one to two metre" rule. Although this discussion is somewhat speculative, a significant difference between adult and children's incubation and contagion periods is not. If, in fact, current youth facility employees adopt a slightly different approach to young offenders, particularly offenders in the youngest age groups, than their adult facility counter-parts, the morbidity rates (and subsequently mortality rates) may be higher for that employee group.

As illustrated in Table 3 on the following page, the various types of provincial facilities that housed adult, youth, and "criminally insane" offenders experienced between 30 to 100 % morbidity rates (inmate and employee). While there were no reported employee fatalities in Saskatchewan's traditional jail facilities (excluding Children's Aid Society and mental health facilities), the mortality rates for inmates varied from 35 to 64 per 1000.

Table 3. Morbidity and Mortality Rates (Saskatchewan Provincial Facilities)

(A) Facility	(B) Estimated Count* During Peak Period	(C) Estimated Capacity	(D) Estimated Morbidity (Percentage)	(E) Number of Inmate Deaths	(F) Estimated Mortality Rate (per 1000)	(G) Estimated Mortality Rate (per 1000) in Adjacent Community
Regina Gaol	85	126	100%	3	35	8.2
Regina Boy's Detention	25	30	100%	0	N/A	8.2
Prince Albert Jail	78	44	Unknown	5	64	8.7
Sask. Prov. Hospital	800	800	Unknown	47	59	5.5

Source: Column B - Department of Public Works, 1918, for the Regina and Prince Albert jails the count is the actual average daily count for October and November 1918 using the entries from their respective logbooks (SAB, Department of Justice and Department of Social Services, 1918). Column C, D and E - SAB, Van Egmond and Storey fonds, 1912; SDPW, 1919. Column G - SPPH, 1921).

The date of each inmate Spanish Influenza death in the Regina and Prince Albert adult provincial jails facilities is known; dates for the SHNB or Children's Aid Society inmate or employee deaths (Alberta) may exist but were not uncovered. Therefore, it is difficult to confirm, other than for the Regina and Prince Albert adult facilities, that the infection arrived and ended quite suddenly — within 30 to 60 days. Across Canada the 30 to 60-day period occurred in the fall and in an early, and apparently severe, winter (Pettigrew, 1983; Lux, 1989). In 1918, Saskatchewan correctional facilities were heated by coal. The Regina Gaol blueprints show large, centrally located coal storage and boiler areas. Relatively isolated, the Regina Gaol had the coal supplies necessary for the winter before the Spanish Influenza arrived. They did not have to rely on replenishing fuel supplies needed for back-up generators that most current correctional facilities count on. And, although infections and death continued in the surrounding communities for at least 16 months, the most devastating 30 to 60-day period in the community was the same as in the jails.

In a province such as Saskatchewan interruptions in electricity or natural gas, depending on the season, have the potential to compound problems caused by a pandemic, more so perhaps than any other single deficiency. Concern over public utility preparedness in the event of a pandemic was raised in the *Regina Leader Post* on November 18, 2006 (p. A1). Similar

concerns are raised in a number of provincial pandemic plans, although the focus is more on the ability of long-term health care facilities to maintain back-up services. For example, the Ontario plan asks, “Has the LTCH [Long Term Care Home] developed plans to ensure continuity of services in the event of internal emergencies (e.g., lack of water, hydro, food, and natural gas failure) related to a disruption of community services?” (OPIP, 2006, p. 19A-2, Item 1.5).

If the peak infection period in a prison occurs at the same time as in the community, and in the middle of winter, it is not only staffing levels, congestion, or personal protective equipment that will be a concern, but also fuel.

Federal Adult Facilities: 1918²⁷

With the enactment of *The Penitentiary Act (31 Victoria Chapter V)* in 1868, the warden of each federal facility was required to submit annual reports to the inspector of penitentiaries for inclusion by the Minister of Justice in federal sessional papers (annual reports to the House of Commons). Prior to 1905, there was a jail in Regina and in Prince Albert but these were labelled territorial jails; their wardens also reported to the inspector of penitentiaries. All wardens’ reports included similar, but non-standardized, summaries of facts and figures and significant events. Perhaps reflecting the transitory nature of bed spaces in a prison, the annual reports included the start and end of year inmate counts, but not the capacities. The 1919 reports each included a brief section on the Spanish Influenza, noting, in narrative form, the percentage of staff and/or inmates that became ill and how many died. Determining an accurate capacity for each federal facility, to comment on any possible correlation between overcrowding and Spanish Influenza infections, was difficult and, in fact, only one reasonable estimate is presented.

The Saskatchewan Penitentiary in Prince Albert opened on May 15, 1911, receiving “36 convicts” from the Alberta Penitentiary the next day (Minister of Justice, 1912, p. 12). The 1916 annual report for Saskatchewan

27. All Library and Archives Canada material was provided courtesy of the Correctional Service of Canada and Ms. Renée Gobeil (Doctoral Candidate, Carleton University), conducted within a five-day time frame.

Penitentiary (Minister of Justice, 1916, p. 24) reported that 208 cells were nearing completion, suggesting these, plus existing cells, would have been available during the peak of the Spanish Influenza. In the 1919 annual report, the warden for Saskatchewan Penitentiary notes:

During the influenza epidemic which spread over this district last fall, not one convict contracted the disease. ‘This’, the surgeon reports, ‘was due to the strict quarantine adopted and enforced in regard to the attendance of officers and visitors and the segregation of newly arrived prisoners’. (Minister of Justice, 1919, p. 22)

With a minimum of 208 available cells and an estimated count during the peak influenza period of 100 inmates,²⁸ Saskatchewan Penitentiary may have had more options than other facilities. If the warden of Saskatchewan Penitentiary and the surgeon had acted quickly they could have, in fact, kept inmates with influenza-like illnesses (ILI) isolated, minimized staff inmate contacts, and segregated new²⁹ prisoners (as claimed by the facilities surgeon).³⁰ Other federal facilities may not have had such options.

Reporting five inmate deaths, the warden for the British Columbia Penitentiary notes:

There were in all 100 hospital cases. The dispensary cases numbered 888, twelve officers were laid up with the disease, throwing extra work on the others. The Deputy Warden, Chief Keeper, and Hospital Nurse were the men upon whom the weight of the burden thus created fell ... two ‘conscientious objectors’ volunteered as nurses. (Minister of Justice, 1919, p. 20)

28. This estimate is based on the count at the start of the year (89) and end of year (116) (Minister of Justice, 1919, p. 20).

29. New arrivals during the peak Spanish Influenza period were likely few as the King’s Bench Court was closed due to the outbreak as discussed in the earlier section on “Courts.”

30. The statement that “not one convict contracted the disease” in Saskatchewan Penitentiary and noting that preventative efforts included “the segregation of newly arrived prisoners” leaves open the possibility that inmates with ILI or actual Spanish Influenza may have already been in, or entered, Saskatchewan Penitentiary.

Without further archival research, it was not possible to determine the capacity of most federal facilities. Information in archived logbooks for Kingston (Ontario) and St. Vincent De Paul (Quebec) Penitentiaries, however, combined with their annual reports, allowed for a slightly more in-depth review of events at these two facilities.³¹ A new surgeon for the Kingston Penitentiary commenced duties on January 1, 1916, and reported that during the last three months of that fiscal year, the overall health of inmates and staff was good: the “officers had very little sickness during the three months. For several weeks there was not a single man off duty, which speaks well of their health” (Minister of Justice, 1916, p. 25). Despite the fact that this observation was made two-and-a-half years prior to the Spanish Influenza, it is nonetheless offered as reflective of normal employee sick-leave patterns for that institution during that era. If this assumption is correct, the absences that occurred in the fall of 1918 represent extreme deviations.

As illustrated in Graph 1 on the following page, employee absences at Kingston Penitentiary due to sickness began to rise in late September 1918. The roster of the Officer’s Day Duty Ledger for Kingston Penitentiary shows a total staff complement of 93 for each 24-hour period from July to November 1918 (Library and Archives Canada [hereafter LAC], *Duty Roster*, 1918, July —November).³² Included in the *Duty Roster* is the daily count for the institution as well as the number of inmates in the hospital wing and the number of staff off specifically due to illness; those on leave or off duty for other reasons were recorded under separate headings.

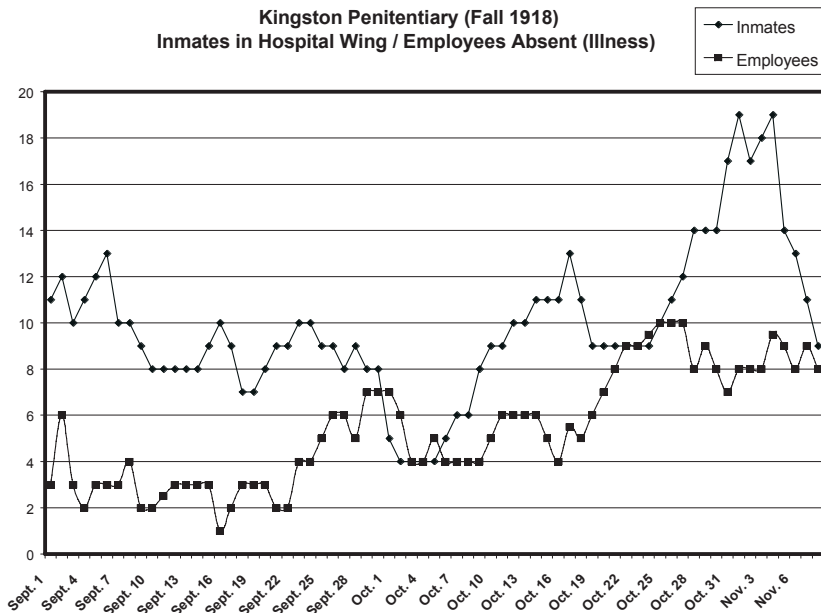
Graph 1 illustrates that as the inmate hospital-wing counts appeared to be declining in late September employee illness began to rise. There were 12 inmates in the Kingston Penitentiary hospital wing at the start of September, but the number dropped slowly levelling off at four on October 2, 1918. During the same time period, employee absence due to illness appears stable but begins to rise, intersecting with the number of inmate hospitalizations

31. Ledger and logbooks for other federal facilities may exist but only a limited number of such books for Kingston and St. Vincent De Paul were located within the time available for the LAC research.

32. Neither the ledgers themselves nor the LAC site included any indication of which institution these ledgers refer to. Based on the fact that all offenders’ sentences mentioned in the ledgers were handed down in Ontario, and women offenders are referred to, this roster could only correspond to Kingston Penitentiary as no other federal institutions housed women at this time (comments courtesy of Renée Gobeil, CSC).

the week ending October 6, 1918. Inmate hospitalizations rose thereafter peaking at 19 on November 1 to 4, followed by a significant drop until November 8, 1918, when the ledger books end (and apparently have been lost or inadvertently destroyed).³³

Graph 1



Source: Canada, LAC, *Duty Roster*. (1918, July - November). Kingston Penitentiary, RG 73, Volume 329. (Graph has been created using daily figures transcribed by Renée Gobeil, CSC).

The slope of the graph of staff illnesses appears to mirror the slope of the inmate hospitalization line but is separated by eight to ten days. The graph

33. Friday November 8, 1918, most newspapers mistakenly reported Germany's surrender which resulted in large scale mass gatherings and celebration on the evening of the 8th and into the 9th. When the real Armistice was signed on November 11, 1918, a second round of celebration occurred. Although this may have had an impact on record keeping from the eighth and over the next few days or weeks, the actual reason why the records cease to exist after November 8 is unknown.

could be interpreted as showing two “waves” occurring in Kingston Penitentiary with employees and inmates passing it back and forth twice. Employee absences rose between September 23 and October 1 and then started to decline. Inmate hospitalizations began to rise October 2 continuing to October 17 and then fell, but staff absences began another upward trend on the 17th through to the 25th. On October 28, employee absences declined slightly and then levelled off. That same day inmate hospitalizations began a second upward swing (as staff illness began to decline) before peaking on November 4, 1918.

The type of illness for inmates or staff is not indicated in the *Duty Roster* but a letter dated November 4, 1918, from Kingston’s warden to the inspector of penitentiaries notes that a medical specialist attended on-site on Sunday November 3, 1918, and declared that none of the patients in the hospital wing were suffering from influenza (LAC, Warden’s Letterbook, 1918, November 4). On the day of the specialist’s visit the hospital wing held 18 inmates, a high number relative to previous months. The November 4th letter also notes that the “prison of isolation” was in readiness should it be required and refers to inoculation of all inmates using a serum to be prepared by Queen’s University Laboratory.

In spite of medical assurances that the Spanish Influenza was not in the Kingston Penitentiary on November 3, 1918, it appears almost certain that late October/early November was, in fact, the peak period for infection in Kingston Penitentiary. The rise in inmate and staff illnesses, combined with increased illness in the community, confusion over diagnosing Spanish Influenza, and a propensity towards down-playing the event, suggests that the attending physician on November 3 made a mistake, either due to lack of knowledge of the infection, or to reduce panic.

Evidence of a significant problem already in the community appears in a letter from the Kingston Penitentiary warden to the inspector of penitentiaries dated November 1, 1918 (LAC, Warden’s Letterbook, 1918, November 1). Referring to the “prevailing malady” the warden outlines problems with finding a replacement for the facilities physician. The physician had become ill with influenza, as did his initial replacement, and a third physician “has his hands full outside.” The Kingston warden sought retroactive permission to hire a medical student from Queen’s University.

At the start of 1918-19, the Kingston Penitentiary inmate count was 413 (including 35 females); at year-end (March 31, 1919) the count was 549

(including 40 females). The warden suggests a partial explanation for the rising count was a large number of “defaulters under the Military Service Act” who were committed to his institution (Minister of Justice, 1919, p. 16). From September 1, 1918, to November 8, 1918 (ten weeks) Kingston’s count rose from 456 to 487, or seven percent (LAC, *Duty Roster*, (1918, July - November). Similar to the Regina provincial jail, it appears the daily count increased as infections in the community were rising, levelled off once infection in the community reached its peak, and then dropped, possibly due to reduced sittings or closure of the Higher Courts in the Kingston Penitentiary catchment area.³⁴ Unlike the Regina gaol, closure of King’s Bench would result in fewer new admissions to penitentiaries. Although Kingston Penitentiary absorbed the initial inmate increase, it is unknown if this was accomplished through double-bunking or the use of improvised overflow areas.

Kingston’s average count was approximately 480³⁵ during what is believed to have been its peak influenza period (October 11 to November 8, 1918). Given the facility’s ability to accommodate 549 offenders at year-end, it is possible that the facility may have been able to provide a degree of separation between inmates, but unlikely to the extent possible at Saskatchewan Penitentiary, which boasted zero infection due to “strict quarantine.”

While the Saskatchewan Penitentiary progressed through the peak Spanish Influenza period unscathed and the Kingston facility in Ontario managed to avoid fatalities, the St. Vincent de Paul Penitentiary in Laval, Quebec, (closed in 1989) suffered one of the highest mortality rates in the country, reporting 21 inmate deaths by November 7, 1918. Table 4 on the following page presents an estimate of counts, morbidity, and mortality rates for all federal penitentiaries operating in 1918.

As illustrated in Table 4, there were other federal facilities with comparable or higher infection rates than St. Vincent de Paul Penitentiary but none that matched that institution’s mortality rate. With the exception

34. From Sunday September 22 to Sunday October 13, 1918, the count rose by 17. Thereafter, and up to November 8, 1918, the count rose by five (LAC, *Duty Roster*, 1918, July - November).

35. The average daily count was compiled from daily entries in the Kingston Penitentiary *Duty Roster* for all dates from October 11, 1918, to November 8, 1918 (LAC, *Ibid*).

of the Saskatchewan and St. Vincent de Paul penitentiaries,³⁶ it is difficult to state which facilities were at, over, or under capacity, or had the ability to effect quarantine or isolation. There is evidence that the Saskatchewan and Kingston penitentiaries engaged in some form of quarantine or isolation,³⁷ although their definition of these terms is unknown.

Table 4. Estimated Mortality Rates — Federal Penitentiaries, Fall 1918

(A) Penitentiary	(B) Estimated Count During Peak SI Period	(C) Estimated Capacity	(D) Estimated Morbidity (Percentage)	(E) Number of Inmate SI Deaths	(F) Estimated Mortality Rate (per 1000)
St. Vincent de Paul	350	472	55%	21	60
Kingston	480	U/K	14%	0	0
Dorchester	200	U/K	50 %	4	20
Manitoba	125	U/K	50 %	0	0
Saskatchewan	100	200	0 %	0	0
Alberta	125	U/K	75 %	6	48
British Columbia	155	U/K	50 %	5	32

Source: Kingston’s estimated count and morbidity figures are based on correspondence from Superintendent Hughes to the Minister of Justice indicating 68 inmates (of 480) at Kingston were infected (LAC, 1919, July 30, Letter from Superintendent W.S. Hughes). Estimated morbidity rates and counts for all but St. Vincent de Paul and Kingston penitentiaries are based on narratives and figures presented in annual reports, Minister of Justice (1919). St. Vincent de Paul’s morbidity rate of 55% is based on a medical report indicating 170 inmates were ill with Spanish influenza up to November 4, 1918 (LAC, Warden’s Letterbook, 1918, November 4).

On October 11, 1918, a regional inspector for the Superior Hygiene Counsel of the Province of Quebec investigated, on-site, the “appearance of an influenza epidemic” at St. Vincent de Paul Penitentiary. In his report (LAC, *Deceased Convicts*, 1918, October 14), the inspector notes that the count at St. Vincent de Paul was 352 and that there were no influenza cases

36. A capacity of 472 cells for St. Vincent de Paul is noted in the *Report of the Minister of Justice as to Penitentiaries in Canada* (1891, p. 23).

37. As noted earlier, Saskatchewan Penitentiary specifically attributed their zero infections to their “strict quarantine.” A letter to the inspector of penitentiaries from Kingston Penitentiary notes, “the prison of isolation has been put in readiness” (LAC, Warden’s Letterbook, 1918, November 4).

as of October 7, 1918. He states that the outbreak within the institution may have originated with an inmate who was admitted to the hospital ward “a couple of days prior.” The letter notes that as of October 11, 1918, there were “53 ill and no deaths.” A letter, three weeks later, from the warden to the inspector of penitentiaries (LAC, *Deceased Convicts*, 1918, November 5) indicates the first case was admitted to the prison hospital on October 3, 1918, but other inmates did not become ill until October 9. He states there had been no new cases since October 26. The warden further reports that although there were 23 officers sick with influenza, there were no officer fatalities.

Correspondence from the St. Vincent de Paul surgeon includes a list of the names of the 20 inmates who died. The actual date of each death is not mentioned, but, based on the report of “no deaths” in the regional inspector’s letter of October 11, 1918, it appears that all but one of the 21 fatalities occurred between October 11 and November 4, a period of less than four weeks (LAC, *Deceased Convicts*, 1918, November 4). The surgeon’s letter also lists known physical ailments for the first 20 deceased inmates. Only four were described as being in good health prior to the outbreak. Three each were “Anemic,” “Tuberculous,” or suffering from “Cardiac bronchitis.” The remainder were described as “Syphilitic,” “Dyseptic, Exhausted,” or “Total Ruin.” The presence of co-morbidities (existing health problems — respiratory, cardio-vascular, HIV, etc.) is cited in all Canadian pandemic plans as a risk factor strongly linked to increased fatalities.³⁸

In sum, it appears that the Spanish Influenza spread extremely rapidly within the walls of St. Vincent de Paul (53 of 352 fell ill within two days) and killed 21 within an equally short period (less than one month). Co-morbidity played a significant role in the death rate, but it is suggested the illness spread so quickly that unless St. Vincent de Paul administrators had a clear and workable isolation plan, social distancing, or the lack of, was probably a contributory factor.

The 2006 Canadian pandemic plan includes specific, detailed reference and general guidance for correctional services. Annex G of the CPIP (2006, pp. 108-112) contains advice for medical personnel associated with correctional facilities as well as general guidelines for correctional

38. A discussion on co-morbidities and influenza appears on pages 222-224 of the CPIP, 2004.

administrators. The medical section outlines treatment to assist with the management of influenza and its complications, and to assist with diagnosis. It suggests that on-site chest X-rays, blood and urine tests, and oxygen supplementation, which is available in most federal maximum and medium security facilities, will be extremely beneficial in attempting to diagnose and treat inmates except those who become critically ill.

Other current pandemic plans that mention corrections all agree that administrators need to be prepared to provide treatment within the walls of the facilities. Few provincial facilities have the on-site chest x-ray equipment or the oxygenation equipment (other than the ability to provide short-term oxygen supplement) noted above, and although most staff at provincial correctional facilities are well acquainted with taking urine specimens, few facilities have on-site analysis capabilities. Further, provincial facilities may have on-staff medical personnel trained in phlebotomy but, similar to urine tests, samples are sent to provincial laboratories. During or in the initial stages of a pandemic, it is probable that off-site specimen analysis will be difficult or subject to delays that would make the results of little use.

In 2007, federal and provincial correctional facilities utilize a combination of on-site contract medical personnel and full and part-time nursing staff.³⁹ Preparing for a potential short or long-term loss of these personnel will be a difficult task for correctional administrators for the same reason it was problematic in the fall of 1918 — there is a shortage of medical personnel in the community. This shortage is already causing difficulties in a number of correctional facilities. It could be argued that the reason for the problem in 1918 was quite different as large numbers of medical personnel serving overseas was causal. Few would argue, however, that Canada currently has an abundance of nurses or doctors. If a high morbidity outbreak occurs in Canada, CJS administrators, particularly those in corrections, may have to consider more creative options for recruiting trained medical personnel or imbed “do without” options into their plans. Any correctional administrator who has struggled with backfilling medical positions during labour stoppages will have experienced a smaller-scale version of this problem.

39. A summary of the general provision of health care services in Canadian correctional facilities is contained in Annex G of CPIP (2004, 2006).

Few pandemic plans, other than the CPIP, make detailed reference to correctional facilities but most do contain a comment similar to that which appears in the Toronto Regional Health Plan:

Correctional facilities will not be able to send all ill inmates to hospitals because there will be no capacity available. Working with these agencies/facilities will need to occur in the future in order to further plan for the issues of isolation in community living settings. (TPIP, 2006, p. 68)

The identified need to work with “these agencies/facilities” in the future may be cause for concern. The general list of suggested future consultations and activities that if completed in a timely fashion will reduce the impact of a pandemic is quite onerous. Most plans have included task lists, often sorted logically under the appropriate heading of the six WHO pandemic phases. While the “future task lists” generally state who should be responsible for further development of each task, leaders from various criminal justice agencies will need to emerge who are prepared and are afforded the luxury of coordinating the various tasks to allow others to continue with daily, weekly and monthly routine operational needs. Failure to strike an appropriate balance in the allocation of existing resources between current on-going tasks and a future potential pandemic leaves the possibility that the event will emerge before corrections and other components of the CJS are prepared.

Being able to demonstrate due diligence is a by-product of thorough business continuity planning. That all reasonable efforts to reduce risk were considered, or implemented, means disruption, illness and death were minimized to the extent possible. Concerning post-event litigation a letter from the federal inspector of penitentiaries to the warden of St. Vincent de Paul suggests pre-event direction from senior levels had in fact occurred. Concern over potential criticism appears to have sparked a directive to administrators to ensure they had a documented list of precautions taken. On October 26, 1918, the superintendent wrote:

May I suggest that either yourself, or your surgeon, should get in touch with the medical health officers of the city of Montreal and also of your immediate district, should you have one, and, if possible, have them visit you with a view to advising you, should

that be necessary, as to further precautions; also to secure from them a statement that they are satisfied that every precaution has been taken by you. Such a document I think would be desirous in case some of those, whose relatives have died in the institution, should attempt to criticise. (LAC, *Deceased Convicts*, 1918, October 26)

In a subsequent post-event report to the Minister of Justice dated July 30, 1919, the superintendent⁴⁰ of penitentiaries outlines the direction he provided to the wardens of each facility. The impetus for the report is unknown but the following paragraph suggests it is in response to the criticism he predicted in his October 26, 1918, correspondence. The superintendent writes:

When the influenza broke out in Canada, I wrote a letter to every warden instructing them to prohibit visitors, had all convicts write their people not to come while the epidemic was on and no outsider was to be permitted inside the walls. Also they were instructed to increase the amount of disinfectants, to boil disinfectants in all cell dormitories and shops and to call in the medical health officer for the community, consult with him and ascertain if he had anything to suggest that they were not already doing. In every case they received a written certificate from these officers that everything was being done that could be done. Two medical officers sent out by Montreal assured the warden of St. Vincent de Paul Penitentiary that the convicts in that institution were receiving better care than those in the Montreal Hospitals. (LAC, 1919, July 30)

A review of archived files at the Library and Archives of Canada was unsuccessful in locating the letter that apparently outlines pre-event guidelines. The October 26, 1918, letter to the warden of St. Vincent de Paul, which contains reasonable advice, was sent well after multiple deaths had occurred.

40. Similar to name and title changes for warden/jailer/director, gaol/jail, keeper/deputy director, and turnkey/guard, the “inspector” of penitentiaries title changed to “superintendent” in 1919.

SUMMARY AND CONCLUSIONS

Sufficient documentation exists to confirm that the Spanish Influenza had an impact on all components of the criminal justice system (CJS) in Canada. The issues that became evident upon review of historical documentation on each of the four major components of the CJS may be of interest to current day pandemic planners despite the obvious differences between the two eras.

For example, communication — the timely flow of accurate information — was a problem in 1918-19 and will be a problem in the next pandemic. But instead of too little information too late the opposite is likely. Most Canadians and all employees of the CJS have access to instantaneous and selective message sharing not only at home but at their work sites. Adherence to official government messages and public (health) service announcements may be weakened unless there is a plan to address inconsistent and conflicting information, or rumours.

There is information suggesting the police in Saskatchewan in 1918-19 often assumed roles that could be construed as “volunteer” — for example, assisting with burying the dead or transporting children orphaned by the disease — but nothing was uncovered that suggests the police community actually used external volunteers. The same appears true for corrections although in one facility non-violent offenders were used as volunteers in a prison hospital ward. It is unknown what type of training (if any) these inmates may have received. Documentation from St. Vincent de Paul Penitentiary indicates it was difficult to obtain professional medical services during the peak of the influenza. If current-day planners believe the void can be filled by volunteers, this belief may need to be tempered as it is possible that the army of volunteers that surfaced in 1918-19 may not materialize in the current era. CJS administrators may need to look elsewhere.

The use of quarantine and/or isolation was allegedly successful in at least one correctional facility (Saskatchewan Penitentiary) although there was insufficient information to rule out serendipity. It appears the terminology was not used consistently in 1918-19 by government officials, in medical journals, or in CJS annual reports. Were those with symptoms isolated and those who may have been exposed quarantined?

Further, while past and recent publications often suggest quarantine has never been effective, there is a possibility this is based on definitions different from those used in 1918-19. Regardless, implementation of this type of non-medical intervention in 1918-19 was rarely invoked in time to have had a chance at success. Current negative views on the efficacy of quarantine tend to focus on quarantine of political borders and entire communities. But the use of such measures in segments already confined and controlled, such as correctional facilities, should not be dismissed. If correctional facilities do consider isolation or quarantine, each area may require different policies and procedures and each will need to be equipped differently; therefore, from the onset, correctional personnel need to be working with a clear understanding of what the two terms mean.

Very little direct reference to the use of personal protective equipment (PPE), such as gloves, gowns or masks, by employees of the 1918-19 CJS components was uncovered. If such items (makeshift or otherwise) were used, the effectiveness would have been questionable given the filtering capability of material available at the time and the probable lack of knowledge on appropriate use. Similar to the topic of quarantine, publicly accessible government health sector pandemic plans and academic literature tend to dismiss the use of special masks, gloves and gowns in anything but health care facilities, often noting there is little evidence to show they are effective in other environments. More recently it has been acknowledged that perhaps the reason there is little supportive evidence is because there have been few studies.

Public health measures similar to those adopted or recommended in 1918-19 are now being reviewed more vigorously in an attempt to complement what was, until recently, an emphasis on the development of vaccines and anti-virals. Hand hygiene, the use of ordinary soap rather than anti-bacterial soap, social distancing, definitions of quarantine and isolation, and personal protective devices are being reviewed or subjected to new research. All were the subject of review in 1918-19 after it was realized that a cure was not forthcoming, and all may be important prevention tools for CJS administrators. But, carrying the concept of non-medical public health interventions one step further, it is suggested that “touch free” washroom facilities (public or shared) is an area that needs further review, particularly in CJS work units.

The attempt in Volume II to establish police and inmate morbidity and mortality rates due to Spanish Influenza admittedly resulted in questionable figures. The number of police and the number of police officer Spanish Influenza deaths were too elusive to develop valid or reliable rates. In the corrections component, the mortality rates are probably fairly accurate, but the number of inmate Spanish Influenza deaths in relation to the low inmate counts diminishes the integrity of these figures (only a few variations would result in significantly different outcomes). Nonetheless, the attempt itself uncovered a number of interesting issues.

It appears that infections in correctional facilities arrived, spread, and killed quickly, and then, unlike in the community, mortality rates just as quickly dropped to zero. All Spanish Influenza deaths in the three facilities where the date of death was known occurred during October and November 1918. In Kingston Penitentiary, although no deaths were reported, the infection appears to have occurred in two waves condensed into the same two-month time period. Spanish Influenza deaths in communities surrounding all correctional facilities often occurred in waves separated by two to four months and fatalities continued for more than a year after the first two-month peak period.

For the police community the value of the 1918 Spanish Influenza peak period morbidity and mortality figures is that the estimates provide a caution to those responsible for smaller offices or detachments. Will there be adequate protection for smaller communities and for the officers who rely on neighbouring offices for support if entire work units (e.g. four to twelve officers) become ill at the same time? Small satellite or neighbourhood offices, common in larger municipal police services, may help in maintaining police services during an outbreak but not if these officers begin and end each shift at the main police headquarters, increasing the risk of cross contamination.

Most publicly accessible pandemic plans note that pandemic preparation should be of direct benefit to (respiratory, small droplet/air borne) contagious disease responses in general. An avian flu pandemic may never materialize, but, according to current literature, most medical professionals suggest some form of pandemic is inevitable. This alone may provide litigation fuel in the aftermath of any potentially foreseeable public health calamity. Civilians in 1918-19 may have been willing to accept a slow or non-existent police response for short periods of time. And, in 1918-19

inmates may have willingly abided by court delays, lengthy periods of confinement, inactivity, and lack of contact with relatives. In the future however, if a widespread infection cripples the ability of CJS components to complete their legally mandated functions, history may not repeat itself — civilians and employees will not be as complacent as their 1918-19 counterparts.

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