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Manitoba Ombudsman

June 12, 2020

The Honourable Chief Judge Margaret I. Wiebe
Provincial Court of Manitoba
5th Floor – 408 York Avenue
Winnipeg, MB R3C 0P9

RE: Inquest into the Death of R.D.

Dear Chief Judge Wiebe:

Since 1985, Manitoba Ombudsman has been responsible for following up with provincial public bodies that are the subject of inquest recommendations made under the Fatality Inquiries Act. This responsibility arises from an agreement between Manitoba Ombudsman, the Chief Medical Examiner, and the Chief Judge of the Provincial Court. Through our follow-up, we determine what action has been taken to give effect to inquest recommendations and then report the outcome to the Chief Judge.

We are writing to advise you of the results of the inquiries made by our office concerning the inquest report recommendations made by Associate Chief Judge Shauna Hewitt-Michta in her report regarding the Inquest into the death of R.D., issued on April 6, 2018.

BACKGROUND

This inquest arose from the death of R.D. on October 2, 2013. R.D. was sixteen years old at the time of her death, and had been a ward of Dakota Ojibway Child and Family Services since her birth. A long-standing foster placement collapsed, and R.D. moved through numerous subsequent placements, abusing alcohol and illicit drugs, and working in the sex trade. She was eventually placed at Specialized Foster Homes, a private foster home in western Manitoba located in a rural environment to make running away difficult. R.D. initially made progress in this home, but this was short-lived and she eventually spiraled into crisis.

R.D. was taken into custody on September 20, 2013 for theft, with other criminal charges pending. A correctional officer conducted a standard risk assessment on her admission to Brandon Correctional Centre, finding her at low risk for suicide. Although a health assessment

on intake identified active prescriptions for psychiatric medications, R.D was not offered her medications and psychiatric service providers did not assess her. Brandon Correctional Centre did not contact Dakota Ojibway Child and Family Services or Specialized Foster Homes for information about R.D or her medications. Neither Dakota Ojibway Child and Family Services nor Specialized Foster Homes contacted Brandon Correctional Centre to provide information about R.D.'s mental health, medication, or vulnerabilities.

At the request of Specialized Foster Homes, R.D.'s lawyer consented to her continued detention while Dakota Ojibway Child and Family Services, Specialized Foster Homes, and other supports worked to identify a release plan for R.D. She turned sixteen in custody, on September 21. No one communicated with her about the reason for her continued detention, nor about the planning that was occurring for her release.

On the evening of September 28, 2013, a Correctional Officer found R.D. hanging in her cell. She succumbed to her injuries on October 2, 2013 at Brandon Regional Health Center. The cause of death was hanging and the Chief Medical Examiner's Office determined the manner of death to be suicide.

RESPONSE TO INQUEST RECOMMENDATIONS

In the inquest report, the judge made five recommendations. We made inquiries with Manitoba Justice and Manitoba Families on January 15, 2019 to determine what steps they had taken to implement the recommendations in this matter. Manitoba Justice's response was received by our office on February 21, 2019. Manitoba Families' response to the recommendations was received on May 23, 2019. Manitoba Families provided additional information on October 9, 2019 and responded to requests for clarification through to December 2019. We sought additional information from both Manitoba Families and Manitoba Justice in March 2020 which was received thereafter.

The judge noted in her report that many of the recommendations that she would have made regarding the Brandon Correctional Centre were addressed through an internal review conducted by Senior Managers from two other provincial correctional facilities as well as the director of Health Services for Manitoba Corrections. Important changes implemented by Brandon Correctional Centre include removal of curtains on exterior cell windows in the Juvenile Unit; installation of suicide grating; elimination of possible tie-off points within the Juvenile Unit; provision of radios and code call training for medical staff; and installation of cameras in all areas of the Juvenile Unit.

Our report on each recommendation is as follows:

Recommendation #1 (complete)

That a review be undertaken of the number and availability of secure foster placements in Manitoba for high-risk youth in crisis, recognizing that the *Youth Criminal Justice Act* prohibits the use of incarceration as a substitute for appropriate child welfare measures.

Manitoba Families advises that there are presently no secure facilities for high-risk youth within the child and family services system in Manitoba. As of March 2019, five semi-secure facilities provide 24 bed spaces, as well as a range of services for crisis stabilization and addictions treatment.

Manitoba Families reports they are also working with stakeholders and other government departments to review recommendations from various reports that speak to the need for continuum of services, including treatment and programming, for at-risk children and youth. As part of this review, they report they will explore options and legislative requirements regarding secure treatment facilities for youth. These reports include:

- Manitoba Advocate for Children and Youth (MACY) report – Learning from Nelson Mandela: A Report on the Use of Solitary Confinement and Pepper Spray in Manitoba Youth Custody Facilities
- Manitoba Ombudsman report – Investigation Report on Use of Pepper Spray and Segregation in Manitoba's Youth Correctional Facilities
- MACY Report - A Place Where it Feels Like Home: The Story of Tina Fontaine
- VIRGO's Report commissioned by Manitoba Health Seniors and Active Living – Improving Access and Coordination of Mental Health and Addictions Services: A Provincial Strategy for all Manitobans
- Manitoba Families internal report - Collaboration and Best Practices to End Sexual Exploitation and Sex Trafficking in Manitoba

In addition, the Departments of Justice and Families have undertaken a joint review of services and inter-relationship between the youth corrections and child and family services systems. They report that the first phase – an inter-jurisdictional scan, detailed analysis of incarceration and recidivism rates among youth involved in both systems, and a review of leading practices to reduce incarceration and recidivism – is complete. This report has not, at this time, been publicly released and decisions about next steps are under consideration.

In making this recommendation, the judge notes the inquest did not hear opinions from experts in child welfare, nor was evidence presented as to the nature, number, and average availability of secure foster placement options in the province. As such the intent of the recommendation is to

draw attention to the need for adequate safe and secure foster placement options for high-risk youth in crisis. In assessing the work on this recommendation, we note that Manitoba Families is aware of the status of such facilities, and is reviewing recommendations from additional reports that speak to treatment facilities for youth. The joint review with Justice will also touch on similar issues.

We consider that Manitoba Families is aware and reviewing the status of services available to at-risk youth and as such has met the requirements of this recommendation. We therefore consider the recommendation to review the number and availability of secure foster placements as complete. Further, we note that both the Departments of Families and Justice continue to review the issue and work towards providing appropriate treatment, programming and placement options for high risk youth.

Recommendation #2 (complete)

That all child welfare agencies in Manitoba, who have not done so already, develop policies and procedures to ensure that either they or their delegates providing care to wards, inform correctional facilities of background, health, and any other information relevant to the ward's safety and well being while incarcerated.

Manitoba Families reports that in June 2014, a Joint Protocol for Working with Mutual Clients between Community and Youth Corrections and Child and Family Services Staff was created and implemented across the province by all CFS agencies and Justice stakeholders. This protocol was agreed to by the four Child and Family Services Authorities and Community and Youth Corrections within Manitoba Justice. It ensures information sharing and clarifies roles and responsibilities of Community and Youth Corrections as well as CFS staff when a young person is involved in both the justice and child welfare systems. This protocol was issued to youth corrections and CFS agencies in November 2014.

As this protocol did not initially apply to adult facilities that accept youth, Manitoba Justice has issued a directive notifying its adult correctional facilities that this protocol will now apply to them, and directing them to implement the relevant processes by April 1, 2019. In addition, Manitoba Families issued a bulletin on CFSIS, the Child and Family Services Information System, regarding the protocol, and has stored it on the application for reference by child welfare staff.

Manitoba Families has also provided the protocol to both Core Curriculum and CFS application (computer programs used by CFS staff) trainers, to ensure it is brought to the attention of child welfare workers.

Manitoba Families also notes that the Protecting Children (Information Sharing) Act enables service providers to collect and share personal information about at-risk children, their parents, and legal guardians without consent when it is in the child's best interests.

As the Joint Protocol for Working with Mutual Clients between Community and Youth Corrections and Child and Family Services Staff speaks to the issues raised in this recommendation, and now applies to adult facilities as well as youth facilities, we consider this recommendation complete.

Recommendation #3 (complete)

That all child welfare agencies in Manitoba, who have not done so already, develop policies and procedures delineating the particular responsibilities of the agency and those of the foster care provider in relation to communication with the correctional facility and communication with the young person while incarcerated.

Manitoba Families informed us that it is the responsibility of the CFS agency, as guardian of the young person, to communicate with the correctional facility as well as the young person during a period of incarceration. This is part of case planning and the responsibility of the CFS worker. A foster care provider would be responsible for notifying the guardian (the CFS agency) of any significant events, such as incarceration. We were told that this was the case at the time of RD's death.

Each CFS agency is mandated by one of four CFS Authorities, who are responsible for the development of service policies and procedures. The senior executive officer of each Authority, as well as the Director of Child Protection within Manitoba Families, comprise the CFS Standing Committee. Standing Committee is an advisory body to the authorities and the government, and is responsible for facilitating cooperation and coordination in the provision of services.

Manitoba Families informed us that Standing Committee has developed a Foster Care Placement Communication Protocol. This Protocol clarifies roles and responsibilities of staff of the CFS Agency and of community organizations who provide foster care services to child and family services agencies. The Protocol does not speak specifically to incarceration, nor to communication with external entities or the young person, but is intended more broadly to strengthen communication between foster care providers and CFS agencies.

If a youth is placed in a group care facility that is licensed by Manitoba Families, the sharing of information and communication expectations are outlined in the Child and Family Services Standards Manual: Volume 2 – Facility Standards. Licensing reviews and audits by Manitoba Families include a review of compliance with these standards. In addition, the CFS Authority

who provides the mandate to the CFS agency is responsible for ensuring compliance of the CFS agency with the standards relevant to service delivery and case management for the child/youth in care, regardless of placement.

We also note that the Protecting Children (Information Sharing) Act was proclaimed in September 2017 to enable sharing of information regarding children and youth, where appropriate.

While we have not noted an action that addresses the specific intent of this recommendation, Manitoba Families has clarified the responsibility of the CFS agency, as legal guardian, in communicating with a correctional facility as well as a young person, if a youth in care is incarcerated. We also note that the Joint Protocol referenced in recommendation 2 identifies the case worker as a point of contact for information about the child. As such, we consider this recommendation to be complete.

Recommendation #4 (complete)

That Corrections review the existing training related to suicide risk assessment, supervisory review of risk assessment, and utilization of the override option, with a view to determining whether core training should be enhanced and whether "refresh" training sessions would be beneficial to existing staff. The review should be undertaken recognizing that not all correctional officers are experienced at completing the assessments and that some correctional officers may be reluctant or uncertain about when to override a computer generated risk designation.

Manitoba Justice advised that the review was conducted and changes were made to the override portion of the training for staff. In addition, Manitoba Justice advised that refresher training takes place every two years for all Correctional Officers, and includes training on suicide prevention at all the correctional and youth centres.

The recommendation does not speak to any specific changes needed but rather to a review being conducted. As a review has taken place, changes made to training, and refresher training put in place, we consider this recommendation to be complete.

Recommendation #5 (complete)

That Corrections provide additional activity options in the Juvenile Unit at BCC.

Manitoba Justice advised that BCC has made the following additions to activity options levels in the unit:

- Addition of an exercise bike to the Youth Unit;
- Addition of a laptop available to youth; programs including life skills programming, resume builder, interview preparation, various educational games, driver's license handbook, math tutorial, self-help;
- Access to schoolwork from the current school that the youth is enrolled in; collection of materials and support with and by the BCC literacy instructor.

As additional activity options have been added in the Juvenile Unit of BCC, we consider this recommendation complete.

ADDITIONAL COMMENTS

In addition to the five recommendations, the judge commented that Corrections may wish to consider ways to encourage and facilitate disclosure of inmate-to-inmate disclosures of suicidal intentions. In response, Manitoba Justice advised that a communication log and Correctional Offender Management computer system are used for inter-staff communication of important issues.

In addition, the Child and Family Services Authorities, in the response received from Manitoba Families, wished to note that they do not support the placement of youth in adult correctional facilities.

CONCLUSION

The purpose of an inquest is to determine the cause, manner or circumstances in which a death occurred so that recommendations can be made to change provincial laws or the programs, policies and practices within provincial government, agencies or institutions to prevent deaths in similar circumstances.

As indicated in the responses above, we consider the implementation of each recommendation made in the inquest into the death of R.D. to be complete. As such, we conclude our follow up and provide our report to you.

Please note that an electronic copy of this report will be posted on the Manitoba Ombudsman website at www.ombudsman.mb.ca.

Yours truly,

Jill Perron
Manitoba Ombudsman

cc: Dave Wright, Deputy Minister, Manitoba Justice
John Leggat, Deputy Minister, Manitoba Families
Dr. John Younes, Chief Medical Examiner, Manitoba Justice