RELEASE DATE: July 6, 2012

Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***

AND IN THE MATTER OF: **C.J. (Deceased)**
Date of Death: July 30, 2010

C.B. (Deceased)
Date of Death: December 11, 2010

Report on Inquest of The Honourable Judge John P. Guy
dated this 3rd day of July, 2012

Restriction on Publication – Pursuant to the Youth Criminal Justice Act there is a restriction on publication regarding this matter.

APPEARANCES:

Ms Jennifer Mann and Ms Kathrine Basarab, Counsel to the Inquest
Mr. Irvin Frost and Mr. Jim Koch, for Manitoba Corrections
Ms Vivian Rachlis, for the Manitoba Adolescent Treatment Centre (MATC) and Winnipeg Regional Health Authority (Child and Adolescent Mental Health Program)
Mr. Jeff Harris, for Awasis Agency of Northern Manitoba
Mr. Harold Cochrane, for Southeast Child and Family Services Agency and the First Nations of Southern Manitoba Child and Family Services Authority
Ms Myfanwy Bowman and Ms Beverly Froese, for the Elizabeth Fry Society of Manitoba Inc. and the Canadian Association of Elizabeth Fry Societies
Mr. Todd Campbell, for Dr. Hygiea Casiano
Mr. Keith Ferbers, for Dr. Simon Trepel

RELEASE DATE: July 6, 2012

Manitoba

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATHS OF: C.J. and C.B.

Having held an inquest respecting the said deaths on April 16, 17, 18, 19, 20 and 30, 2012 and May 1, 2, 3, 7, 8, 9, 10, 16 and 17, 2012 at the City of Winnipeg, in the Province of Manitoba, I report as follows:

(a) The name of the deceased is: **C.J.**.

The deceased came to her death on the 30th day of July, 2010, in the City of Winnipeg, in the Province of Manitoba.

The deceased came to her death by the following means:

Suicide by hanging.

(b) The name of the deceased is: **C.B.**.

The deceased came to her death on the 11th day of December, 2010, in the City of Winnipeg, in the Province of Manitoba.

The deceased came to her death by the following means:

Suicide by hanging.

I hereby make the recommendations as set out in the attached report.

Attached hereto and forming part of my report is a schedule of exhibits as required to be filed by me.

Dated at the City of Winnipeg, in Manitoba, this 3rd day of July, 2012.

Original signed by Judge John. P. Guy

_____

John P. Guy
Provincial Judge

copies to: Dr. T. Balachandra, Chief Medical Examiner (2)
The Honourable K. Champagne, Chief Judge, Provincial Court of Manitoba
The Honourable A. Swan, Minister of Justice and Attorney General
Mr. Jeffrey Schnoor, Q.C., Deputy Minister of Justice and Deputy Attorney General
Mr. Michael Mahon, Assistant Deputy Attorney General
Ms Shauna Curtin, Assistant Deputy Minister
Ms Lorraine Prefontaine, Director of Specialized Prosecutions
Mr. Larry Hodgson, Acting Director of Regional Prosecutions
Ms Jennifer Mann and Ms Kathrine Basarab, Inquest Counsel
Mr. Irvin Frost and Mr. Jim Koch
Ms Vivian Rachlis
Mr. Jeff Harris
Mr. Harold Cochrane
Ms Myfanwy Bowman and Ms Beverly Froese
Mr. Todd Campbell
Mr. Keith Ferbers

Manitoba

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATHS OF: C.J. and C.B.

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LEGISLATIVE FRAMEWORK

CME review of investigation report

19(1) Subject to subsection (3), upon receipt of an investigation report, the chief medical examiner shall review the report and determine whether an inquest ought to be held.

CME to direct holding of an inquest

19(2) Where the chief medical examiner determines under subsection (1) that an inquest ought to be held, the chief medical examiner shall direct a provincial judge to hold an inquest.

Inquest mandatory

19(3) Where, as a result of an investigation, there are reasonable grounds to believe

(a) that a person while a resident in a correctional institution, jail or prison or while an involuntary resident in a psychiatric facility as defined in *The Mental Health Act*, or while a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*, died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause; or

(b) that a person died as a result of an act or omission of a peace officer in the course of duty;

the chief medical examiner shall direct a provincial judge to hold an inquest with respect to the death.

Provincial judge to hold inquest

26(1) Where a direction is given by the chief medical examiner under section 19 or by the minister under section 25, a provincial judge shall conduct an inquest.

One inquest for related deaths

26(2) Where the minister, in making a direction under section 25, or the chief medical examiner, in making a direction under section 19, recommends that two or more deaths that are closely related in time or place be the subject of the same inquest, the provincial judge receiving the direction shall conduct one inquest with respect to the related deaths unless the provincial judge considers it impractical in the circumstances or contrary to the administration of justice to do so.

Duties of provincial judge at inquest

33(1) After completion of an inquest, the presiding provincial judge shall

(a) make and send a written report of the inquest to the minister setting forth when, where and by what means the deceased person died, the cause of the death, the name of the deceased person, if known, and the material circumstances of the death;

(b) upon the request of the minister, send to the minister the notes or transcript of the evidence taken at the inquest; and

(c) send a copy of the report to the medical examiner who examined the body of the deceased person;

and may recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest.

In camera evidence and culpability

33(2) In a report made under subsection (1), a provincial judge

(a) may disclose in camera evidence that is received during the inquest where the judge is satisfied that disclosure of the evidence

(i) is essential to setting forth when, where and by what means the deceased person died, the cause of death and the material circumstances of the death, and

(ii) is in the public interest;

(b) shall not express an opinion on, or make a determination with respect to, culpability in such manner that a person is or could be reasonably identified as a culpable party in respect of the death that is the subject of the inquest.

MANDATE OF THE INQUEST

[1] On February 16, 2011 the Provincial Chief Medical Examiner called an inquest into the deaths of C.J. (date of death July 30, 2010) and C.B. (date of death December 11, 2010).

[2] The Chief Medical Examiner stated:

> Thus, in accordance with *The Fatality Inquiries Act*, I direct that an inquest be held into the death of C.J. for the following reasons:
>
> 1) to fulfil the requirement for an inquest as defined in Section 19(3)(b) of *The Fatality Inquiries Act*;
>
> **Inquest mandatory**
>
> 19(3) Where, as a result of an investigation, there are reasonable grounds to believe
>
> (a) that a person while a resident in a correctional institution, jail or prison or while an involuntary resident in a psychiatric facility as defined in *The Mental Health Act*, or while a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*, died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause; or
>
> (b) that a person died as a result of an act or omission of a peace officer in the course of duty;
>
> the chief medical examiner shall direct a provincial judge to hold an inquest with respect to the death.
>
> 2) to determine the circumstances relating to C.J.'s death; and,
>
> 3) to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

and

> Thus, in accordance with *The Fatality Inquiries Act*, I direct that an inquest be held into the death of C.B. for the following reasons:
>
> 1) to fulfil the requirement for an inquest as defined in Section 19(3)(b) of *The Fatality Inquiries Act*;
>
> **Inquest mandatory**
>
> 19(3) Where, as a result of an investigation, there are reasonable grounds to believe
>
> (a) that a person while a resident in a correctional institution, jail or prison or while an involuntary resident in a psychiatric facility as defined in *The Mental Health*

Act, or while a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*, died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause; or

(b) that a person died as a result of an act or omission of a peace officer in the course of duty;

the chief medical examiner shall direct a provincial judge to hold an inquest with respect to the death.

2) to determine the circumstances relating to C.B.'s death; and,

3) to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

***Note*: *The inquest should have been called pursuant to section 19(3)(a), not (b).*

INTRODUCTION

> A Sometimes it's, it's, like, this is just an opinion, but it's almost like they think of themselves as, they don't have, they don't value their lives the same way that I would want them to, sort of. It's kind of like, well, I'll kill myself then. And you're like, really? Just all cazh (phonetic) like that, you're just going to up and kill yourself and yeah, some of them are really – I mean, they've come from such different places. They've come from trauma and abuse and I mean, there's a reason that they get there. They're not just rotten little kids that end up at MYC one day. It's like, you know, they don't, they don't see the light at the end of the tunnel. They don't see that if they work harder, that, you know, they might enjoy the fruits of their labour. They just see, like, it doesn't matter which way I turn, I'm screwed, kind of thing. So it's, you know, they learn to sort of, you know, kids learn with what they're given growing up. So it's kind of sad state, really.
>
> - Registered Psychiatric Nurse
> (Transcript April 19, 2012, page 47, lines 24 to 34; page 48, lines 1 to 7)

[3] One always hopes the efforts of a well-trained, caring staff will be sufficient to tackle the ever-present problem of suicide risk in a correctional institution and prevent a tragedy.

[4] The subject matter of this inquest - the tragic suicides of two young girls within six months of each other while in custody at the Manitoba Youth Centre – severely challenges that hope.

[5] Despite the knowledge of their suicidal ideation, despite the extensive monitoring, despite the abilities and expertise of the staff and despite significant changes between the first suicide and the second suicide, these tragic deaths still occurred. The frustration and depression of all concerned of not being able to prevent such not unexpected behavior is palpable. Three shifts, 24 hours a day, at least three staff, sometimes more, were trying minute by minute to prevent self-harming actions. A daily roller coaster of emotions for both staff and residents.

[6] And to make matters worse, reports indicate a very high percentage of the residents are at some level of suicide risk – fortunately many low risk but nevertheless a suicide risk - young women under the age of 18.

[7] The two young girls in question were obviously beset with guilt. One because she thought she should have been present when her sister accidentally drowned, coupled with the loss of several other family members within a relatively short period of time. The second girl was overcome with guilt for causing the death of her sister's partner.

[8] These feelings were not surprising and staff were aware and knowledgeable about them and were tackling the issues with each of the girls but failure resulted.

[9] Many feel that if an individual is adamant about committing suicide, it is almost impossible to prevent. The logic is that appropriate intervention will succeed and over a period of time their thought processes can be changed. We still must try.

[10] What is the answer; what, if anything, could have been done differently?

TO DETERMINE THE CIRCUMSTANCES UNDER WHICH C.J.'S DEATH OCCURRED

[11] A call from the Manitoba Youth Centre was entered as a medical emergency at 11:34 hours on July 27, 2010. The police investigation began as the victim C.J. was in custody at Room 10, Sage Cottage, Manitoba Youth Centre. The evidence revealed at approximately 11:30 hours when the staff was trying to deliver lunch to the victim's room, the staff had difficulty opening the door. When staff entered the room they found the victim hanging from the top hinge of the door. A code red was called and the victim was lifted in an attempt to get her down. First responders attended and she was cut down using a rescue knife. 911 was called and first aid (CPR) administered until the ambulance arrived. The piece of cloth that C.J. used to hang herself was the top seam of a pillow case.

[12] The school teacher indicated that she had been speaking with the victim approximately five minutes before the discovery.

[13] On July 30, 2010 the decision was made to remove life support and C.J. passed away.

[14] The specific evidence heard at the Inquest involving C.J.'s death can be divided into two parts.

[15] The first part of the evidence dealt with a reconstruction of the conduct and condition of C.J. from her incarceration on July 1, 2010 and the Manitoba Youth Centre staff's dealing with her over that period of time.

[16] The second part was the testimony of the staff in Sage Cottage at the time of her discovery, the testimony of the first responders to the code red and the efforts of the nursing staff with respect to life-saving measures.

[17] It was clear from the evidence that C.J. was a very troubled child, having to face the tragic loss of several family members – sister, stepbrother, grandfather – all within a relatively short period and feeling some guilt particularly with respect to her sister. These losses, coupled with her incarceration, led to numerous acts (incident reports) of self-harm and previous attempts at suicide. The juvenile counsellors of Sage Cottage, the mental health workers (psychiatric nurses) and the Manitoba Youth Centre psychiatrist were fervently and constantly dealing with C.J. to assist with her mental health.

[18] The day before July 26th, because of suicidal thoughts and her being in possession of sheets capable of being used for possible suicide, she was searched and

placed in shackles. As her behaviour improved due to staff intervention the shackles were removed and improvements were seen.

[19] At the time of her suicide there was a feeling by staff the situation was under control.

[20] The testimony painted an atmosphere of constant diligence with a roller-coaster tension depending on the mental state of C.J., the staff having to respond immediately and strongly depending on the nature of the behaviour, and constantly endeavouring to anticipate and respond to the behaviour. The analogy may not be appropriate but the impression given was that staff patrolled the cottage with a fire extinguisher trying to determine whether the behaviour warranted the usage of the fire extinguisher or not.

Issues

[21] A review of all the circumstances raised issues that needed to be explored even if ultimately rejected as unimportant or irrelevant. In no particular order the following issues were uncovered, just to mention a few:

(a) Access to clothing, etc. – laundry

[22] Access by residents to the means to attempt self-harm or suicide will constantly be present. Whether it be their own clothing which they may be able to tear or cut or materials to be found in the laundry room, it would appear to be impossible to completely eliminate such access. Efforts have been made to improve the sheets and pillowcases so they cannot be torn and to better control access to the laundry room where materials were kept. Important steps but not foolproof considering the number of residents and their movements.

(b) Suicide risk and assessment

[23] This will be dealt in more detail in general later in the report but specifically with C.J. a few comments need to be made. The assessment of suicide risk will always be somewhat controversial. It must depend on the staff's individual interpretation of the mental state of the resident at that point in time. That mental state may change in five minutes due to some circumstances outside the control of staff, i.e., phone call, or despite the resident's assurance of safe behaviour the resident may not be telling the truth in order to conceal her intention. These are just a couple of examples of which there are many. The interpretation must be based on the training and experience and there are bound to be differences of opinion because of constantly changing factors. C.J. was on a medium suicide watch – SUM. Although there were factors that might

have raised that level, staff who dealt with her shortly before her death were satisfied the level was appropriate. Hindsight is 20/20.

(c) Contact (visual and otherwise) with resident

[24] Although because of the five-minute checks now implemented, the contact is frequent. Only the high suicide risk assessment would warrant constant monitoring or the placing in a specialized unit. In the context of C.J.'s case the monitoring was appropriate for her suicide risk assessment and she had been seen within the 10-minute check policy.

(d) Physical layout of cottages and residents' room

- **Location of video**
- **Lighting**
- **Covering of windows**
- **Hinges**

[25] Little needs to be said as most of these factors were not critical in the death of C.J.. She was being monitored and the lighting and covering of windows were not decisive factors. Doors have hinges and therefore can be a source of tragedy. Considerable efforts have been made concerning the hinges and their design and they will continue to be assessed.

[26] On the whole, changes to the physical layout of the cottages and the residents' rooms have been one of the major changes as a result of these deaths.

(e) Response to the critical incident

[27] There was some discrepancy in the testimony concerning the reaction of staff to the discovery of C.J. However, once again, it was not critical. These things work out according to plan in training but quite often the actual circumstances can affect the staff quite emotionally. Despite their emotional state they reacted appropriately in all the circumstances. Occasional re-enactments will provide greater confidence in their responses.

[28] In summary, certain things should be noted concerning the tragic death of C.J. C.J. was not a young person who died because no one was aware of her desperate situation. She was receiving a great deal of attention and resources available to the Manitoba Youth Centre. Staff was vigilant, caring and constantly trying to support C.J.. That very day and up to minutes before her death the staff was talking to her, obtaining assurances from her concerning her well-being and making every effort to support her

and keep her safe. They thought they had done so. They had no knowledge that she had the means to effect her death or that she wished to harm herself at that time.

[29] The death of a young woman in these circumstances is always tragic – it is doubly tragic because of the efforts of juvenile counsellors, mental health workers and psychiatric staff to prevent her death.

Divisional Review

[30] As a result of the death of C.J. at the Manitoba Youth Centre, a Divisional Review was conducted by a Correctional Review Team pursuant to Corrections Policy. The Review resulted in a number of recommendations, many of which had been implemented or were being implemented at the time of the second suicide at the Manitoba Youth Centre in December 2010.

[31] The Divisional Review Team's recommendations were as follows:

(a) Physical Environment:

The Review Team recommends that each of the girls' cottages at the Manitoba Youth Centre immediately designate four specific rooms for suicide watch purposes. Ideally, these rooms would be those closest to the staff desk.

In each of these designated rooms, a door be installed that has a full view window for the top half portion of the door for increased visibility.

It is recommended that an alternative door hinge be researched and installed on the doors of these designated rooms so that the attachment of a ligature is not possible.

It is recommended that a surveillance camera be installed in each of the designated rooms and if required that Manitoba Youth Centre Standing Orders be created relating to the staffing and operation of the surveillance monitoring.

Furthermore, it is recommended that any side panel windows that are scratched and compromise visibility be replaced immediately, starting with the designated suicide watch rooms.

It is recommended that an accurate time stamp be programmed into the video surveillance recording system.

To further enhance with staff documentation of suicide watches, it is recommended that a permanent file mounting system be attached to the wall

outside the designated suicide rooms (i.e., similar to that in a doctor's office). This file storage system would hold the suicide observation reports for the youth that is being monitored in the particular room.

(b) Policies/Standing Orders:

The Review Team recommends that the Manitoba Youth Centre suicide policy become inclusive of all components of the Divisional Youth Suicide Policy.

The Review Team recommends that Manitoba Youth Centre staff should be educated on the existing suicide policy and any future revisions or updates.

The Review Team recommends that Manitoba Youth Centre develop policy and procedure with respect to the preservation of the scene of a critical incident.

The Review Team recommends that Manitoba Youth Centre develop policy and procedure with respect to maintaining the Automated External Defibrillator (AED) and the Emergency Medical Bag in a static location and designate a specific staff member to transport these items to Code Reds.

(c) Operations:

The Review Team recommends that all SUM and SUH residents be assigned rooms directly across from the staff desk; even if it means doubling up youth in these rooms.

The Review Team recommends that a physical head count of residents be conducted at shift change with one staff from the outgoing and one staff from the incoming shift.

The Review Team recommends that a specific staff member be designated the responsibility of completing suicide observation monitoring.

The Review Team recommends that Unit Managers perform quality assurance measures by routinely reviewing DVR recordings of staff performing their duties. This would allow the Unit Manager to address any performance management concerns. Unit Managers review and sign off all Suicide Observation Reports/Records to ensure that they are completed according to policy.

The Review Team recommends that staff deployment/distribution in the cottages be based on staff to resident ratios. If a resident group is being split, the majority of staff should remain with the largest group of residents.

The Review Team recommends no youth ever be allowed to cover up their night light or any portion of their window.

The Review Team recommends that the quantity of personal items that residents are allowed to have in their possession be limited to the very basic of necessities.

(d) Human Resources:

The Review Team recommends that the staffing complement on the night shift in the Manitoba Youth Centre girls' units be increased to one staff per cottage and a float assigned between the two cottages.

The Review Team recommends that Senior Unit Officer coverage in the female unit be increased to 16 hours per day seven days a week.

The Review Team recommends that additional Mental Health Support Workers be assigned to each female unit.

The Review Team recommends that a full-time female Elder or Kookum be hired to work with the female populate at Manitoba Youth Centre.

(e) Training:

The Review Team recommends that Mental Health First Aid Training become mandatory for all staff.

(f) Health Services:

The Review Team does not have any recommendations to offer in this area.

TO DETERMINE THE CIRCUMSTANCES UNDER WHICH C.B.'S DEATH OCCURRED

[32] On December 8, 2010 at approximately 2325 hours, investigating officers Detective Sergeant E. Chalmers and Detective T. Bramadat were notified there was an attempted suicide by hanging at the Manitoba Youth Centre. C.B. was found hanging in her room and subsequently transported to Children's Hospital. Initial information revealed that C.B. was on medium suicide watch and was to be checked every 10 minutes. She was seen at 2110 hours and found unconscious at 2120 hours. Apparently a band from a pillowcase had been used. The victim had been on medication for panic attacks and for post-traumatic stress disorder.

[33] The officers arrived at the Manitoba Youth Centre at midnight and began interviewing the three juvenile counsellors and the supervisor who were working in the Nightingale Cottage at the time of the incident.

[34] Exhibits were seized including cottage log sheets, monitor sheets, video, etc. An interview schedule was set up for the staff members.

[35] The investigation revealed that C.B. was having a rough time and wanted a time out. A juvenile counsellor attended on C.B. and after conversing with her was satisfied she was okay, good for the night and would not hurt herself.

[36] Another juvenile counsellor indicated although C.B. had wanted to go to the observation unit, she was told that may not be an option but they spoke to her and were satisfied she was settling down. The juvenile counsellor checked C.B. at 9:10 and C.B. was getting into bed. She had got some paper that C.B. had requested and slid it under the door. The juvenile counsellor attended to her checks a few minutes later and tried to open the door. She found C.B. hanging from the second hinge of the door. Code Red was called, C.B. was lifted up, the rescue knife was used to cut the pillowcase band and CPR started right away. She was taken to the Health Sciences Centre.

[37] Some of the issues that emerged as a result of the incident were her request for a time out and the fact she was being consequenced for her behaviour and somehow, despite searches, she had obtained material to hang herself. C.B. had seen the mental health nurse that day and had received a great deal of attention right up to the time of the incident.

[38] On December 11, 2010, C.B. passed away.

Issues

[39] As can be seen from the evidence, some of the same issues reoccurred on this occasion.

(a) Access to clothing, etc. – laundry

[40] Again it was unclear in this case how the victim obtained the pillowcase with which she hung herself. There is no foolproof way of preventing numerous individuals, up to 17, in a dormitory not to obtain some means to self-harm.

(b) Suicide risk and assessment

[41] This victim also was on SUM risk but she was having difficulty that evening and the staff was extra vigilant in light of this. The staff was satisfied in their inquiries that the victim had settled down and would remain safe.

(c) Contact (visual and otherwise) with resident

[42] At this time visual checks were being conducted every 10 minutes. A check was conducted at 2110, at which time some paper to draw on was requested and given. This was viewed as a good sign. When the second round of visual checks was conducted at 2120, the discovery of the victim was made. The monitoring was appropriate in the circumstances and pursuant to policy.

(d) Physical layout of cottages and residents' room

- **Location of video**
- **Lighting**
- **Covering of windows**
- **Hinges**

[43] Improvements can always be made but these issues were not critical to her death. She was being monitored and could be seen. The hinge issue is again being reassessed.

(e) Response to the critical incident

[44] The response of the staff was appropriate and pursuant to protocol. The loss of this young life was not due to lack of appropriate response.

Divisional Review

[45] As a result of this second death a Divisional Review was conducted in the circumstances surrounding the suicide of C.B.

[46] The following recommendations flowed from the Review:

(a) Physical Environment:

Windows – The Review Team recommends all resident doors within the institution be changed or retrofitted to include windows (note: a significant number of doors have already been retrofitted in the female cottages). It is noted that this is a significant change, so the Review Team suggests this task first be completed in Female Cottages.

Surveillance Cameras – The Review Team recommends a surveillance camera be installed in each of the designated suicide watch rooms and, if required, that Manitoba Youth Centre Standing Orders be created relating to the staffing and operation of the surveillance monitoring.

The Review Team recommends an accurate time stamp be programmed into the video surveillance recording system.

(b) Policies/Standing Orders:

Suicide Policy – The Review Team recommends Manitoba Youth Centre's Suicide Policy should be revised to become inclusive of all components of the Divisional Youth Suicide Policy.

The Review Team recommends Manitoba Youth Centre staff should have working knowledge of the Policy/Standing Orders:

- Policy changes should be reviewed in person, led by the Cottage supervisor and/or a staff training officer;
- Staff should be required to sign and date a policy review form that indicates that they have read and understood the changes.

The Review Team recommends emails intended to communicate changes to the Policy and/or Standing Order requirements should be identified as "Interim Directives" by the Superintendent or Deputy Superintendent.

- Any emails that are intended to communicate changes to the existing Policy and Standing Orders be identified as "Interim Directives", be dated,

signed and included in the “Suicide Prevention Binder”. Any interim directives should require review/sign off between management and staff.

The Review Team recommends in-person checks are always completed in accordance with the policy/directive timelines.

- Note: only one instance of non-compliance was observed during the review process.

The Review Team recommends the Direct Observation Report forms be reviewed to determine the practicality and effectiveness of signing off on five-minute checks for SUM and SUH specifically – as five-minute checks are now being completed on all residents.

The Review Team recommends Suicide Risk Re-assessments (SRA) be completed in teams wherever possible. Staff who could be involved will vary from Case Managers, Nurses, Unit Managers, Chaplain, etc. There should be a Suicide Risk Team Manager who coordinates the process of soliciting the information. All staff involved in the re-assessment should be listed in the documentation in the Running Record/Progress Notes.

Critical Incident Policy -The Review Team recommends Manitoba Youth Centre develop policy and procedure with respect to the preservation of the scene of a critical incident.

The Review Team recommends Manitoba Youth Centre incorporate critical incident “drills/trials” to assist with the training and preparation for critical incidents that may occur (similar to a fire drill).

- In reviewing Manitoba Youth Centre Standing Orders, there is Policy #03-933 that reflects the “Institutional Response to a Serious Incident” but the procedures outlined are more specific to an assault situation between staff and resident. Having a similar process identified for a suicide attempt/completion would enable the in-charge person to provide clear direction on how to manage the scene of a critical incident – i.e., which staff to remain on scene and to ensure that the scene is preserved, documenting activities, etc.

(c) Operations:

Suicide Watch Rooms – The Review Team recommends all SUM and SUH residents be formally assigned rooms directly across from the staff desk, even if

it means doubling up on youth in these rooms. This information should also be incorporated into Manitoba Youth Centre Policy and Standing Orders.

Personal Items – The Review Team recommends the quantity of personal items that residents are allowed to have in their possession be limited to the very basic of necessities. Each youth should be provided with an appropriate container to store their personal belongings outside of their room.

(d) Human Resources:

Staffing Levels – The Review Team recommends the current staffing complement in the Female Cottages (three staff on day and evening and two on nights) be continued indefinitely in an effort to support case planning and coordinated interventions for every young person, consistent program delivery and increased organized activity offerings during free time.

Mental Health Support Workers – The Review Team sees the benefit of continuing with this practice to support the role of Mental Health Support Workers.

(e) Training:

Automated External Defibrillator (AED) – The Review Team recommends that Manitoba Youth Centre designated code responders and Health Services Staff be trained with respect to the AED including its static location and when it is to be deployed in a code situation. Documentation should also be kept of who has been trained in the Manitoba Youth Centre training database.

(f) Health Services:

Medical File Documentation – The Review Team recommends that when medical staff document about self-harm or a specific behaviour, it is also important to provide the full details in the Progress Notes including when it occurred.

MENTAL HEALTH SERVICES IN THE MANITOBA YOUTH CENTRE

At Present

[47] The inquest heard evidence concerning the duties of the psychiatric nurses at the time of the incidents. Briefly, the psychiatric nurse when coming on duty would check the population sheet and, particularly, the estimation of suicidality – SUL, SUM, SUH. Obviously SUH received the highest priority. Any staff referrals in the referral binder would also be noted.

[48] Upon receiving this information the nurse would proceed to triage the residents in order of risk and safety. Those judged to need the assistance of a psychiatrist would be referred to the attendance of the psychiatrist on the days scheduled.

[49] As can be seen by this regime, the gathering, compiling and recording of as much information as possible on the resident is absolutely crucial. Any miscommunication or lack of communication could be dire. A new procedure implemented has the nurse involved to attend with the resident upon the psychiatrist and thus can receive the instructions as to treatment firsthand, thus preventing delay and lack of communication. An excellent reform.

[50] However, one cannot help but feel that the process is a very reactive one, responding day to day, rather than a proactive one, following a treatment process suggested by Dr. Daniel Rothman's report. A more collaborative, consultative team approach may diminish areas of potential conflict such as "turf", "good guys and bad guys" to one in which everyone is on the same page. There will always be conflict in a correctional institution between behavioural concerns and mental health concerns, i.e., conflict behaviour vs. suicide risk, but discussions and shared decision-making should be the approach.

Dr. Daniel Rothman's Report

[51] Dr. Daniel Rothman, a registered psychologist, on the retainer of the Elizabeth Fry Society, prepared a report called Mental Health Services for Youth in Correctional Facilities in Manitoba, Recommendations for Best Practices (Exhibit 6) for the Court's assistance. Since the two young girls, who were on suicide watch, died by their own hands the issue of mental health services in the Manitoba Youth Centre was a very live issue to all the parties to the inquest.

[52] The report by Dr. Rothman was a literature review regarding best practices, both with respect to suicide prevention protocol and also regarding the delivery of mental health services to youth in custody. It is important to note that Dr. Rothman did not

have the specific files relating to the two deceased and did not have access to all the material filed with the inquest.

(a) General Principles

[53] Dr. Rothman first dealt with the mental health needs of youth in custody and some of the evidence revealed in the literature which indicated:

- Youth in custody tend to require higher mental health needs;
- Higher rates of exposure to trauma, particularly female youth;
- Co-occurring disorders – female youth – post-traumatic stress and addiction issues;
- Female needs are more outstanding;
- Aboriginal youth in custody – needs are even more complex – higher rates of exposure to different dysfunction and neglect thus greater disorders and needs;
- Suicide rates of Aboriginal youth in custody – females – seven times as high;
- Features of incarceration accentuates some of the known risk factors for suicidality in kids, i.e., confinement to one's room, segregation, isolation and discrimination from family supports, feelings of powerlessness and humiliation (i.e., restraint, etc.);
- High suicidal situations – initial incarceration, sentencing, transfer to another facility, bad news from outside;
- Written suicide prevention policies are necessary but even if best practices model they need to be adhered to and mechanisms for monitoring the adherence be in place.

[54] Even if the above-noted principles were not totally surprising it was important that they be confirmed/expressed and it is to be noted how many of them were potentially present in the two cases under review.

(b) Screening for Suicide Risk

[55] The literature recommends the youth be screened for suicide risk within 24 hours of entering the facility. Dr. Rothman was of the view that the ISA, the screening tool used at the Manitoba Youth Centre, was not designed for this population nor was

specifically designed for suicide risk which he thought should be essential. In his view a screening instrument specifically for youth population should be obtained or created and standardized and researched to confirm its appropriateness and value.

[56] The second essential point raised by Dr. Rothman is that all youth deemed at any level of suicide risk be referred for further evaluation. This is extremely important because suicide risk can change quickly and dramatically as a result of many variables.

[57] Thirdly, Dr. Rothman was of the opinion if the initial screening indicated a suicide risk there needs to be a broader mental health assessment conducted. The statistical data, referred to previously, would indicate that substantial mental health issues involving this population is tremendously high and therefore for the safety of the child, other residents and staff, the identification of these mental health needs would be important.

[58] The detection of the mental health needs, identification of the treatment needs and the creation of a treatment plan would be tremendously important.

[59] Fourthly, it is essential that a qualified mental health professional specializing in mental health concerns with child and adolescent populations be involved in the assessment. Best practices would indicate this broader mental health assessment should occur within two weeks of being identified as a result of the screening conducted within the first 24 hours.

[60] Fifthly, the third component, after the screening within the first 24 hours and the mental health needs assessment, would be ongoing monitoring. Because of youth dynamics their mental health needs can change very quickly and therefore ongoing monitoring is essential.

[61] Dr. Rothman's review then dealt with training as an important part of a successful suicide prevention program – CPR, first aid, basic counselling skills.

[62] A distinction was emphasized between actively suicidal children (constantly monitored – within eyesight of staff at all times) and non-actively suicidal children (close observation – checks not in excess of every 15 minutes).

(c) Effective Mental Health Intervention

[63] The report points out areas of present practices that may need reappraisal – room confinement, consequences such as isolating, removal of clothing.

[64] It is also very important that that the decision-making around mental health concerns would also benefit from collaboration and consultation between the professional mental health staff and the frontline staff.

[65] Statistics have indicated that the collaborative problem-solving approach – a kind of verbal dialogue based on procedures for de-escalating kids – may replace physical restraint practices in some circumstances.

[66] Ideally an effective mental health intervention should not be primarily crisis-oriented. Interventions need to be more strategic – addressing underlying mental health concerns, determining what is behind displaying of symptoms, behavior or suicide attempts. The causes need to be identified so the appropriate intervention can be implemented to address those causes.

[67] Identification of the triggers and having a plan of therapeutic intervention in response to those triggers is essential. To be successful this will require a multi-systemic approach involving juvenile counsellors, case managers, mental health professionals and psychiatrists who all are involved in implementing the plan.

[68] The youth being in custody, even for a short period of time, can provide an opportunity for the preparation of a comprehensive mental health assessment to identify a treatment plan, identifying treatment targets and modes of implementation. The individual then could continue to benefit by receiving mental health services once released.

[69] Although this is a very brief summary of some of the important points in Dr. Rothman's summary of his report (Exhibit 6), it addresses many of the issues raised at the inquest.

[70] A couple of quotes from Dr. Rothman's testimony serve to illustrate the thrust of his position:

> A I would need to add to that, to that statement, to which I fundamentally mostly agree, I would need to add that there are so many different ways to implement the services that I have recommended in my report that I think any reasonable person would consider it to be practical and doable and relatively inexpensive. So in the question of cost benefit, which I think is part of what you're getting at, if I read you right, I think that if the implementation of the measures that I've recommended would save lives among other things, and also very directly reduce the recidivism rates of the children in the criminal justice system being held there because these interventions are effective and have been proven effective, they're not just broad mental health concerns, but also criminal behavior concerns, then I think everybody wins. (Transcript May 9, 2012, page 69, lines 6 to 20) (Emphasis is mine)

....

A That's fair. What I hope, what I, what I hope that I'm able to provide to this inquest is a picture of what proper mental health services ought to look like and, and to have demonstrated that many of these are, are practical and feasible and easily implemented and ought to be implemented where they're not. (Transcript May 9, 2012, page 71, lines 9 to 14)

….

THE WITNESS: Okay. For starters, you screen every kid when they come in, and I can save you some time. I have some information that's been provided to me that more recently the Manitoba Youth Centre has implemented a screen that every kid gets.

THE COURT: Yes.

THE WITNESS: I believe you even use an instrument that's well researched and validated for use with correctional populations called the MAYSI-2. If my information's correct –

BY MR. FROST:

Q Yes.

A -- I commend the youth centre for doing that. I think that's important, because if you want to provide services you've got to first detect the kids. That's really going to help detect those kids. But it's only going to be useful if you have the ability to do something about it once you've detected those kids. And I don't know that – I don't – well, I'll talk about how to do something about it.

For starters, there's going to have to be some more hirings. There's absolutely going to have to be some more hirings of qualified mental health professionals. Corrections is going to have to ensure that the professionals that are professionals that are already there that you call mental health nurses are actually qualified to be doing the work, and I don't know whether they are or not. I don't have that information, but I know that as far as with the policies spoke to, there wasn't a requirement for them to even be a psychiatric nurse and maybe they all are psychiatric nurses and that would be awesome. (Transcript May 9, 2012, page 78, lines 22 to 34; page 79, lines 1 to 18) (Emphasis is mine)

….

THE WITNESS: -- treatments or some of these interventions, so if, if the – if corrections is put into a place a broader mental health screening, great, it will flag kids who, it'll flag a lot of kids and a lot of kids accurately who will be in need of further – of follow-up, mental health service follow-up. So that's what a broader assessment comes in. And that doesn't mean, you know, a 15 page report from a psychologist about, you know, outlining a treatment plan, et cetera, et cetera. It just means that a qualified expert needs to be assessing that kid and then needs to be identifying what the treatment goals,

> what the treatment targets need to be, what the treatment goals need to be and how an intervention can be carried out, and that in and of itself isn't an incredibly labour intensive process, particularly when, when you have access to collateral information. (Transcript May 9, 2012, page 82, lines 7 to 22)

[71] Dr. Rothman very emphatically emphasized that it is essential that individuals conducting the mental health screening be qualified to perform the task and that will mean they possess these essentials – they must be specialists in child and adolescent populations and specialists in child and adolescent mental health.

[72] It is important the qualified mental health professional be the driver of the implementation of the treatment plan. The collaborative approach using all the information, observation and data gathered by the juvenile counsellors, the case manager and the psychiatric nurses will go into the effective carrying out of the treatment plan. Under the direction of the qualified mental health professional and through consultation and collaboration, the treatment plan can be adjusted pursuant to the available information gathering.

[73] It is essential that the communication among all parties be current and clear so everyone is on the same page.

[74] To be effective the contact should be strategically consistent with the overall treatment and addressing the underlying issues identified.

> A Yeah. Well, partly I do. I mean, you make an important point, because it, you know, it leads to your other point earlier on about other systems needing to pick up the ball and run with it, and I think that where corrections could play an important role in that, I mean, aside from providing comprehensive assessment while you have that kid as a captive audience, and starting to provide some interventions while you have that kid as a captive audience, two really key things, the other thing is for case management to be starting to through their coordination duties start to arrange and link that kid up to community resources and do their best to ensure that those community resources are in place so that for instance if the kid is attached to child welfare, the child welfare agencies have the necessary information at the very least to be able to, to implement services for that kid. So their power is very limited. You're quite right, the power and control of Corrections, but they really have I think a key role to play that can be very helpful to that child upon release, and that's the coordination. (Transcript May 9, 2012, page 91, lines 19 to 34; page 92, lines 1 to 4)

[75] In conclusion, Dr. Rothman, through his evidence and through his report, has set out a plan of action which if implemented would have the possibility of dealing with the primary issue of this inquest, the safety and security of everyone at the Manitoba Youth Centre, and the added possibility of reducing further criminal behavior, an equally exciting possibility. An important legacy of these two tragedies.

CONCLUSION

[76] The two deaths, the subject matter of this inquest, were the first two deaths in decades at the Manitoba Youth Centre. This is an enviable history in light of the number of residents being dealt with and the complexity of the problems they face. Such success can only be attributable to the policies, training and caring of the staff.

[77] Because of the deaths at the Manitoba Youth Centre and the Divisional Reviews conducted as a result, a number of very significant changes have taken place. The Court and counsel for the parties with standing to the inquest had an opportunity to have a viewing of Sage Cottage and some of the changes already made. Without listing them all in detail, these changes have encompassed the physical surroundings, increase in staff, policy revisions and training reassessment. The Manitoba Youth Centre should be commended for the actions taken to try and prevent future reoccurrences.

[78] Besides the recommendations that flowed from the Divisional Reviews, the staff made over a hundred recommendations. Although some were duplicitous, all were helpful.

[79] At the inquest the witnesses were asked if they wished to make any recommendations that might assist in the preparation of the inquest report. Many took the opportunity to do so.

[80] Counsel representing those with standing at the inquest also took the opportunity to provide input into areas that should be considered for change.

[81] As a result there has been no absence of suggestions for change or for recommendations for consideration.

[82] Since the deaths occurred in 2010 obviously many of the recommendations from within the institution have been considered, some implemented and some awaiting implementation. I also trust that as a result of the testimony, exhibits and recommendations given at the inquest the Corrections department will assess the evidence and consider further changes. It is extremely important that Corrections take advantage of and make use of the great quantum of material and thought presented at the inquest.

[83] The area that was new and specific to the inquest was the report of Dr. Rothman (Exhibit 6) referred to early in this report. Because it covered areas not previously explored, because it deals with the crux of the issue before the inquest (suicide risk and mental health) and because potentially it could have far-reaching consequences for the

safety and security of the residents of the Manitoba Youth Centre, the report and Dr. Rothman's evidence will be the principal, if not exclusive, thrust of my report.

[84] Anyone hearing all the evidence would be amazed at the number of youthful offenders being dealt with, the complexity of the problems they present and the dedication of the staff dealing with them.

[85] One also could not help but feel the situation is one where the staff is constantly reacting to potentially life and death situations. The situations depend on correct reactions, critical decision-making and crucial information. The evidence indicated that a plan was not always in place, information was not always available to everyone and, therefore, decisions might be made in less than optimal circumstances. This led to the staff making numerous recommendations in order to change these circumstances and better enable them to keep residents safe.

[86] Three significant issues raised at the inquest need to be addressed – the tool used in detecting suicide risk, the tool used for mental health assessments and the degree of communication amongst the staff.

[87] Dr. Rothman expressed the view that the present suicide risk assessment tool should be reassessed in light of the fact it has not been empirically assessed or validated for the use for young offenders. This view was concurred in by Dr. Casiano. The use of a new suicide risk tool should be implemented and evaluated.

[88] It appears a new mental health screening tool, the Massachusetts Youth Screening Instrument (MAYSI), is in the process of being implemented and its appropriateness should be evaluated. Its introduction should be commended.

[89] With the introduction of two new assessment tools, the third issue often raised was the communication amongst staff of updated, current information concerning the resident's mental health and circumstances. The attendance of the psychiatric nurse with a resident upon the psychiatrist is an excellent step towards closing the communication gap. A further step in this direction would be a collaborative, consultative teamwork approach to the implementation of a treatment plan of which everyone is aware and able to contribute to its successful implementation.

[90] Dr. Rothman's quote bears repeating:

> A I would need to add to that, to that statement, to which I fundamentally mostly agree, I would need to add that there are so many different ways to implement the services that I have recommended in my report that I think any reasonable person would consider it to be practical and doable and relatively inexpensive. So in the question of cost benefit, which I think is part of what you're getting at, if I read you right, I think that if

> the implementation of the measures that I've recommended would save lives among other things, and also very directly reduce the recidivism rates of the children in the criminal justice system being held there because these interventions are effective and have been proven effective, they're not just broad mental health concerns, but also criminal behavior concerns, then I think everybody wins. (Transcript May 9, 2012, page 69, lines 6 to 20)

[91] His plan would, in my view, address many of the areas still outstanding. The plan is comprised of the following essentials:

1) Suicide assessment within 24 hours should be conducted;

2) If suicide risk determined, of any level, a further mental health assessment should be conducted within two weeks;

3) This mental health assessment is to be conducted by a qualified mental health professional, which I take to mean a professional with expertise in child and adolescent populations and mental health issues in these populations;

4) As a result of this mental health assessment a mental health plan would be created and this plan would be the template for the entire Manitoba Youth Centre staff – juvenile counsellors, case managers, psychiatric nurses and psychiatrists under the direction of the qualified mental health professional (probably the psychiatrist) to implement and follow.

[92] Dr. Rothman expressed the opinion this plan was doable with the hiring of a few new personnel and the shortness of duration of stay of some of the residents was not problematic. Dr. Casiano's view was consistent.

[93] The potential of such a plan to assist in suicide prevention, dealing with mental health issues in general and creating a framework for the treatment of the future behaviour of the resident should excite anyone dealing with the youth in our correctional facilities.

[94] I would hope that serious consideration be given to this plan and consultation concerning the implementation be conducted with the appropriate experts.

RECOMMENDATIONS

1. The Manitoba Youth Centre investigate the replacement of the current suicide risk assessment tool (ISA – Inmate Security Assessment) with an instrument designed for use with adolescent populations and also which has been empirically validated. Until such a replacement can be found or created, the present instrument will have to continue to be used for each new admission within 24 hours of admission coupled with the staff's experience, knowledge and information. If such an instrument cannot be located, the creation of such an instrument through inquiry and consultation would seem possible, keeping in mind the principles behind such an instrument.

2. All youth deemed at any level of suicide risk should be referred for further evaluation. The Massachusetts Youth Screening Instrument (MAYSI) presently being reviewed and considered by Manitoba Corrections should be adopted to assist in evaluation and assessment.

3. The Manitoba Youth Centre retain sufficient qualified mental health professionals with expertise in adolescent populations and in adolescent mental health in order to create a mental health treatment plan for those identified by the suicide and mental health screening tools and assessments.

4. The mental health treatment plan created as a result of the assessment and under the direction and guidance of the qualified mental health professional should be communicated to staff so that collaborative, consultative and responsive interventions can take place with the resident. The implementation of the treatment plan should involve juvenile counsellors, case managers and psychiatric nurses under the control of the appropriate qualified mental health professional.

5. This targeted mental health strategy can only have success with improved lines of communication of all the appropriate information among all staff responsible for the safety and security of the resident.

6. A social worker should be hired to assist in the gathering of information from available sources, both within and outside the institution, to ensure that the mental health professionals have all the information required in order to make proper assessments and develop treatment plans. This individual can also assist in coordinating the continuation of treatment after release.

7. Manitoba Corrections review and consider implementing the Collaborative Problem-Solving Approach.

8. The Manitoba Youth Centre exercise its best efforts to hire a Kookum as an additional resource for the female Aboriginal population.

9. The Manitoba Youth Centre apparently will be 40 years old next year. It is accepted that the number of residents, the gender of the residents, the seriousness of the charges faced by the residents and the complexity of the problems faced by the residents have all greatly changed in those 40 years. The institution was built to deal with the type of youth that may no longer exist. It may be time to anticipate the needs of future residents and create blueprints for a new institution.

These recommendations in no way divert the Manitoba Youth Centre from the path it has taken. It is hoped the recommendations enhance and complement that path. Despite the commendable changes already undertaken by the Manitoba Youth Centre, it is hoped it will consider even further changes, to be undertaken through consultation and collaboration, in order to reach the goal desired by all – the safety and security of our youth in custody.

Schedule "A"

EXHIBIT LIST

EXHIBITS ENTERED APRIL 16, 2012

Exhibit #1 Letter from the Chief Medical Examiner calling the inquest into the death of C.J. (4 pgs, filed by Crown)

Exhibit #2 Booklet of Photographs of C.J. (6 pgs, filed by Crown)

Exhibit #3 Four accordion folders of documents (Sections I – IV: A – H) with three CDs for C.J. (filed by Crown)

Exhibit #4 Letter from the Chief Medical Examiner calling the inquest into the death of C.B. (filed by Crown)

Exhibit #5 Two accordion folders of documents (Sections I – IV: A – F) with three CDs for C.B. (filed by Crown)

EXHIBITS ENTERED APRIL 17, 2012

Exhibit #6 Report by Dr. Daniel Rothman, Ph.D., C. Psych. entitled *Mental Health Services for Youth in Correctional Facilities in Manitoba: Recommendations for Best Practices* dated April 2012 (64 pgs) and author's CV (7 pgs) (filed by M. Bowman)

EXHIBITS ENTERED APRIL 19, 2012

Exhibit #7 Organizational Chart for Manitoba Youth Centre (1 pg, filed by Crown)

Exhibit #8 MYC Position Descriptions for:

(A) Superintendent (8 pgs)

(B) Deputy Superintendent (13 pgs)

(C) Institutional Operations Managers (3 pgs)

(D) In-Charge Responsibilities (5 pgs)

(E) Teacher (4 pgs)

(F) Senior Unit Officer (5 pgs)

(G) Mental Health Nurse (4 pgs)

(filed by Crown)

Exhibit #9 Child's Social History – Awassis Agency of Northern Manitoba (10 pgs, filed by Crown)

EXHIBITS ENTERED APRIL 20, 2012

Exhibit #10 Welcome to Sage: Information Booklet (Koala on front) - MYC (3 pgs, filed by Crown)

Exhibit #11 Welcome to Sage: Information Booklet - MYC (5 pgs, filed by Crown)

EXHIBITS ENTERED APRIL 30, 2012

Exhibit #12 Winnipeg Police Service Forensic Identification Report (5 pgs, filed by Crown)

Exhibit #13 Winnipeg Police Service Statement of Yvonne Berube (1 pg, filed by Crown)

EXHIBITS ENTERED MAY 7, 2012

Exhibit #14 Manitoba Youth Centre Incidents of Self Harm/Suicide Attempts 2011 (1 pg, filed by I. Frost)

Exhibit #15 Manitoba Youth Centre Incidents of Self Harm/Suicide Attempts 2010 (1 pg, filed by I. Frost)

Exhibit #16 MYC SUM/SUH Classified Residents For The Fiscal Year of 2010 (1 pg, filed by I. Frost)

Exhibit #17 MYC SUM/SUH Classified Residents For The Fiscal Year of 2011 (1 pg, filed by I. Frost))

Exhibit #18 Manitoba Youth Centre – Programs Offered to Sentenced and Remanded Youth (5 pgs, filed by I. Frost))

Exhibit #19 ASIST – Applied Suicide Intervention Skills Training (1 pg, filed by I. Frost))

Exhibit #20 ASIST – 1 Day Refresher (1 pg, filed by I. Frost))

Exhibit #21 MYC Suicide Prevention Refresher – Outline (2 pgs, filed by I. Frost))

EXHIBITS ENTERED MAY 8, 2012

Exhibit #22 Policy #03-961 Subject: Suicide Prevention (11 pgs, filed by Crown)

Exhibit #23 Manitoba Youth Centre Project: Occupational Therapy Environmental Assessment and Sensory-Based Recommendations (26 pgs, filed by Crown)

Exhibit #24 Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) – recommended (see attached) (4 pgs, filed by Crown)

Exhibit #25 **I**nternal Review Commendations: July 27/10 and December 8/10 (7 pgs, filed by Crown)

EXHIBITS ENTERED MAY 9, 2012

Exhibit #26 MATC: Description of Services (2 pgs, filed by Crown)

Exhibit #27 Management and Delivery of Care to Patients Admitted to PY1 Who are in the Custody of the Manitoba Justice System: Practice Guidelines Child and Adolescent Mental Health Program: Health Sciences Centre (2 pgs, filed by Crown)

EXHIBITS ENTERED MAY 16, 2012

Exhibit #28 Pictures of C.B. (2 pgs, filed by Crown)

Exhibit #29 CV of Dr. Hygiea Casiano (5 pgs, filed by Crown)

EXHIBITS ENTERED MAY 17, 2012

Exhibit #30 Screening for Suicide Among Juvenile Delinquents: Reliability and Validity Evidence for the Suicide Screening Inventory (SSI) from the International Journal of Offender Therapy and Comparative Criminology (15 pgs, filed by Crown)

Exhibit #31 Seven disks of C.J. - July 25 - 27, 2010 (filed by Crown)