Release Date: April 11, 2018

IN THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF:	***The Fatality Inquiries Act*, C.C.S.M. c. F52**
AND IN THE MATTER OF:	**An Inquest into the Death of:**
	R.D. (DATE OF DEATH: October 2, 2013)

Report on Inquest and Recommendation of
Associate Chief Judge Shauna Hewitt-Michta
Issued this 6th day of April, 2018

APPEARANCES:
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L.M., grandmother of R.D.
JIM KOCH and **ALAN LADYKA**, Manitoba Justice Legal Services Branch on behalf of Manitoba Corrections
DEAN KROPP, Counsel for Dakota Ojibway Child and Family Services
DAVID SWAYZE, Counsel for Prairie Mountain Health Authority, Dr. Arturo Tamayo, and Dr. Charles Penner
STEVEN BEERNAERT, Counsel for Specialized Foster Homes
ROBERT PATTERSON, Counsel for the City of Brandon, Fire and Emergency Services
ANDREW BOUMFORD, Counsel for Dr. Keith Jenkins

M A N I T O B A

The Fatality Inquiries Act, C.C.S.M. c. F52

Report by Provincial Judge on Inquest

Respecting the death of: R.D.

BAN ON PUBLICATION:

Pursuant to *sections 110 and 111* of the *Youth Criminal Justice Act,* the names of the deceased, her grandmother, and witness J.S. appear as initials. No person shall publish the name of the deceased young person or any other information related to the young person if it would identify her. No person shall publish the name of witness J.S. or any information related to that young person if it would identify him.

On the evening of September 28, 2013, a Correctional Officer found sixteen-year-old R.D. hanging in her cell at Brandon Correctional Center in Brandon, Manitoba. 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.

R.D. was a ward of Dakota Ojibway Child and Family Services at the time of her death. Apprehended at birth, she spent most of her short life in Manitoba's child welfare system. A long-standing foster placement collapsed when R.D. learned she was not a biological member of the family. An all too familiar story ensued. She endured a sexual assault at the hands of a male connected to her family of origin. Feeling displaced and abandoned, she became a chronic runaway from fourteen other foster placements. She abused alcohol and illicit drugs. She ended up on the streets of Winnipeg exploited by a gang, working in the sex trade. She repeatedly ran from foster placements, including a specialized placement in Winnipeg for sexually exploited youth, to resume work in the sex trade.

In February of 2013, Dakota Ojibway Child and Family Services placed R.D. at *Specialized Foster Homes*, a private foster home business in western Manitoba, licensed at the time by Dakota Ojibway Child and Family Services. Positioned in a rural residence strategically located to make running away difficult, she initially seemed to do well; she remained in the placement, accessed psychiatric medications and therapy, and attended school. R.D.'s progress was short-lived. Ongoing access to drugs and alcohol, contact with negative influences, and repeated instances of absconding in order to return to the sex trade appear to have been factors in R.D.'s downward spiral into crisis.

R.D. returned to custody for the final time on September 20, 2013 for allegedly stealing *Nytol* from a drug store. She had other pending criminal charges. A standard risk assessment, conducted by a correctional officer shortly after her admission, determined she was low risk for suicide. A routine health care assessment during intake identified R.D.'s active prescriptions for psychiatric medications. Medical staff did not offer her medications and psychiatric service providers within the facility did not assess R.D.

No one from Brandon Correctional Center contacted Dakota Ojibway Child and Family Services or *Specialized Foster Homes* to seek out information about R.D. No one from Dakota Ojibway Child and Family Services or *Specialized Foster Homes* contacted Brandon Correctional Center to provide the detailed information they possessed about R.D.'s specific mental health struggles and her particular and pronounced vulnerabilities. *Specialized Foster Homes*, who delivered daily doses of her psychiatric medications in the community, did not deliver or offer to deliver her medications to Brandon Correctional Center.

Specialized Foster Homes requested R.D.'s lawyer consent to her continued detention while they worked to identify a release plan that would keep R.D. in the care of *Specialized Foster Homes*. No one visited R.D. in custody. She turned sixteen on September 21. No one communicated with her about the reason for her continued detention. No one told R.D. people were meeting and discussing a release plan.

R.D. had been in remand custody for eight days in the Juvenile Unit of this primarily adult correctional facility when she tied a bed sheet round her neck, looped it through the grating of a vent in her cell, and stepped off a stationary desk. Shortly before doing so, she may have told two male youths in other cells in the unit that she was going to kill herself. They probably tried to dissuade her but did not attempt to get the attention of correctional officers, which likely required them to yell or bang on their cell doors.

The purpose of an inquest is not to assign blame but to report on the circumstances of the death and to make any recommendations that might prevent future deaths. This report is an examination of circumstances and not an impeachment of individuals. This particular inquest highlights concerns about secure placement options for high-risk vulnerable youth like R.D.; the potential value of information-sharing when entities, agencies, and institutions have overlapping or concurrent responsibility for high-risk youth in care; and the challenges and limitations of assessing and predicting risk of suicide.

This report contains my findings and recommendations after reviewing evidence taken on December 19-23 of 2016; March 9 and 21 of 2017; and after hearing the submissions of counsel on October 5, 2017. This report includes lists of the witnesses called and the Exhibits admitted during the inquest. This Court orders the return of all Exhibits to the Exhibit Officer, Provincial Court of Manitoba to be held in compliance with the Consent Disclosure Order endorsed by and filed in this Court and with release only upon application to this Court with advance notice to any party with a privacy interest.

Thank you to counsel who participated in this inquest. They were diligent, courteous, and well prepared. Superintendent Bonnie Carnegie and DOCFS representative Robin Bjornson were present throughout the entirety of the inquest proceedings and I am grateful for their thoughtful contributions.

I wish to express my sympathy to the family and friends of R.D. She was by all accounts a bright young woman with abundant potential. Her tragic death has already served as impetus for important changes that may prevent similar deaths in future.

Dated at the City of Brandon, in the Province of Manitoba, this 6th day of April 2018.

"original signed by ACJ Hewitt-Michta"

Associate Chief Judge Shauna Hewitt-Michta
Provincial Court Judge

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14. Robert Patterson, Counsel for the City of Brandon
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M A N I T O B A

THE FATALITY INQUIRIES ACT, C.C.S.M. C F52

REPORT BY PROVINCIAL JUDGE ON AN INQUEST

RESPECTING THE DEATH OF R.D.

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I. INQUEST MANDATE AND PARTIES WITH STANDING

1. The Inquest is mandatory by operation of *section 19(3)* of *The Fatality Inquiries Act* because R.D. died unexpectedly while resident in a correctional facility.

2. By letter dated August 8, 2014, The Chief Medical Examiner for the Province of Manitoba (as he then was), Doctor T. Balachandra, MBBS, FRCPC, FCAP, directed that a Provincial Judge conduct an Inquest into the death of R.D. for the following reasons:

   a. to fulfill the requirement for an inquest, as defined in *section 19(3)(a)* of *The Fatality Inquiries Act;*

   b. to determine the circumstances relating to her death, including suicide assessment by the staff at Brandon Correctional Centre;

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

<u>Standing</u>

3. I granted standing to the family of R.D., represented by her grandmother L.M.; Manitoba Corrections, represented by Alan Ladyka and Jim Koch; Dakota Ojibway Child and Family Services, represented by Dean Kropp; Prairie Mountain Regional Health Authority, represented by David Swayze; City of Brandon Fire and Emergency Services, represented by Robert Patterson; Elizabeth Fry Society, represented by Tracy Booth; Specialized Foster Homes, represented by Steven Beernaert; and Doctor Jenkins, represented by Andrew Boumford.

4. Although granted standing, neither the City of Brandon nor the Elizabeth Fry Society actively participated in the inquest. Andrew Boumford attended solely for the purposes of Dr. Jenkins' testimony. Because no issues arose concerning the medical treatment R.D. received while in the care of Prairie Mountain Health Authority, David Swayze's role was limited.

II. REVIEW OF THE EVIDENCE

5. A summary of evidence received during the Inquest follows. The summary is not exhaustive. It is not chronological in terms of the order in which witnesses testified nor is it strictly chronological in terms of the sequence of events leading up to R.D.'s death. Dakota Ojibway Child and Family Services, *Specialized Foster Homes,* and Brandon Correctional Center had overlapping involvement with R.D., which resulted in multiple witnesses testifying about some of the same incidents and circumstances albeit from unique perspectives. A summary of the circumstances related to R.D.'s death and my recommendations follow this review of the evidence.

A. Dakota Ojibway Child and Family Services [DOCFS]

6. Most of the evidence about R.D.'s background and interaction with the child welfare system came through Robin Bjornson. Ms. Bjornson was the case manager for DOCFS between September of 2012 and August of 2013 following which she began her current position as Specialized Resource Manager with DOCFS. From January of 2013 until her death, Ms. Bjornson was R.D.'s caseworker. She took on the role when R.D.'s preceding worker left as Ms. Bjornson had an established rapport with R.D. She testified about her direct involvement with R.D. and shared information from the DOCFS file.

7. R.D. was born on September 21, 1997. DOCFS apprehended R.D. at birth, one week after the apprehension of her older siblings. The agency obtained a three month Temporary Order of Guardianship in December of 1997, which the court extended to September of 1998 when she went to a foster home. She remained in that home for eight years. During this time, her file transferred to Intertribal Child and Family Services [ICFS] and they obtained a Permanent Order of Guardianship in 2004. The placement broke down when R.D. learned the foster family was not her biological family. She began to act out. ICFS then placed R.D. with her grandmother and in 2010, her file transferred back to DOCFS at the grandmother's request.

8. Between 2010 and 2012, the agency moved R.D. between fourteen foster placements. She was acting out. She was strong-willed. She was a habitual run-away. She began abusing alcohol and illicit drugs, which further led her to risky situations including eventual participation

in the sex trade. R.D. told her worker Robin Bjornson that she would take or do any drug available to her including marijuana, methamphetamines, and cocaine. She was primarily dependent on alcohol. She fell victim to domestic violence and was sexually assaulted and exploited. It was difficult for the agency to connect her with counselling and treatment services because she would not stay where placed.

9. In March of 2012, R.D. attempted suicide. Admission to the Child and Adolescent Treatment Center [CATC] followed, where diagnoses of adjustment and mixed disturbance of mood and conduct disorders first arose. In addition to the exploitation in the sex trade, she disclosed sexual abuse at the hands of a person known to her family. The attending psychiatrist believed her to be suffering from Post-Traumatic Stress Disorder. Prescriptions for *Prozac* and *Trazodone* issued.

10. The agency's primary goal following her discharge from CATC was stable placement in order to keep her off the streets. Recognizing a more structured and comprehensive placement would be necessary, DOCFS placed R.D. in the *New Directions* Program in Winnipeg. *New Directions* was a specialized placement associated with TERF and TRAILS programs. It included private schooling and in-house counselling services. It offered a program specific to sexually exploited youth in Winnipeg.

11. R.D. continued to run away while at *New Directions*. She reportedly ran dozens of times and continued to end up on the streets of Winnipeg, sexually exploited and abusing alcohol and drugs. By September of 2012, she was in "complete crisis" according to Ms. Bjornson. When Ms. Bjornson took over as R.D.'s caseworker in January of 2013, she believed R.D.'s situation in Winnipeg was worsening and looked to a placement outside the perimeter.

12. Commencing in January, 2013 Ms. Bjornson testified she would meet with R.D. in person once or twice a month. Before this they spent time together including driving sometimes for hours moving her between placements. Their meetings were mostly informal, travelling in a vehicle or having lunch together. During their meetings, Ms. Bjornson said R.D. was open about her substance abuse but refused to discuss anything related to her sexual abuse or exploitation.

They did discuss matters related to her family and specifically R.D.'s feelings of rejection and abandonment as well as confusion about where she fit or belonged. R.D. was smart. She did well in school when she attended. They also discussed goals. Ms. Bjornson encouraged R.D. to get her driver's license. R.D. initially did not believe she would ever have a license or money to buy herself a car. Ms. Bjornson tried to challenge those beliefs, to encourage this goal as possible for her. R.D. expressed interest in piano lessons and playing hockey as well.

13. R.D. ended up in custody at the Manitoba Youth Center [MYC] at the end of her time with *New Directions.* On February 6, 2013, Ms. Bjornson brought R.D. from MYC to a private specialized foster home owned and operated by Jesse and Cristy Dourado called "*Specialized Foster Homes*" [SFH]. DOCFS intended the move to take R.D. away from the negative influences and exploitation in Winnipeg. Ms. Bjornson testified R.D. seemed pleased with the move because she had friends in Brandon and had spent time there before. R.D. was placed at a home within SFH referred to as "the farm" because of its rural location. "The farm" was strategically located to discourage youth from running away.

14. Ms. Bjornson believed SFH would be able to offer intensive supervision and supports for R.D. She understood R.D. would have access to private schooling as well as psychiatric supports through staff psychiatric nurses and a psychiatrist contracted by SFH to provide service.

15. Ms. Bjornson reported that the placement went well for about four months. R.D. was remaining in placement more consistently than she had been at *New Directions*; attending school; and engaging with Dr. Jenkins and Psychiatric Registered Nurse [RPN] Jill Lennon. While R.D. continued to struggle and did accumulate further criminal charges, it was noteworthy progress for her.

16. Ms. Bjornson was receiving regular communication and updates from Mr. Dourado informally by way of email, text, and telephone as well as formal quarterly reports. Eventually she was receiving separate reports from the clinical psychiatric supports working with R.D. though she testified she did not ever see RPN Jill Lennon's comprehensive treatment notes until after R.D. was deceased. The reports she did receive alerted her to medication changes and

compliance. She was aware Doctor Jenkins prescribed *Seroquel* to replace ongoing marijuana use but said she was surprised after R.D.'s death to see a reference in RPN Lennon's notes about R.D. "huffing" aerosols.

17. The improvements were short-lived. Ms. Bjornson testified R.D.'s behavior began to spiral by June of 2013. She ran away in June and again in July. She was gone a couple of days each time and missing person reports were filed with police by SFH. With respect to her disappearance in July, she was on a home visit in the Portage area when she ran. The family did not report her disappearance. On July 22, DOCFS became aware and advised Jesse Dourado that R.D. had posted pictures to an escort website. Exhibit 18 is an email authored by Jesse Dourado that details to some extent her return at that time to the sex trade and drug use in downtown Winnipeg. Ms. Bjornson testified that she was "shocked and disappointed" that R.D. ended up back in the sex trade. She met with R.D. who would not discuss the exploitation.

18. Ms. Bjornson testified that Jesse Dourado informed her by email of R.D.'s August 30 arrest. He advised her R.D. was intoxicated and gestured suicide while in police custody. He told Ms. Bjornson that R.D. was designated high risk for suicide by Brandon Correctional Center staff.

19. Ms. Bjornson testified that between August 30 and September 19, there was a dramatic escalation in R.D.'s running away. She received notification from Jesse Dourado that on September 5 and 9; R.D. was the victim of physical assaults by another resident in the foster home. Jesse Dourado advised Ms. Bjornson that on September 9, R.D. made comments related to suicide and was taken to hospital for mental health assessment, cleared, and released. Shortly after, Ms. Bjornson saw R.D. when she was at the Dourado corporation offices for another meeting. Ms. Bjornson asked if she wanted to talk. R.D. had a black eye and seemed to have "an attitude" that day. She did not want to talk to Ms. Bjornson.

20. Because of altercations involving girls from the group home, R.D. reportedly no longer wanted to stay at "the farm". Ms. Bjornson testified that she and others involved were getting worried about R.D. They moved her to a different SFH home this time in the City of Brandon.

R.D. ran away on September 14, fleeing in a waiting taxicab. She returned the following day but ran again. She was located back in Winnipeg on September 18. She returned to Brandon and was back in custody at BCC by the early morning hours of September 20.

21. Ms. Bjornson testified that when R.D. ended up in custody again on September 20, she attempted to set up a meeting with Jesse Dourado and the psychiatric clinical supports because she sensed that R.D. was destabilized and spiralling and "we needed to do something fast". Her email read "*I'm thinking we need to meet with all her collaterals and see if we can come up with a better safety plan for her as she has gone AWOL three times in the last week. The sooner the better.*" She sent the email to Jesse Dourado. She agreed that the risks she was concerned about were in relation to sexual exploitation, drugs, and alcohol abuse. She said she was not concerned about suicide. Ms. Bjornson believed the meeting did not actually occur until September 25 because the group was waiting for psychiatrist Doctor Jenkins to be available.

22. At the meeting, there was discussion about placing R.D. in a stand-alone SFH residence, possibly a two-bedroom apartment where she would have a single foster parent working one on one with her.

23. The DOCFS worker did not visit R.D. while she was in custody at BCC. She did not contact BCC to provide any information about R.D.'s mental health challenges or psychiatric medications nor did she provide any information to BCC about R.D.'s history in terms of suicide nor her background or recent spiralling. Ms. Bjornson testified that the agreement between DOCFS and SFH made clear that SFH was responsible for day-to-day care of R.D. She did not provide information to BCC because she had no reason to believe SFH would not be taking care of that as part of their responsibility for the day-to-day care of R.D. She said that DOCFS might provide this type of information for a youth in a non-specialized foster home placement but not for a youth in a specialized foster placement like SFH. She did not agree with suggestions that a release form was required in order for SFH to provide verbal information to BCC. Ms. Bjornson said her expectation was that someone from SFH would have been maintaining contact with R.D. and updating her on plans and discussions. Had SFH requested she sign a waiver to share

information with BCC, she would have done so. She signed many waivers and forms at the request of SFH.

24. When pressed by counsel about lack of information sharing with BCC, Ms. Bjornson finally said "*Well, she's been in there so many times that I would just assume that you guys would have a lot of that stuff on file. She's been in there many times.*"

25. Ms. Bjornson testified to her belief that R.D.'s arrest in the early morning hours of September 20 would be followed by her release the next day. She testified that she heard R.D. misbehaved in custody and assumed this was why she was remanded all the way to the following Thursday. Ms. Bjornson later in her evidence agreed she was included in an email exchange wherein Jesse Dourado contemplated asking that R.D. be detained until Tuesday of the following week in order for the group to meet and identify a plan for R.D.'s release. Ms. Bjornson said one of the reasons people agreed R.D. should be remanded in custody related to comments she had made about "hitting the streets" on her sixteenth birthday. They felt she would be safer in custody because they did not have a secure placement for her.

26. R.D. was allegedly one of many young girls victimized by a Winnipeg man arrested in 2012 and eventually sentenced to 15 years in prison for operating a prostitution ring of underage girls and filming child pornography. R.D. was on the crown's witness list in 2013 when the case was ongoing. Ms. Bjornson testified that R.D. was very aware the case was underway and she believed its approach likely contributed to the deterioration in R.D.'s behaviour.

27. Ms. Bjornson agreed, in hindsight, it might have assisted if BCC received more information about R.D. and her situation in light of all that was going on in her life by September of 2013.

28. It is clear to me that Ms. Bjornson cared for R.D. and continues to feel the impact of her death. R.D.'s case was difficult and Ms. Bjornson made efforts to find suitable placements for her. She expressed sorrow and articulated sympathy for R.D.'s family.

B. Specialized Foster Homes [SFH]

29. "Specialized Foster Home" is a child welfare term referring to a foster home with more intensive supports than a typical foster home. Staff in a specialized foster home generally receive enhanced training. Jesse and Cristy Dourado adopted this child welfare term as the name of their foster care business – *Specialized Foster Homes*.

30. Child welfare agencies license foster homes in an effort to ensure they meet and maintain specified standards. Ms. Bjornson testified that while regular foster parents are arguably under-compensated, specialized foster homes like SFH are very well compensated and especially so when high risk youth like R.D. are placed in their care.

31. In 2013, SFH operated as a collection of eight foster homes with private schooling and access to clinical psychiatric services. A small management team of five, including Jesse Dourado, oversaw the foster care business, which employed a foster parent for each home and numerous respite workers. In 2013, the SFH homes were licensed by DOCFS and DOCFS was guardian to all of the children placed with SFH. As guardian, DOCFS was in charge of case management for each child and made all of the big decisions while SFH handled day-to-day supervision.

32. Many of the children in SFH's care in 2013 had mental health concerns and prescriptions for psychiatric medications. SFH filled prescriptions; stored them at their central business office; and the on call manager delivered daily doses to the various foster homes. The on call manager picked up the empty and unused prescription packages at the end of the day. SFH staff maintained medication records including whether medications were offered and whether they were accepted or declined.

33. SFH employee, Michael Pople, testified at the inquest on behalf of SFH. A former probation officer, Michael Pople had been the "Training and Risk Manager" for SFH since 2011. He testified that in 2013, up to four children were placed in each foster home. Each foster home had a licensed foster parent and a small team of respite workers. The homes were staffed by a

minimum of one foster parent and one respite worker, or two respite workers if the foster parent was on respite leave.

34. Mr. Pople testified that internal communication as well as communication with outside entities, particularly with DOCFS, was generally "in real time" by phone or text message with a follow up email so there was a written record. Foster parents and respite workers were required to complete shift reports then forwarded by email to the management team at the end of every shift as a record of the events of the day. Foster parents were also required to submit weekly reports and monthly statistic reports.

35. When a child in care went missing from a SFH home, Mr. Pople testified that typically staff would try to contact the youth by cell phone, check with other kids in the foster home, and check known locations before filing a missing person report with police.

36. R.D. came to SFH in early February of 2013. Mr. Pople's evidence mirrored that of Ms. Bjornson's in that both said R.D.'s placement at a home in a rural location aimed to curb her pattern of running away. Mr. Pople said R.D. stole a vehicle from SFH early in her time at "the farm" but otherwise settled in and briefly did better than she had been doing in Winnipeg.

37. It was Mr. Pople's job to prepare a Resident Safety Plan for each child placed with SFH. Safety plans, typically completed after a youth was in placement for approximately one month, identified safety concerns and a plan to manage risk factors. Mr. Pople said he considered all available background and collateral information and took into account observations over the first month in placement. Safety Plans were automatically reviewed every six months but could be revisited earlier if circumstances or behaviour suggested an altered risk level.

38. In R.D.'s case, Mr. Pople did not complete a safety plan until April of 2013. Mr. Pople conceded the safety plans he prepared in 2013 were quite simplistic compared to those he began to prepare after R.D.'s death. Some of the information in the 2013 safety plans was boilerplate and appeared in every child's safety plan. Other parts were individual to the particular youth.

39. R.D.'s safety plan identified safety issues and concerns related to R.D. as well as a plan for how the concerns and risks would be managed. The safety plan is Exhibit 28. The plan indicated that R.D. had no psychiatric illness and did not require medication. It identified sexual exploitation as a factor as well as other traumas but suggested she was coping appropriately. The plan noted that she was vulnerable to the influence of older males and that she was vulnerable to returning to the sex trade. It noted a prior suicide attempt with pills. It identified an active association with a long-time drug dealer and pedophile in Brandon. It identified that she was accessing and using marijuana regularly while at SFH. The risk management plan provided for regular interaction with the clinical services team in terms of mental health assessments and therapy; continued placement at a rural property and limitations on free time; noting R.D.'s clothing whenever she leaves the home and keeping a current photo on file because of the risk of running away; a ban on intoxicants; and regular property searches for items that could be used to self-harm. Mr. Pople admitted that at the time he did not understand or appropriately distinguish between self-harm and suicide, which are quite distinct.

40. Mr. Pople conceded he was in the early stages of drafting a new safety plan on September 10 but the revised plan was in its very early stages and he admitted was probably started in preparation for the automatic six-month review. He did not re-assess the safety plan when mental health issues were identified and psychiatric medication was prescribed. He did not re-assess her safety plan when R.D. began to run away more frequently nor when she made suicidal comments in August and September.

41. Exhibit 24 is a timeline prepared by SFH of a number of incidents during R.D.'s time at SFH.

42. On March 15, R.D. and another SFH resident stole a vehicle from the farm but got it stuck before they got very far.

43. On March 20, R.D.'s best friend committed suicide. SFH staff reported to DOCFS that R.D. was sad but not hopeless.

44. On March 31, R.D. ran away but was intercepted by RCMP and returned to “the farm” within a short time.

45. On April 1, R.D. again ran from “the farm” but was caught and brought back to “the farm” at 5:10AM.

46. On April 25, R.D. ran from her supervisor while on free time. When she was located, she was intoxicated.

47. On June 25 or 26, R.D. and another youth did not return from free time. They were located in Winnipeg on June 27 after being gone forty-two hours. SFH staff learned the youth had been drinking, consuming drugs, and engaged in the sex trade while absent.

48. On July 19, R.D. was transported to the Portage area for a family visit. She left shortly after arriving and family members did not report her absence. On July 22, DOCFS alerted Jesse Dourado to R.D. posting pictures on an escort site and R.D. advised SFH staff she was no longer in the Portage area. A missing person report was filed by SFH. An off duty SFH staff member happened upon R.D. on a downtown street corner clearly engaged in the sex trade. The staff member tried to persuade R.D. to come with her but R.D. refused. The staff member returned to her hotel room; called Jesse Dourado; and texted R.D. the hotel and room number telling her to meet her in the morning for a ride back to Brandon. R.D. stayed out on the streets that night engaged in the sex trade. R.D. met the SFH employee in the morning and they drove back to Brandon. The SFH employee took her to her sister’s home on the way back where R.D. sold phones she had been using to “work” in Winnipeg “for two grams”. R.D. was tearful during the drive and disclosed she smoked “meth and crack” all weekend; that she had gone to the city to party with her friends and that she worked in the sex trade in order to pay for the partying. She said she would spend a lot of money when she was in Winnipeg and she did not know where she spent it.

49. Following this concerning incident, Jesse Dourado authored an email suggesting a meeting “to brain storm ideas” for R.D., suggesting the group not focus on the recent “AWOLS”

that resulted in R.D.'s return to the sex trade but rather the months of success. The email presumed or perhaps advocated the continuation of R.D.'s placement with SFH despite arguably recent lapses in supervision and / or control.

50. On August 5, a respite worker with SFH learned through R.D.'s grandmother that R.D. had left a family visit without permission and attended to Winnipeg.

51. On August 30, R.D. was arrested for stealing alcohol from a store in Souris on two separate occasions while away from the foster home for free time. R.D. was intoxicated when arrested and wrapped a telephone cord around her neck, gesturing suicide, while in the custody of the RCMP. When admitted to Brandon Correctional Center, she was designated a high risk for suicide and placed in a suicide gown. When released from custody on August 31, SFH staff took her to the Child and Adolescent Treatment Center where she was assessed and released. She denied being suicidal, saying she had gestured suicide to stop the RCMP officer from speaking to her. During the assessment, a SFH staff member made note that R.D. said, *"I think of suicide one to two times a month but those are thoughts not actions. If I wanted to kill myself, I would be dead already."*

52. On September 5, R.D. was involved in a physical altercation with another female from the foster home while on a SFH recreational outing at a bowling alley. The other female seems to have been the aggressor and R.D. the victim. While detained by police, R.D. four times expressed suicidal ideation and was transported to the hospital for assessment. She was cleared by Doctor Jenkins and released. She refused to return to "the farm" and gestured as though to jump from the moving vehicle operated by SFH staff. Once stopped, she fled from the vehicle on foot but was pursued and persuaded to return to "the farm" with SFH staff. The other female from the altercation was placed at a different foster home for the night and R.D. stayed at "the farm".

53. R.D. was away for a family visit from September 6 -9 and when she returned to "the farm" on September 9 she found her clothing had been cut by other residents of the foster home who had also read her diary and posted to social media a video of the September 5 assault on

R.D. When confronted by R.D., the other female attacked and assaulted R.D. causing a swollen lip. SFH staff noted R.D. to be “quietly upset”.

54. On September 10, R.D. was moved from “the farm” to another SFH foster home in the city of Brandon.

55. On September 14, R.D. fled into a waiting taxi and went to Winnipeg. She returned willingly to Brandon with a SFH staff member in the early morning hours of September 16.

56. On September 17, R.D. again ran from SFH and returned to Winnipeg. She was again gone overnight.

57. On September 19, R.D. and another female were caught on video shoplifting *Nytol*, a sleep aid medication containing *diphenhydramine,* from a drug store in Brandon. Multiple packages of the medication were discovered during a search of the foster home. Brandon Police Service arrested R.D. in the early morning hours of September 20 when she returned to the foster home.

58. On September 20, R.D. appeared in court and the charges were remanded to September 26.

59. On September 21, R.D. turned sixteen in custody.

60. On September 26, at the request of Jesse Dourado, defence counsel for R.D. sought a remand of her charges to October 1.

61. Mr. Pople testified that in 2013 when a child in SFH’s care went into custody, SFH reported this immediately to DOCFS and attended court for remand dates. Staff would not be able to speak to the youth at court but they could watch the proceedings. He said SFH management and staff did not visit their youth while in custody unless the incarceration was longer-term. Because SFH is not the guardian, Mr. Pople said a staff member would have to go

through an authorization process if they wanted to visit. Mr. Pople, in hindsight, was not concerned with the fact no one from SFH visited R.D. while she was in custody. He said youth in custody got one phone call per week and could use it to call SFH if they wished. Mr. Pople testified that R.D. called Jesse Dourado on September 20 or 21 and that she called another manager on September 27. The manager she spoke to on September 27 later told Mr. Pople that the discussion did not raise any red flags about R.D.'s well being or risk level.

62. Mr. Pople further testified he was not concerned with SFH's lack of contact with R.D. because they expected R.D. would be out on September 26. This testimony conflicted with evidence of an email exchange between Jesse Dourado and R.D.'s Legal Aid lawyer. Jesse Dourado asked R.D.'s lawyer to remand R.D. over to a date in early October.

63. Mr. Pople conceded SFH did not ever contact BCC to share any information. He said SFH could not do so without a release from the guardian. He agreed in cross-examination that SFH did not seek a release from the guardian in order to share information with BCC about R.D. He also conceded that SFH sometimes shared confidential information with only verbal permission from the guardian. Mr. Pople asserted it was the guardian's job to visit R.D. in jail and to pass along any information the agency felt the jail should have. Mr. Pople acknowledged that *section 76* of the *Child and Family Services Act* allows for release of otherwise confidential information about a child in care if necessary for the safety and protection of the child. Mr. Pople said that SFH did not believe R.D. was at risk. He said she was at lower risk for suicide than others in SFH care at the time because she had protective factors and future-orientation. Even if he had felt free to share information, he did not believe R.D. was at acute risk or that there was information the jail needed to have. Mr. Pople suggested if the jail had contacted SFH with concerns and if SFH had the proper release, they would have gladly shared information. His evidence was perhaps contradictory in the sense that he asserted it was the responsibility of DOCFS to share confidential information with a correctional facility but admitted SFH reviewed its practices after R.D.'s death and made changes to provide this type of information going forward.

64. Mr. Pople agreed that SFH did not attempt or offer to deliver R.D.'s psychiatric medications to the correctional center while R.D. was in custody. There is evidence suggesting that before R.D. ended up in custody SFH may have occasionally delivered medication to BCC for youth in custody but this was not a regular occurrence and Mr. Pople himself does not recall ever doing so until December 2013 after R.D.'s suicide. He said it would not have occurred to him that delivering medication to the jail would be possible.

65. Referring to R.D.'s medication records, leading up to her suicide, Mr. Pople confirmed R.D. sometimes accepted and other times refused medications the last week in August and the same was true of the first two weeks in September except the days when she absconded. SFH either misplaced or has no record for R.D.'s medication the week of September 9. It is unknown whether she was offered medications, and if so, whether she accepted or refused. Mr. Pople's guess was that a record might have been overlooked or misplaced because of R.D.'s move from "the farm" to Brandon that week.

66. Mr. Pople acknowledged that while R.D. was living in SFH, management was aware of her association with a local adult male pedophile whom she considered her boyfriend. Management was aware R.D. was regularly accessing marijuana while in the SFH placement.

67. In response to concerns about the number of times R.D. was able to abscond from SFH, Mr. Pople defended the business saying they were not operating a lockdown facility and they were not prepared to use physical force on a child with trauma in their background to prevent them from leaving. He suggested that if you confine a youth they spend all of their time thinking about how to escape. He expressed the belief that it was important to make youth want to stay.

68. Mr. Pople did not share the view of other witnesses, including Doctor Jenkins, who said that R.D. was spiralling or in crisis by September of 2013. Mr. Pople said her repeated returns to the sex trade while in SFH care were part of the process of leaving the sex trade. He testified he has heard that individuals go back to the sex trade on average seven times before finally leaving. Contradicting the evidence of Ms. Bjornson, he said that R.D. did not know she was to be a witness at the high profile sexual exploitation trial in Winnipeg.

69. Following R.D.'s suicide, SFH reviewed its policies and practices and made some noteworthy changes. During preplacement phase, it ensured a release of information was signed by the guardian to safeguard its ability to share what might otherwise be considered confidential information with Corrections if they felt they were in possession of information the jail should have. SFH designated a specific person within the corporation to be responsible for liaising with BCC. SFH instituted a new practice of providing medications to the jail where appropriate or helpful. In most cases, BCC is able to fill prescriptions but SFH adopted a practice of sharing medication when necessary in sufficient amount to last until the youth's next court date. Mr. Pople testified that if a child known to have current suicidal thoughts or intentions now goes into custody, the business contacts BCC to provide that information.

70. The entity that used to be SFH now operates as *Brightscape Endeavours*. The corporation no longer operates foster homes. While they continued to be licensed and utilized by DOCFS for some time after R.D.'s death, the relationship was eventually terminated for reasons not specified during the inquest. *Brightscape Endeavours* is no longer licensed to operate foster homes. It provides Residential Childcare Facilities, which are similar to foster homes but without being subject to foster home regulations. Staffing structures are similar to that of SFH but homes now have three children rather than four.

<u>Clinical Psychiatric Services</u>

71. Doctor Keith Jenkins is a Child and Adolescent Psychiatrist employed by Prairie Mountain Health Authority. He worked as a psychiatrist consultant for SFH in 2013. He worked on contract paid directly by SFH for an average of six to eight hours per week or as otherwise required. Doctor Jenkins provided some supervision in terms of the RPN's at SFH as well. He interacted on a number of occasions with R.D. in two settings - during her admissions to the Child and Adolescent Treatment Center [CATC] and as a consultant to SFH. He worked closely with R.D.'s social worker, Robin Bjornson, and with staff at SFH. Two Psychiatric Registered Nurses were in the employ of SFH in 2013, including RPN Jill Lennon. The RPN's sat in with the consulting psychiatrist during sessions and facilitated counselling or therapy as deemed appropriate depending on the youth's assessment and circumstances.

72. In March of 2012 (prior to R.D.'s placement with SFH), R.D. attempted suicide prompting her admission to CATC. Doctor Jenkins felt she had a major depressive disorder and he suspected she might be suffering from Post Traumatic Stress Disorder [PTSD], an anxiety disorder. She was experiencing relational difficulties in her foster placement.

73. When R.D. moved to SFH in February of 2013, she underwent an initial mental health assessment with Doctor Varley who was the contract psychiatrist with SFH Clinical Services at the time. RPN Jill Lennon sat in on the assessment and became R.D.'s primary contact and therapist in SFH clinical services. The initial assessment included a suicide risk evaluation. Each session that followed would have gauged suicide risk as well, recognizing that most of the youth in care of SFH were at elevated risk for suicide.

74. After the initial assessment, R.D. generally met with RPN Lennon one time per week for counselling except during the month of March when RPN Lennon was on medical leave. R.D. was welcome to see RPN Lennon more often if she was struggling. Sessions were not compulsory and if R.D. did not show up another was scheduled. RPN Lennon reviewed R.D.'s social history as provided by DOCFS and was aware of R.D.'s history of trauma, sexual abuse, and sexual exploitation. She was aware going into the counselling relationship that R.D. had been working for a gang in the sex trade in Winnipeg prior to coming into SFH care.

75. RPN Lennon's first impressions of R.D. were that she was engaged, intelligent, and forthcoming. RPN Lennon's initial focus with R.D. was on grief and loss because R.D. was feeling tremendous grief over the foster family she resided with from ages two through ten. She considered the woman who cared for her those years to be her mother. She had a desire to reconnect but was hesitant and fearful of rejection arising from her subsequent participation in the sex trade. R.D. identified supports including her two sisters, Jesse Dourado and a female manager from SFH. She had educational goals and career aspirations that might have included studying to become a doctor. R.D. valued her education.

76. RPN Lennon testified she was aware throughout the time she worked with R.D. that she was actively and regularly abusing drugs and alcohol. She attempted to address this through motivational interviewing. She observed R.D. to be generally good at reaching out for help and verbalizing feelings though there were times when she attended sessions but did not engage well. She had one on one meetings with R.D. on February 14, 21, 27; April 4, 10; May 7; 9, 15; 29; June 6, 25; July 3, 25, 31; August 7, 15, 19; and September 3, 11, and 17.

77. On May 7, R.D. met with RPN Lennon after self-disclosing wrapping a purse strap around her neck. She was distressed. She told RPN Lennon she did not do this because she wanted to die but that it was a wake-up call for her that things were not going well. Because R.D. had gestured suicide and was in distress, RPN Lennon arranged for her to meet with Doctor Varley that same day. R.D. had not been taking any psychiatric medications up to that point and RPN Lennon wanted Doctor Varley and R.D. to discuss whether that might be helpful. Management at SFH would have been advised of the incident with the purse strap, as would DOCFS according to RPN Lennon. RPN Lennon again met with R.D. two days later to check-in and to assess whether there was any elevated risk of suicide. RPN Lennon concluded that there was not and the focus of the discussion was the issue of whether to re-establish a connection to the original foster family. R.D. was still feeling anxious and depressed and agreed to try some medication. She had been resistant up to that point, believing that taking psychiatric medicine showed weakness. Doctor Varley prescribed *Ativan (Lorazepam)* shortly thereafter.

78. RPN Lennon testified that by the end of May, R.D. was noticeably increasing her participation in risky behaviours. She believed the change was provoked by R.D. becoming reacquainted with an individual in Brandon with strong ties to the sex trade in Winnipeg.

79. On July 24, 2013, Doctor Jenkins met with R.D. in his consultant capacity with SFH. RPN Jill Lennon was R.D.'s primary therapeutic contact and Doctor Jenkins understood R.D. to be engaging well with her. R.D. was avoidant and guarded with Doctor Jenkins. He attempted to discuss her sexual exploitation but she would not engage. He was aware of substance abuse concerns and may have raised it with her but it was not the focus of their time together. Sexual exploitation was the primary concern for everyone working with R.D, including Doctor Jenkins.

He opined R.D. was exhibiting a counter-phobic response to early sexual trauma. She was putting herself in risky situations through the sex trade because she wanted to gain mastery over the trauma and to feel stronger.

80. Doctor Jenkins was aware through RPN Lennon that at this time, while resident at SFH, R.D. was accessing and using marijuana daily. He took her off the *Ativan (Lorazepam)* prescribed by his predecessor for philosophical reasons. He prescribed *Fluoxetine (Prozac)* in its place. Doctor Jenkins assessed her for risk of suicide and testified she was not endorsing suicidal ideation, meaning she was not speaking about wanting or planning to die.

81. On August 15, R.D. disclosed to RPN Lennon that she had been struggling the last couple of weeks and had been feeling the need to smoke marijuana every day to avoid being overwhelmed by her stress and anxiety. She also disclosed "huffing" hairspray. She was agreeable to meeting with Doctor Jenkins soon to discuss increasing medications in place of marijuana and "huffing".

82. August 19 was R.D.'s next appointment with Doctor Jenkins. It was a scheduled appointment. Doctor Jenkins noted her to be again presenting with symptoms of PTSD. R.D. did not feel the *Prozac* was helping and Doctor Jenkins agreed the prescribed dose was not doing enough. Doctor Jenkins was aware that R.D. was continuing to access and use marijuana regularly but had escalated to "huffing" with aerosol when she was unable to access marijuana, which was a serious concern. He increased her *Prozac* prescription and added a prescription for *Seroquel* on an as needed basis. *Seroquel* is an atypical antipsychotic medication, which in low doses as prescribed to R.D., can be calming and sedating. Doctor Jenkins hoped R.D. would use the *Seroquel* rather than resorting to marijuana and "huffing". Doctor Jenkins testified that he assessed R.D. with respect to suicidal ideation but did not find her to be at elevated risk.

83. On August 30, R.D. ended up in custody and Corrections designated her high risk for suicide because she wrapped a telephone cord around her neck while in RCMP custody. When RPN Lennon met with R.D. on September 3, they discussed the incident. R.D. complained about her dealings with police. She told RPN Lennon she had to wear the suicide gown while at BCC.

She denied being suicidal during her interaction with RCMP. RPN Lennon testified R.D. was laughing and joking about having done it just to get the police officer to stop talking to her. RPN Lennon believed R.D. was sincere and that she had not in fact been suicidal during that incident. She suggested this was consistent with R.D.; that she was stubborn and if she did not want to do something, she would not do it and often found ways to up the ante.

84. On September 5, Doctor Jenkins was working at the hospital in Brandon when R.D. was brought to the emergency department because of suicidal ideation after being assaulted by another female from the foster home. Four times in the police car, she said she wanted to kill herself. She was assessed and released.

85. September 17 was RPN Lennon's last interaction with R.D. She testified that R.D. was grumpy. She was unhappy because of her 9:00PM curfew at the foster home. She showed up to the meeting with RPN Lennon quite high on marijuana. It was unusual for R.D. to show up to a session in that condition. She denied feeling suicidal. RPN Lennon challenged R.D. about the problems with other girls in the foster home. R.D. denied that the incidents bothered her and RPN Lennon suggested that R.D. might be reluctant to admit it bothered her because doing so could feel like the girls were winning; that R.D. might feel powerless or weak. RPN Lennon did not believe R.D.'s risk of suicide was elevated and did not feel the need to alert SFH to any concerns.

86. RPN Lennon concurred with Michael Pople's evidence about R.D. having protective factors in terms of suicide, most notably her own resilience; her future orientation in terms of education and other goals; and a sense of loyalty and responsibility to her two sisters. She agreed with the suggestion that the fact R.D. seemed to calm after being in custody for a few days and that she was asking for schoolwork was indicative of her protective factors functioning.

87. Twice in her evidence, RPN Lennon referred to R.D. as being a "very high risk for suicide" and she seemed to be suggesting this was the case generally, not arising from or elevated by any one episode. The second time she said this she went on to say that R.D. was at even greater risk of ending up missing and murdered. She seemingly contradicted herself near

the end of her evidence when she said that she was absolutely shocked by R.D.'s suicide and that had BCC staff called to ask her about R.D. she would not have said she was at very high risk for suicide. The contradiction was never pursued or resolved. I took her evidence overall to be that suicide was always a risk for R.D. but that it was not usually the primary safety concern.

88. RPN Lennon, like Mr. Pople, did not agree with a description of R.D. as spiralling or in crisis in September. However, she did agree that R.D.'s behavior had been escalating; she was engaging in more risky behaviours; and it reached a point by September where those working with her wanted to stop the behaviour.

89. RPN Lennon, like Michael Pople, did not believe that R.D. was aware that she might have to testify as a witness at the upcoming high profile sexual exploitation trial in Winnipeg. This contradicted the evidence of DOCFS worker Robin Bjornson. RPN Lennon authored a letter just before R.D.'s death advocating R.D. be excused from testifying at the trial.

90. Both of the medications prescribed for R.D. were "very forgiving" according to Doctor Jenkins. Neither interacts dangerously with marijuana or alcohol. *Prozac* typically takes four to six weeks to become fully therapeutic and it self-tapers such that it can remain in the system for ten days or longer and does not cause significant discontinuation symptoms. *Seroquel,* prescribed at this low dose, can be stopped "cold turkey" without any difficulty other than it is not in the system to ease anxiety or agitation. He would have preferred that she continued to receive her medication while in custody at BCC but he would not speculate that failure to take the medication caused her to become suicidal.

91. Doctor Jenkins agreed that depression and PTSD both increase the risk of suicide. History of suicidal ideation or attempts increase risk of suicide. Family history of suicide increases risk of suicide. He agreed that applying stressors to a person could increase their risk of suicide. A healthy person can likely fend off stress better than an unhealthy person can. Doctor Jenkins did not agree that placing an individual like R.D. in custody in a relatively isolated situation would necessarily be undesirable or increase her risk for suicide. He suggested much

would depend on the individual and their particular circumstances. He said seclusion is sometimes used to calm and safeguard extremely agitated individuals.

92. Doctor Jenkins did not agree that R.D.'s risk of suicide would necessarily have been decreased were she provided with her prescribed medications while in custody. He testified the purpose of the medications was to ease the painful symptoms and one of the medications had the potential to increase risk of suicide. The medication was intended to treat her depression and PTSD. He monitored her for suicidal ideation because of her history and because the medication could itself increase her risk for suicide. He said assessing suicide risk is more complicated.

93. Doctor Jenkins did not agree with the suggestion that assessing suicide risk based solely on self-reporting without information that is more comprehensive was inferior. He agreed it was a limited approach but said it was also likely the only way to assess suicide risk in the moment. He did agree that more information is always better than less when assessing risk.

94. Doctor Jenkins' approach when assessing suicide risk is to ask explicitly whether the individual is or has been thinking about suicide. He acknowledged the approach is limited because it relies on honest reporting but said it is one of the only tools for gauging someone's risk of suicide. He testified that measuring a person's suicide risk is almost impossible. He agreed that evidence of forward thinking is a reassuring sign in terms of suicide risk. He himself does not level suicide risk because the evidence does not support a belief that we are able to do so with accuracy. Medicine, he testified, does not yet have a reliable test – all tests currently in existence miss a significant portion of people who are suicidal. A person who shows no risk factors may commit suicide and a person who shows many risk factors may never attempt suicide. He described suicide as very hard to predict and very hard to prevent. In his opinion, it is better to devote the majority of his time with a patient on therapy. He also voiced a concern that when someone is assigned a risk level, people may become complacent, less vigilant about continuing to assess risk, which can fluctuate in accordance with circumstances and a variety of factors.

95. Doctor Jenkins agreed that isolation can be a stressor and that R.D. did not handle stress well. If she were very stressed, he opined one would not be dealing with a high functioning R.D but rather “one who’s barely hanging in there”.

96. Doctor Jenkins testified that from a therapeutic standpoint, if a child in care goes into custody, care and control of the child shifts to Corrections. Brandon Correctional Center has its own medical treatment team including a psychiatrist. He said there are good reasons for this including the fact that medications, which make sense in the community, may not be acceptable in a jail setting.

97. Doctor Jenkins agreed that ideally information sharing should occur between Corrections, child welfare agencies, and foster homes. He testified that a release of information needs to be signed for him to be able to send information to the jail. In his view, when a child comes into care, it is important for the new caregiver to seek out collateral information. He agreed it was also important for people in possession of such collateral information to share it with a new caregiver though he believed patient confidentiality restrictions would require a signed release.

98. Doctor Jenkins and RPN Lennon both participated in the September 25 meeting concerning a release plan for R.D. Doctor Jenkins said everyone was worried about R.D. because SFH was having trouble containing her. She was spiralling and in crisis. She was absconding and being exploited and they knew that she would soon be required to testify at the high profile trial in Winnipeg, which he believed would re-traumatize her. Her progress in therapy had been slow because R.D. was avoidant and she was now disengaged therapeutically. She no longer wanted to be at SFH. She wanted the lifestyle that went with being in Winnipeg and sexually exploited. Doctor Jenkins said that was a crisis and everyone was worried. The focus of discussion was not on compliance with prescribed medication or suicide risk. He testified the focus was on coming up with a plan for R.D.’s safe release from jail. It was his view that she needed a more restrictive environment with safeguards that prevented her from fleeing. The risk of suicide was always present in the background with R.D. but the greater concern was her running and putting herself in a dangerous situation on the streets of Winnipeg. He was much more concerned with someone else hurting R.D. than he was about R.D. hurting herself. RPN Lennon said the primary concern

was that R.D. was going to end up missing and murdered. She said the consensus of the group was to pursue a one-on-one placement likely in an apartment. Because R.D. had been living such an adult life from ages ten to fifteen, it was not easy to engage her with age appropriate peers or activities.

99. Corrections, including probation services, were not invited to participate in the meeting and RPN Lennon opined the exclusion related to the fact they were focussed on planning for R.D.'s release from custody.

100. On September 26, RPN Lennon wrote a letter advocating for R.D.'s release from custody on condition of a very strict curfew with no free time and one on one supervision. The letter indicated the concern was her return to Winnipeg to the sex trade. Suicide was not a pressing concern at the time.

101. Doctor Jenkins agreed that given the number of days R.D. was in BCC, it would have been helpful if someone had visited her so she felt supported. It was reasonable to conclude, he said, that failure to visit would likely have resulted in R.D. feeling abandoned and unaware whether anyone was doing anything on her behalf.

C. Community Corrections - Probation Services

102. When R.D. relocated from Winnipeg to western Manitoba, she was subject to two probation orders and supervision of those probation orders transferred to Brandon. Probation Officer Erin McLennan met briefly with R.D. in February of 2013 to review the orders and expectations. A risk assessment in Winnipeg determined R.D. was high-risk to become involved in criminal activity. Accordingly, she was subject to an enhanced level of supervision, which included reporting to her probation officer once or twice monthly and participating in the Intensive Support and Supervision Program [ISSP]. Daily contact with an ISSP worker was required. R.D. was to contact her ISSP worker daily between 8:00PM and 10:00PM to check-in. She was to follow a 10:00PM curfew and the ISSP worker performed regular curfew checks by phone or in person. R.D. was re-involved in criminal activity and another probation order resulted in May of 2013.

103. R.D. reported as directed to Ms. McLennan. Appointments ranged from five to thirty minutes duration depending on R.D.'s engagement. R.D. usually cooperated but could be quiet and sometimes presented with an attitude. She did not like being on ISSP and was at times resistant to calling the ISSP worker to check-in. Lapses are common with young people on ISSP. R.D.'s compliance with ISSP deteriorated with the passage of time and some of the problems seemed to coincide with family visits authorized by her DOCFS worker.

104. Between February and March, R.D. failed to call-in to her ISSP worker nine times but she complied with her curfew. She reportedly participated in a vehicle theft in mid-March. Between March and April, she missed thirteen check-ins with her ISSP worker but seemed to be compliant with her curfew. Between April and May, she missed nineteen check-ins and there were issues with curfew compliance. On May 20, she reportedly returned to the foster home highly intoxicated. From May to June, she missed twenty-four ISSP check-ins and breached her curfew multiple times. On June 24, RCMP returned her to SFH at 1:30AM. On June 26, the ISSP worker filed an incident report owing to non-compliance. Between July and August. R.D. failed to call-in sixteen times and there were three occasions where she could not be located.

105. On July 23, Ms. McLennan emailed Jesse Dourado of SFH to identify concerns about family visits because for a second or third time R.D. had gone to the Portage area for a family visit and ended up missing in Winnipeg. Ms. McLennan asked Mr. Dourado to speak with R.D.'s social worker because R.D. was subject to a condition requiring that she reside as directed by probation services and Ms. McLennan was not included in the decision-making about R.D. being allowed to stay overnight with family in the Portage area. Ms. McLennan discussed this concern with R.D. once she returned from Winnipeg and R.D. agreed it was not a good idea for her to visit family overnight anymore.

106. After R.D.'s arrest on August 30, Ms. McLennan received information by way of an email from Jesse Dourado of SFH about R.D. making suicidal comments while intoxicated during her detention. The email provided information about R.D.'s personal circumstances including involvement with a psychiatrist. Ms. McLennan agreed that SFH staff were the people

with the best information about R.D. because of their daily dealings with her. There seemed to be no impediment to Mr. Dourado sharing this helpful information with the probation officer.

107. Ms. McLennan testified she had conversations with R.D. about the future. R.D. spoke of plans including the possibility of modelling and finishing school as well as an intention to leave behind some negative lifestyle choices. At no time did Ms. McLennan see indications that led her to believe R.D. was at risk for suicide. She was shocked by R.D.'s suicide.

D. Brandon Correctional Centre [BCC]

i. Admission to BCC

107.1 BCC has a population of 300 to 320 inmates on any given day. Roughly, 2000-3000 people pass through the institution annually. Anywhere from approximately zero to seven youth might enter the facility on any given night. The average stay for youth on remand status at BCC in 2013/2014 according to the Divisional Review data was nine days, however, Superintendent Bonnie Carnegie testified the number in the Divisional Review was incorrect and that the average duration was just under five days (4.8) in 2013/2014.

107.2 R.D. entered BCC on September 20, 2013.

ii. Suicide Risk Assessment

107.3 For each admission to BCC, a Correctional Officer [CO] completes an Institutional Security Assessment as well as a Suicide Risk Assessment. The two assessments are summary in nature; generally completed at the same time; and typically require about fifteen to twenty minutes to complete. A CO in the Juvenile Unit completes these assessments for any juvenile admission following which a supervisory CO reviews the assessments.

107.4 The assessment relies on the inmate self-reporting in response to six questions as well as a review of information contained in the Manitoba Corrections database – Corrections Offender Management System [COMS]. The officer inputs "yes" and "no"

answers to the electronic assessment form as well as anecdotal comments based on information provided by the inmate and / or gleaned from COMS entries. The assessor does not seek out information from collaterals for purposes of this assessment. The computer program tallies the number of "yes" and "no" responses and generates a suicide risk level of **NE** (no suicide risk); **SUL** (low risk); **SUM** (medium risk); or **SUH** (high risk). There is an override option should the assessing or reviewing officer conclude or be persuaded that the computer-generated risk level fails to accurately reflect the individual's actual suicide risk level. Anecdotal information entered on the form serves to make the assessment more fulsome and should assist the officer completing the assessment and any officer reviewing the assessment in determining the accuracy of the automated risk level. An inmate's risk level is subject to review and adjustment at any time should an inmate's circumstances change or concerns arise. Risk level is automatically re-assessed following sentencing.

107.5 Inmates assessed at low risk of suicide are subject to checks every thirty minutes. A medium risk designation results in placement with a cellmate or checks every fifteen minutes. Inmates determined to be at high risk for suicide wear a suicide gown and are placed in a cell with few items and continuous monitoring.

107.6 Superintendent Carnegie explained that essentially a person is low risk if there is a history related to suicide. If there are current thoughts related to suicide, the risk level rises to medium. If an inmate has a plan for suicide, a high-risk designation attaches.

107.7 If a CO is unable to complete a risk assessment due to the inmate being uncooperative, the individual is deemed at medium risk until the assessment can be completed.

107.8 CO Dixon was responsible for R.D.'s suicide risk assessment, which he completed on September 20. He testified that he first reviewed R.D.'s COMS history including risk assessments from her eleven previous admissions and then met personally

with R.D. to complete the assessment. The assessment contains two sections, primary and secondary indicators.

107.9 In terms of "secondary indicators", the assessment poses two questions. In response to whether the young person reports or shows significant feelings of loss / stress, CO Dixon inputted "no" and anecdotally commented, "states no". The second question asks whether the young person reports or shows symptoms of hopelessness / helplessness or "invitations for help". The officer inputted "no" and again anecdotally commented that R.D. "states no".

107.10 With respect to "primary indicators", the assessment asks three questions. On the issue of prior suicide history, it questions whether the young person reports or whether there is verbal or written information indicating the young person has a prior history of suicide in their own life or significant others. CO Dixon inputted "yes". Duplicated word for word are the anecdotal comments from the same section in her last assessment (January 2013):

> "*Youth admits to prior suicidal history. States her most recent attempt was approx. 1 year ago, where she attempted to hang herself with a belt, but someone came home and interrupted her. Youth no longer sees suicide as an option*."

107.11 The officer acknowledged this was information duplicated from the previous assessment but that he confirmed with R.D. that the information remained accurate. Superintendent Carnegie further explained that COMS pre-populates the suicide risk assessment form with anecdotal comments from the most recent previous risk assessment, if there is one. While this apparent "cut and paste" process came under some fire from counsel during the inquest, it is a feature of the computer program that arguably adds value. The information helps the assessor determine whether the inmate is contradicting or

omitting information; it is a check on the accuracy of information provided by the inmate during the current suicide risk assessment.

107.12 CO Dixon admitted that he missed documenting COMS information about a suicide by her uncle; suicide attempts by her mother; and history with other family members. He conceded that the entry was no longer accurate in the sense that the suicide attempt referenced would now have been twenty months in the past. He further conceded that he did not include information about documentation of a more recent incident of suicidal ideation. He failed to note that on August 30, 2013 R.D. came into custody intoxicated and having made suicidal comments resulting in a SUH designation. CO Dixon was not sure why he did not include the information. He opined he might have omitted it because it was just further support for the "yes" he had already inputted or perhaps because the suicidal ideation occurred while R.D. was intoxicated. He did not feel it was information that would have caused him to doubt the SUL result because it was not current suicidal ideation or planning.

107.13 The assessment next questions whether the young person has current suicidal thoughts. CO Dixon inputted "no" and added the comment "states does not have any current suicidal thoughts". In response to whether the young person has a current plan to commit suicide, the officer entered "no" and added "states does not have a current plan for suicide". Finally, with respect to whether the young person reports feelings of being alone or lacking resources, CO Dixon entered "no" and commented "youth states she can speak to her sisters for support. Aware of resources available at BCC".

107.14 The computer determined R.D.'s suicide risk level to be low. CO Dixon believed this to be an accurate rating based on R.D. not admitting or evidencing any signs of current suicidal ideation or planning. He exercised his judgement and did not approach a supervisor about overriding the automated risk level.

107.15 Senior Unit Manager CO English reviewed the assessment and approved the result. He saw no reason to override the assigned risk level. He testified he would not favor

overriding a SUL designation without evidence of current ideation or intention. To override because of recent suicidal ideation or intention he opined would have to involve something within days not weeks of admission. He conceded that in six years as a supervisor he has never once exercised his discretion to override a computer generated risk level though he was aware of situations where overrides had occurred. CO Husak, an officer with considerable experience doing suicide risk assessments, was asked about overrides and confirmed that she occasionally overrides where she knows the inmate is under-reporting or not being forthright.

107.16 CO English testified that supervisory review of suicide risk assessments is not usually comprehensive, requiring as little as five minutes. It is a relatively quick check to ensure there is no disconnect with previous assessments or COMS entries. For example, a finding of no risk for suicide is uncommon and may trigger a check of previous assessments for mention of suicidal ideation or intention. The supervising CO does review all of the intake assessments because decisions other than risk level need to be made including placement in the institution.

107.17 In response to counsel's concerns about the assessment for suicide risk not including questions about mental health concerns or psychiatric medications, CO English pointed out that the health care assessment done within twenty-four hours of admission is part of the intake process and covers these types of questions. Risk level is adjustable if the health care assessment identifies concerns favoring an increase in risk level.

107.18 It was conceded by a number of witnesses that inmates who are aware of the implications of being designated SUH may have an incentive to withhold information in hopes of avoiding wearing a suicide gown, losing freedoms, and being scrutinized more closely. This may not have been a factor specific to R.D. as she had some history of forthrightness with BCC staff about suicidal ideation.

107.19 In terms of training to administer the suicide risk assessment, officers testified that it forms part of core training and that new CO's receive assistance from experienced

officers in learning to administer the assessment. Clearly, some officers are more experienced than others are in doing suicide risk assessments. Depending on assignment within the institution, a CO may do as many as 20 security and suicide risk assessments in a single shift. Superintendent Carnegie articulated a suggestion that more formalized training for staff involved with completing and reviewing suicide risk assessments might be beneficial.

iii. Medical Unit

107.20 The Medical Unit at BCC is staffed by two Registered Nurses [RN's] daily from 7:00 AM to 11:00PM as well as one full time and one half time Registered Psychiatric Nurse [RPN] Monday to Friday. A contract psychiatrist visits BCC once weekly and a medical doctor is on contract to visit three times weekly. The Medical Unit is equipped with a medication dispensary though it is not a complete pharmacy.

107.21 Nurses do not complete the same core-training program as CO's. In addition to their professional designations, nurses take further professional training as may be required to stay current and they also receive programming through Corrections, including training on suicide detection and prevention. All nurses dispense medication. RN's work primarily with the physical medical needs of inmates while RPN's focus on inmates with mental health issues.

107.22 Correctional Offender Management System [COMS] is a database employed by Corrections staff as it relates to individual offenders. All CO's and nurses have access to basic information including running records which are day-to-day entries. There is a separate tab for critical incidents with more detailed entries. CO's have access to COMS throughout their shift. At shift change, staff muster for purposes of passing information about happenings on the unit during the preceding shift. Any behavioural issues or change in suicide rating is shared. A logbook is also kept in each unit with handwritten entries detailing the over all comings and goings of the shift. Any loss of privileges by an inmate is noted there.

107.23 ORAMS is part of COMS. It allows medical staff to access a list of all inmates at BCC and their assigned suicide risk level. There are separate adult and youth lists.

107.24 Nurses working at BCC are able to access COMS information inputted by CO's but staff outside the medical unit do not have free admission into medical files because of privacy legislation and safeguards. The medical files are paper files, not electronic. Medical staff communicate to other Corrections staff information as may be necessary to ensure the safety and well-being of the inmate. An inmate with diabetes, for example, may need to be monitored in terms of insulin levels. If concerns about an inmate's mental health relevant to risk for self-harm or suicide is present, the information could be shared with other Corrections staff to inform assessment of appropriate risk level.

107.25 The medical unit maintains a communication book intended to facilitate communication between unit staff and to promote continuity in treatment of inmates. In addition, the unit creates a chart for each inmate with notes documenting interactions between the inmate and medical unit staff.

a. Health Care Assessment

107.25.1 Every new admission or transfer to BCC undergoes a health care assessment administered by a RN within twenty-four hours. This assessment relies significantly upon self-disclosure and aims to identify any pre-existing medical conditions that might require care; medication that should be offered; and whether or not mental health issues are present. A nurse inquires of the individual whether they are currently taking any medications. A DPIN check for Pharmacare records identifies to the admitting nurse any prescribed medications. If the individual presents with medical or mental health issues, a referral to the appropriate department is to follow. In the case of mental health issues, referral to a psychiatric nurse is routine. If collateral information seems necessary following the medical intake, the nurse may ask the inmate to sign a consent to release of information so the medical unit can follow up with a doctor or hospital. BCC is not a primary health

care facility but is equipped to provide essential services to inmates with physical or mental health concerns.

107.25.2 RN Theresa Stannick conducted a health care assessment with R.D. on September 21 in the common area of the juvenile unit. Her practice is to conduct the assessment in private. If the youth is alone in the unit then the common area might suffice or, if necessary to secure privacy, she might borrow the unit office or use the lawyer room in the admissions area. While she could not say with certainty, RN Stannick believes the common room must have afforded sufficient privacy or she would have done the assessment elsewhere. She did concede that because of curtains on the cell windows, R.D. might not have known at the time whether there were other youth in the unit.

107.25.3 CO Husak was in the common area during the assessment. RN Stannick agreed this is not ideal but does sometimes occur if there are safety concerns or if an inmate's behavior warrants the precaution. When RN Stannick attended to the unit, R.D. was asleep in her cell. She was difficult to wake and uncooperative in terms of getting up and participating in the assessment. RN Stannick tried to engage R.D., even "moonwalking" outside the cell whilst calling for R.D. to "come look at the old lady moonwalking". R.D. did leave the cell and participate in the assessment but it was difficult to extract information, as she was neither talkative nor forthcoming. CO Husak does not recall specifically whether she remained in the common area for the entirety of the health care assessment. She said it would not be her practice to stay unless there was a safety or security issue. She believed that she would have been present to gain R.D.'s compliance and that she would then have left the area.

107.25.4 It is apparent from the assessment form that R.D. disclosed prescribed medications of *Seroquel* and *Fluoxetine* but said she had not been taking them. RN Stannick's notes from the assessment indicate that R.D. gave conflicting information and the nurse was unable to determine with certainty whether R.D. had been taking her medication or not. R.D. denied being suicidal or having thoughts about harming

herself. She demanded to return to her cell to sleep. She did not appear to be under the influence of alcohol or drugs at the time of the assessment. RN Stannick did not believe based on the assessment that R.D. was a risk for suicide.

107.25.5 RN Stannick conducted a DPIN, which is a Pharmacare search that provides a list of all medications prescribed and filled at a pharmacy in the preceding six months. It denotes the medication, dose, duration, and prescribing physician. The DPIN confirmed R.D. had recent prescriptions for *Seroquel*, an anti-psychotic medication sometimes used to address sleep issues, and *Fluoxetine* (*Prozac*), a commonly prescribed anti-depressant. The DPIN further evidenced a slightly less recent prescription for *Lorazepam,* an anti-anxiety medication.

107.25.6 RN Stannick did not take any steps to obtain or offer to R.D. her prescribed medication and she testified it was not BCC policy for her to do so at that time. Potential concerns about offering the prescribed drugs based solely on the pre-med assessment included: not knowing whether R.D. had been taking the medication prior to her incarceration; potential interactions with other drugs if R.D. was "coming off" something she had recently used on the street; and dosage concerns arising from DPIN entries potentially consistent with R.D. having obtained prescriptions from different doctors without their knowledge. RN Stannick agreed all were reasons it would be better for an RPN to consider the situation further prior to administering medications.

107.25.7 RN Stannick testified that based on the health care assessment completed with R.D. identifying recent prescriptions related to mental health concerns, she referred R.D. to the psychiatric nurse for follow up. She did so by placing the health care assessment form on R.D.'s chart along with chart notes indicating uncertainty about whether R.D. had been taking her medication and indicating a note had been left for mental health staff to see R.D. if she was not released following court on Monday. RN Stannick said she left the chart along with "a sticky note" on the RPN's

desk as it was the weekend and the RPN would not be back on the unit until Monday. She also noted the interaction and referral in the communication book.

b. Psychiatric Services

107.25.8 Jennie Steel is a full time RPN employed at BCC. BCC has one additional half time RPN. Ms. Steel received training on suicide risk assessment during her university education and has the benefit of ASIST (Applied Suicide Intervention Skills Training) through Corrections. She does not assess every new admission to BCC, only those individuals referred to her because of mental health concerns. Referrals can come from a variety of sources including CO's doing intake assessments, staff in the medical unit, probation officers, family members, and inmates themselves. Inmates assessed as SUM or SUH upon admission or anytime after are automatically seen by an RPN.

107.25.9 When RPN Steel meets with an inmate referred to her, she completes a psychiatric assessment, which includes a suicide risk assessment. She completes these assessments in private. If there is a security concern and a CO needs to remain she typically asks the inmate for permission to do the assessment with the CO present. She assesses mood, affect, eye contact, thought process and content, whether the individual is delusional or hallucinating, any suicide attempts or other history, what is going on currently, and available supports in and out of jail. If someone discloses recent suicidal ideation, she assesses for current thoughts, plans, or suicidal intent. She asks about resources, supports, and checks for future orientation and plans. She evaluates, if possible, what led up to the thoughts and tries to ascertain whether the person was intoxicated at the time. If after assessing an inmate, she feels their risk level is incorrect, she has the discretion to immediately raise the risk level. She is not, however, permitted to decrease the assigned risk level. She is a member of the Suicide Risk Review Committee. The Committee meets weekly and may adjust suicide risk level though any decrease in risk level must be graduated, one level maximum per review.

107.25.10 RPN Steel testified that a triage list is in use since 2010 to alert RPN's to referrals. The form includes spaces for the name of the person referred, date of referral, date reviewed, specific mental health concern, and initials of the RPN who reviewed. She concedes that RN Stannick made a referral note in the medical unit communication book for R.D. and that she did not see the note. She testified, however, that the communication book is not for referrals. It is a record of what medical staff do during the day. She testified that she had on previous occasions caught referrals in the communication book that should have been entered on the triage list. The triage list is the correct way to refer and R.D.'s name was never included on the list. She further testified that R.D.'s file was not on her desk with a referral note when she returned to work on the Monday following R.D.'s admission.

107.25.11 RPN Steel testified that RN Stannick could have bridged the prescribed medications offering them to R.D. until a psychiatric evaluation could be done or, alternatively, could have put R.D. on the list for review on the next Doctor day. She agreed that *Prozac* and *Seroquel* are medications regularly in stock in the dispensary at BCC.

107.25.12 RPN Steel did not agree that it would be helpful to have a default SUM risk assessment for every youth admitted to BCC until after the medical assessment and psychiatric assessment, if appropriate. She said her workload is "overwhelming most days" thanks particularly to changes following R.D.'s death; increasing numbers of inmates with mental health concerns; and the lack of psychiatric services in Dauphin and The Pas Correctional Centers leading to inmates being transferred to BCC from those institutions for psychiatric services. She also raised concerns with arbitrarily potentially exacerbating an individual's risk level saying it could be seen as a punitive measure and might add stress to an individual who is properly assessed at no risk or low risk.

107.25.13 RPN Steel testified that back in 2013 it was quite rare for any referral to come from a foster home including SFH or from a child welfare agency. At that time,

medical unit staff would chase medication and mental health information by sending out signed release forms and making phone calls to collaterals. Sometime after R.D.'s death, SFH began contacting the medical unit about youth coming into custody including providing information about type and dose of prescribed medications as well as mental health information from SFH's clinical file. While RPN Steel agreed that it is her responsibility to seek out collateral information where psychiatric medications or history are disclosed, she indicated that it can takes weeks to receive information after she sends out a signed release. Given that youth are transferred out of BCC at the earliest opportunity, usually within a very few days, there is significant value in collaterals with important information providing it to BCC right away and without being asked.

107.25.14 BCC will accept medications delivered to them for bridging purposes so long as the medication is in a blister pack from a pharmacy but the medical unit will not accept bottles of mixed pills, for obvious reasons.

107.25.15 A new policy requires CO's to alert the RPN to any youth admitted with a SUM or SUH risk level.

c. Collection of Collateral Information

107.25.16 RN Theresa Stannick noted that most youth they deal with at BCC are in custody a short period. She was aware that R.D. was a resident of SFH. She did not contact SFH during the health care assessment and it was not typical for health care assessments to include contact with collaterals.

107.25.17 RN Stannick expressed a hope that SFH would have brought R.D.'s prescribed medication to the jail. She said that in her experience, although SFH know almost immediately of an arrest, they never delivered prescription medication to BCC unless BCC called to request it. Even then, she recalled SFH claiming an inability to deliver more than individual daily doses seemingly because of SFH's internal medication delivery protocol or practices. She testified that even when, with

other inmates, she had called to ask for delivery of medication, she had to call again the following day to remind SFH staff to deliver another daily dose.

107.25.18 On September 20, CO Husak spoke by telephone to Jesse Dourado of SFH concerning R.D. being in custody. Mr. Dourado advised he would not be attending R.D.'s court appearance but would have someone in attendance. He provided no information about R.D.'s personal circumstances; prescribed medications; recent behaviour or mental health concerns; or any plan to support her release back into SFH care.

107.25.19 While Superintendent Carnegie agreed that ultimate responsibility probably lies with BCC to reach out to collaterals for information where necessary, she suggested one would like to think that a parent, agency or foster parent with important information potentially affecting the youth's functioning and wellbeing while in custody would share the information with staff at BCC. She did not agree with suggestions that it might be frustrating or difficult to deal with BCC's automated phone system.

iv. September 20 to 28, 2013

107.26 BCC had four cells in the Juvenile Unit in September of 2013. BCC is not a youth correctional facility. Its purpose is to house youth on a short-term basis. The Juvenile Unit houses males and females. In 2013, communication between male and female inmates was forbidden. When females were in the common area for free time, males were locked in their cells and vice versa. Decisions about discipline were made at the supervisory CO or Unit Manager level.

107.27 On September 21, CO McLean (also referred to in Exhibit materials as CO Daoust) was working as a platoon officer in the Juvenile Unit on the evening shift. A platoon officer is an unassigned officer used to fill in where needed for officers on leave or absent.

107.28 The day shift left word that R.D. wished to call her family, specifically her mother. CO McLean brought R.D. into the unit office that evening and attempted to telephone her mother without success. R.D. then wished to call a friend from the foster home. BCC policy does not allow youth in custody to phone friends, only family members or foster parents. Despite this explanation, R.D. was said to be challenging and argumentative with staff.

107.29 Other behavior concerns arose on September 21. R.D. reportedly persisted in talking to male juveniles despite repeated direction not to do so. Day shift unit staff made note and left a written recommendation that she lose her free time the following day.

107.30 At approximately 11:00PM, CO McLean heard glass breaking and found R.D. seated on her mattress on the floor of her cell. R.D. admitted removing a large fluorescent bulb from a ceiling panel and smashing it against the wall. She and her roommate complied with direction to shake out their mattresses and sweep up the mess then returned to their cell without incident.

107.31 On the afternoon of September 23, R.D. was disrespectful towards staff and flushed her underwear down the cell toilet. An acting shift supervisor attended to the cell to speak with R.D. who threw a book at the supervisor. R.D. was moved to another cell in the Juvenile Unit that did not have a toilet. Problems continued and the supervisor returned because R.D. reportedly persisted in being disrespectful and was now ripping her clothing. The supervisor again entered the cell and questioned R.D. as to the reason for her behaviour. R.D. shrugged but offered no explanation. R.D.'s mood seemed fine and there was no indication of a mental health justification for the behavior. The supervisor suspected R.D. was acting out perhaps because there were other youth in the unit. For this reason, R.D. was moved to a cell in the Admissions Unit with a camera and no toilet. She was compliant during the move. She asked and was allowed to use the washroom while in the admissions area, however, she continued to rip her clothing. The cell she was in smelled of urine and she complained. It was suggested that if she changed her behaviour she could return to the youth unit. She continued to destroy her clothing, she was required

to change into a suicide gown to stop the destruction, and so she would not end up unclothed in a cell with video surveillance. The supervisor saw no reason for concern in terms of R.D.'s mood or mental health nor was she concerned that R.D. was at elevated risk for suicide. She said it appeared to be a case of a juvenile acting out. Use of the suicide gown may not have been intended as disciplinary but, in hindsight, it was effectively a punishment and a misuse of the gown. The move from the Juvenile Unit to Admissions and into the malodorous cell was a punitive measure.

107.32 On September 25, CO Holian began his shift in the Juvenile Unit doing rounds and giving the youth in the unit an opportunity to clean their cells. He noted R.D.'s cell to be messy with puzzle pieces strewn across the cell as well as clothing and bedding on the floor. He gave R.D. five minutes to start cleaning the cell. She complied without incident. A messy cell in the Juvenile Unit is not unusual. During his interactions with R.D. that day he saw no warning signs or cause for concern in terms of self-harm or suicide.

107.33 Literacy Officer Dean Werbiski visited R.D. on September 26 at the request of the Unit Manager because R.D. was expressing interest in working on school. Mr. Werbiski observed R.D. to be positive and enthusiastic about receiving schoolwork. He was persuaded by her eagerness to skip the usual education assessment. Upon discovering that she had been attending school through SFH, he told her he would contact her teacher at the school and ask to have her schoolwork sent to BCC. He left a message for Jesse Dourado at SFH but did not receive a call back that day. Mr. Werbiski has a background in counselling. He saw no warning signs in respect of suicide. He was shocked to learn of R.D.'s suicide when he returned to work the following Monday.

107.34 On September 27, CO Holian facilitated a phone call by R.D. to a house parent at SFH. He knew there had been some behaviour concerns with R.D. during her time in the Juvenile Unit though his experiences with R.D. were quite positive. He took the opportunity to commend her on September 27 for her positive attitude and improved behaviour. Again, he testified that he saw no red flags in terms of suicide. He agreed it is not unusual for a young person's behaviour in custody to stabilize over time.

107.35 CO Husak also interacted with R.D. on September 27. R.D. shared with the officer some of the changes she was planning to make in her life with the goal of remaining out of custody. They discussed R.D.'s plans for school as well as establishing friendships and companions that are more positive in future. To CO Husak it appeared R.D. was happy; excited about school; and committed to improving her interactions with others. She saw no evidence of risk for suicide.

107.36 CO Husak worked the day shift in the Juvenile Unit on September 28. There were three youth in the unit, two males and R.D. She testified it was a typical day. In the afternoon R.D. was in the common area for free time when she was observed trying to communicate with one or both males. She could not say whom specifically R.D. was speaking to; what was said; nor whether either male was responding. R.D. was returned to her cell for this rule violation. She appeared to understand why she was being returned to her cell. Around 3:30PM CO Husak spoke to R.D. about the earlier rule violation. She laid out expectations for R.D. including not talking to the males. R.D. appeared to understand and agreed to follow the rules. She was allowed to resume her free time in the common area. CO Husak testified R.D.'s affect was normal and she was calm. Nothing stood out to her as unusual about R.D.'s behaviour or mood. She had no concerns about elevated risk for suicide.

107.37 CO Foubert and CO Kaye worked regularly in the Juvenile Unit in 2013. Staff assignments of one-year duration were common for stability and consistency reasons. Both interacted with R.D. during the days leading up to the critical incident. Neither recalled being aware R.D. was on previous occasions designated SUM though the information was accessible through COMS. They were aware that the suicide rating of an offender was reviewable if behaviour or circumstances warranted. Both noted signs of future-orientation as R.D. talked positively about working on school. She was eager to work with teacher Mr. Werbiski. She spoke to CO Kaye about submitting an assignment for a contest she read about in the *GrassRoots* paper. To CO Foubert, R.D. spoke of plans to play on a hockey

team. CO Foubert described R.D. as personable in her dealings with him though he was aware that she could be difficult at times with other staff members.

v. Critical Incident

107.38 R.D. was in her cell the evening of September 28, 2013. R.D.'s SUL designation meant checks were to occur at thirty-minute intervals. CO Foubert randomized checks within the thirty-minute parameter to make his appearances less predictable.

107.39 At approximately 9:30PM CO Foubert attended to R.D.'s cell. A small blue curtain on the exterior of the cell obscured the window. When checked twenty minutes earlier, R.D. was on her bunk in a seated position seemingly reading a book. Lifting the curtain, he now observed her hanging with a bedsheet tied round her neck and further tied off to the grating of a ceiling vent. It appeared she had used a stationary desk in the cell to reach the vent and as a stepping-off point.

107.40 CO Foubert reacted quickly. He broadcast a "*Code Red*" (i.e. medical emergency) on his radio then unlocked the cell and entered. He did his best to elevate R.D. hoping to relieve pressure to her neck. CO Kaye joined him within seconds and assisted. She called for a rescue knife and climbed on the desk to help elevate R.D. and to try to loosen the sheet around her neck. The security video recording suggests an excellent response by Corrections staff in terms of speed as well as number of responders. Within seconds, numerous officers were present.

107.41 Acting Shift Supervisor CO Seniuk was en route when he heard the request for the rescue knife. He backtracked to retrieve it. At the time, there were three such knives on the premises, stored strategically throughout the institution. The rescue knife is a cutaway tool specifically intended to cut someone down from a hanging position and to cut away material wrapped around the neck. CO Seniuk passed the knife to CO Hladky who used it to free R.D.

107.42 Corrections Staff moved R.D. to the floor of the common area where CO Seniuk cut the sheet from her neck. RN Michael Briol happened upon the unit coincidentally as CO's were responding to the "*Code Red*". He checked R.D. and found she was not breathing and had no pulse. He commenced cardiopulmonary resuscitation [CPR] mouth-to-mouth while CO's took turns administering chest compressions. R.D.'s eyes were closed. She was pale and non-responsive. RN Jen Seitz was dispensing medication in another unit when she heard the "*Code Red*". She ran to the Juvenile Unit and seeing no emergency kit, she ran to retrieve one from the medical unit. The Automated External Defibrillator [AED] utilized advised against administering any shock to R.D. CPR efforts by CO's and then nurses were continuous until Emergency Medical Services [EMS] responders arrived promptly and relieved institution staff.

107.43 EMS workers intubated R.D. and established an intravenous line for the administration of *epinephrine*, which revived a pulse at 10:02PM. EMS then transported R.D. by ambulance to Brandon Regional Health Center [BRHC]. RN Seitz contacted the emergency department alerting them that R.D. was in transit and informing them of her condition and about the incident. RN Bristol provided further information to the hospital from R.D.'s medical file on request.

107.44 CO Seniuk secured the cell and common area where the critical incident occurred at the direction of Brandon Police Services.

107.45 CO Baldwin retrieved next of kin information for R.D.

vi. Other Youth in Juvenile Unit during Critical Incident

107.46 J.S. is an adult male. When he appeared as a witness during the inquest, he was in custody at Headingley Correctional Center serving a sentence for robbery. In September of 2013, J.S. was a youth and he lived at the same SFH placement as R.D. who was his girlfriend's best friend. J.S. came into custody twice on September 28 both times under the *Intoxicated Persons Detention Act*. The first admission was at 12:45AM. He was released

around 2:00PM. He was returned to custody at approximately 8:30PM and placed in the Juvenile Unit.

107.47 J.S. suspected his brother K.P. as well as R.D. were likely in the unit because they had been there earlier in the day. He called out to his brother and confirmed K.P. was still there. He told the court that the two had some conversation and R.D. joined in. R.D. reportedly told J.S. and K.P. that she was going to kill herself and J.S. testified they both tried to talk her out of it. J.S. thought he told her that she would probably be getting out soon. He said R.D. did not seem sad or emotional. He described the tone and context as "a normal conversation". He estimated she mentioned killing herself twice during the conversation.

107.48 J.S. said R.D. got quiet; that she was no longer responding to or participating in the conversation. He said he assumed she wanted to be alone and was perhaps reading a book. He said he did start to wonder if something was wrong. He said he did not bang on the door or call out to an officer for help though he conceded since the incident that he thinks he should have. He could not remember a CO lifting the curtain on his cell window to check on him between the time he arrived on the unit and when he heard the "*Code Red*". He estimated twenty or thirty minutes passed between the time R.D. stopped talking and when he heard the "*Code Red*" call.

107.49 K.P. is since deceased and sadly unavailable to this Inquest.

107.50 J.S. appeared sincere and I had no concerns about his demeanor when he appeared at the inquest. He seemed serious and thoughtful. I have no doubt the experience was traumatic given his proximity to the critical incident and his familiarity with R.D. It is, however, difficult to attach much weight to the evidence of J.S. owing to his intoxication and apparent lack of recall of anything more than the barest allegation of a conversation with R.D. Impairment diminishes one's ability to accurately perceive and later recall details of even very significant events. The event is now years in the past. J.S. has been in and out of custody with sufficient frequency that, other than R.D.'s death, this visit to BCC

was not noteworthy or distinguishable from many others. J.S. appears not to have been interviewed after the critical incident and there was nothing written from which J.S. could properly have been invited to refresh his memory.

107.51 J.S. was unable to detail any of the conversation surrounding R.D.'s assertions about suicide. He could not recall how, within the conversation, R.D. brought up suicide. He did not articulate anything that was said verbatim and spoke only in generalities. He has no recall of CO's placing him for a time in a cell with his brother K.P. after the incident nor any recall of a conversation with CO Foubert the following day. He could not remember talking to SFH staff about the incident after he was released from custody.

107.52 I can come to no conclusion but that it would be dangerous to treat the evidence of J.S. about what happened in the minutes leading up to the critical incident as reliable. I am not dismissing his evidence. It is possible things happened as he said they did but it is not certain. This is not to say there was no value in J.S.'s appearance in this matter. The possibility of a disclosure by R.D. to proximate inmates in the Juvenile Unit just before she acted prompts consideration of what preventative measures might increase the chance of such inmate-to-inmate disclosures coming to the attention of staff. Further, J.S.'s evidence offered an inmate's perspective on the suicide gown and confirmed suspicions that an inmate might downplay factors tending to increase risk level for suicide in order to avoid the consequences of a SUH designation. Finally, J.S.'s evidence highlighted the difference and value in relationship between inmates and correctional officers at stand-alone youth facilities versus those in a very short-term placement at an adult facility like BCC.

E. Prairie Mountain Health Authority - Brandon Regional Health Centre

108. EMS transported R.D. directly to BRHC where she was admitted to the Intensive Care Unit [ICU]. Doctor Bookatz was the attending ICU doctor. R.D. was placed on a ventilator. She was comatose and presenting with a feature known as *myoclonic jerks* which manifests as twitching throughout the body. Because *myoclonic jerks* are typically a sign of serious brain damage, Doctor Bookatz requested a neurology consultation.

109. Doctor Tamayo, an expert in neurology, examined R.D. on September 29 to evaluate the extent of the damage to R.D.'s brain. Based on lack of meaningful response to a number of tests, he identified two possible scenarios but the prognosis for both was very poor. He suggested further testing and medication some of which was intended to make R.D. more comfortable and to stop the *myoclonic* jerks because they could be upsetting to R.D.'s loved ones. If she survived, it was probable she would be in a non-functioning vegetative state.

110. On October 1, Doctor Penner, an expert in respiratory and intensive care medicine, took charge of the ICU at BRHC. Sixty hours had passed since the critical incident. Doctor Penner was briefed about the incident and R.D.'s resulting medical condition. He removed sedation and tested R.D.'s responsiveness to various stimuli with a view to determining whether there was any possibility of a good outcome. She was not responsive. He noted that she was triggering the ventilator, which is to say her body was putting forth some effort towards breathing. Doctor Penner concluded that R.D. did not have a good chance at making any meaningful recovery. She was severely brain-damaged. He did not believe she would survive. Even being generous and assuming survival for some period, he did not believe she would ever function in any meaningful way.

111. Doctor Penner met with the family. While DOCFS was the legal guardian and entitled to make medical decisions about R.D., they deferred to her family. There was agreement that it would be reasonable to withdraw intensive care therapy but the family requested that Doctor Penner hold off until the following day so that other family members could attend.

112. Doctor Penner again met with the family the following afternoon. He explained that in the night R.D.'s temperature spiked indicating the hypothalamus was not functioning. He further advised R.D. was no longer triggering the ventilator and that he believed she was very close to brain death. He asked whether anyone disagreed with the plan to withdraw life support mechanisms. There was no dissension and the family concurred with proceeding.

113. Intensive care therapy was withdrawn at 2:33PM on October 2 with Doctor Penner at R.D.'s bedside in case of distress. There was none. There were weak attempts at breathing but

this was brief. Thirty-seven minutes later, all electrical activity ceased and death was pronounced at 3:10PM.

114. Doctor Penner signed the Death Certificate and consulted with the Chief Medical Examiner to ensure completeness.

115. Both doctors who testified confirmed that by the time R.D. reached BRHC there was little medically they could do. It was unknown how long R.D. was in a hanging position. Duration speaks to how long she was deprived of oxygen. The longer the oxygen deprivation, the greater the risk of damage to the brain which informs likelihood of survival. Doctor Penner opined that four minutes would be enough time to result in permanent damage to the brain depending on how complete the oxygen deprivation was. With only partial deprivation, a longer period might be required. The assessment of how long R.D. must have been deprived of oxygen to cause her serious brain injury is speculative and dependent on a number of unknown factors including effectiveness of the ligature cutting off blood flow and the extent to which she struggled, as struggling increases the rate of oxygen consumption.

F. Manitoba Corrections – Divisional Review

116. Bonnie Carnegie was Deputy Superintendent of BCC and the senior manager on call the weekend of the critical incident. She is now Superintendent of the institution and has been since 2015. As such, she has been instrumental in overseeing BCC's response to the Divisional Review that followed the death of R.D. The review was conducted by Senior Managers from two other provincial correctional facilities as well as the director of Health Services for Manitoba Corrections. Recommendations flowing from the review were persuasive but not mandatory.

117. The Divisional Review Report (Exhibit 2) is a comprehensive analysis of the circumstances surrounding the suicide of R.D. insofar as those circumstances involved Manitoba Corrections. The review digests R.D.'s background and interactions with Manitoba Corrections including the days leading up to her suicide. The report analyzes the critical incident and staff response. Authors of the review appear to have exhaustively studied the relevant documents

including policies and standing orders; the physical configuration of BCC; staffing levels, training, and challenges particular to this institution; and the provision of health services at BCC.

118. The Divisional Review culminated in a list of thirty-nine recommendations almost all of which have been implemented at BCC. The recommendations are divided into six categories: physical environment; policies / standing orders; operations; human resources; training; and health services. While a few of the recommendations relate directly to preventing a future suicide attempt in the Juvenile Unit at BCC, most are important suggestions for general improvements that came to light during this very thorough examination of BCC's Juvenile Unit.

119. The report highlighted a number of concerns with the management of youthful inmates at BCC around the time of R.D.'s death. BCC is not a facility intended to house youth. It is an adult facility. The Juvenile Unit includes four cells. They do not have windows to the outside and curtains obscured the cell window to inhibit communication between inmates. Youth were spending significant amounts of time locked in their cells and there were few activities available to occupy their time in the unit. There was not a clear procedure in place dictating progressive sanctions for misbehaviour. Conditions in the Juvenile Unit were akin to segregation. Staff were stretched thin such that there were periods when no CO was in the actual unit. There was evidence that prescribed rounds were occasionally missed though this was not a factor contributing to the critical incident. There was no case management work done with youths.

120. Important and clearly relevant preventative recommendations include the 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. These are recommendations I would have included in this report had BCC not already implemented them. With respect to additional security cameras in the Juvenile Unit, it should be noted they are not continuously monitored. No staff person is designated to monitor them around the clock. The security cameras are an added tool for unit staff.

121. Best practice recommendations which could be preventative, though may not have been in the case of R.D., include completion of Community Release Plans for all youth; dedicated continuous staffing of the Juvenile Unit; creation of a policy on progressive sanctions for youth; increased activity options and access to school work for youth; implementation of collateral contact requirements for youth with prescribed medications; prohibition against health care assessments being conducted in the Juvenile Unit; strategic placement of AED's; requirement that BCC Health Services comply with Divisional Nursing Documentation Policy; and the triage policy for youth admissions with psychiatric history.

122. Correctional Officers are all trained in doing case management but were previously doing it for adult inmates only. Case Management (i.e. community release planning) is now done with youth at BCC though it is necessarily different from that done with adults owing to typically very short stays for youth at BCC. The value of case management for youth at BCC is found in the increased contact between staff and youth for purposes of checking-in and, in some cases, the collection and consideration of information from collateral contacts.

123. The best practice recommendations resulted in the enactment of some written protocols / procedures at BCC. Exhibits 9, 16, and 17 are representative.

124. Exhibit 9 is the now formalized "Procedure for Medication Verification and Continuation". It confirms a health assessment is to occur within 24 hours of admission; establishes a procedure for medications that accompany an inmate; and establishes timelines for file review by physician / psychiatrist.

125. Exhibit 16 is a formalized protocol entitled "Procedure for Referral to Psychiatric Services at Brandon Correctional Center". It mandates that these referrals go through the Medical Unit and may be triggered by admission history, SUM or SUH designation arising from suicide risk assessment, existing psychiatric care plans, court order, inmate request, or staff referral. The protocol further requires consistent documentation of referrals including the name being placed in the appropriate logbook and on the Mental Health Alert List.

126. Exhibit 17 is a July 2014 email directive sent to Medical Unit staff dictating that any juvenile admitted to BCC with a psychiatric history is to be referred to the RPN for triage, including placing the name on the Mental Health Alert List.

127. Additional recommendations arising in the course of the review that likely improve the living conditions for inmates in the BCC juvenile unit include no longer using the youth unit as a thoroughfare for adult offenders; installation of soft night lighting in youth cells; and greater access to youth-specific training. Other recommendations aimed to improve post-critical incident procedures.

128. Superintendent Carnegie was steadfast in her view that the SUL rating for R.D. was accurate based on available information and in terms of the appropriateness of the Suicide Risk Assessment instrument used by Corrections throughout the province.

129. She nonetheless acknowledged the value of the Divisional Review, agreeing that implementation of most of the recommendations resulted in positive improvements particularly for the Juvenile Unit at BCC.

III. DETERMINATION OF CIRCUMSTANCES SURROUNDING R.D.'S DEATH

130. *The Fatality Inquiries Act* mandates the determination of the circumstances relating to R.D.'s death. To that end, I provide the following summary.

131. R.D. was a sixteen-year-old Indigenous female at the time of her death by suicide. Apprehended at birth, she was a ward of Manitoba's child welfare system. While placed in the care of a relative, she was the victim of a sexual assault at the hands of a man known to her family of origin. As a young teenager, she began and continued to abscond habitually from foster home placements and became entangled in the sex trade, working under the direction of a street gang. She was enticed back to the sex trade repeatedly by negative influences, the lure of fast money, and easy access to drugs and alcohol. A psychiatrist who treated R.D. opined she used the sex trade in an attempt to gain mastery over the fear and trauma of her earlier sexual abuse.

132. Approximately seven months prior to her death and despite the breakdown of a specialized foster placement in Winnipeg, DOCFS moved R.D. to SFH, a private foster home business operating in the Westman area. The move aimed to give R.D. access to the supports of a specialized foster home while decreasing her proximity to the sex trade and negative influences in Winnipeg. She initially resided at a home in a rural location to make running away more difficult. While there were continued attempts to run away and while she was re-involved in some criminal activity, she settled and remained in the placement with greater success than in previous years and homes. She had the support of her DOCFS worker, a probation officer, SFH management and staff, and access to a psychiatrist and RPN for ongoing assessment and therapy related to trauma and exploitation.

133. With the knowledge of SFH management and staff including clinical psychiatric service providers, R.D. was regularly accessing drugs (marijuana primarily) and alcohol while in the care of SFH. She escalated to “huffing” aerosols. When on the run, they knew she used dangerous street drugs like cocaine and “meth”. SFH management were aware of ongoing contact between R.D. and an adult male in Brandon described as a pedophile and with a connection to the sex trade in Winnipeg.

134. R.D.’s progress at SFH was short-lived. Within a few months, she was absconding again to Winnipeg and working in the sex trade. She was able to run away repeatedly. She was the victim of two assaults at the hands of another youth in the foster home. Youth in the foster home also damaged her clothing and posted one of the assaults to social media. R.D. made suicidal gestures and / or comments in May, August, and September. Contrary to a Resident Safety Plan created by SFH, which specifically identified continued placement at a rural location as important to managing her flight risk, she was moved to a different SFH home in the City of Brandon without a fresh safety assessment being completed by SFH. She was absent from that final home more days than she was present.

135. In the early morning hours of September 20, R.D. was arrested for allegedly stealing *Nytol* from a drug store. She was detained at BCC. The standard safety and suicide risk assessments determined her to be at low risk for suicide. The suicide assessment was completed

by a CO who inputted "yes" or "no" responses along with brief anecdotal information into a computer program which generated a risk level based on the number of "yes" and "no" responses. The assessment was pre-populated with information from R.D.'s previous assessment and the assessing CO did not update that information. There was more anecdotal information apparent from COMS that the officer could have noted including information related to family history of suicide and R.D.'s high risk for suicide designation during her August 30 incarceration at BCC. The CO did not recommend an override of the computer generated risk SUL designation. The supervisory CO who reviewed R.D.'s risk assessment saw no reason to override the SUL designation. The supervisory CO could not recall ever having overridden a computer generated risk level.

136. A health assessment performed by a nurse within twenty-four hours of R.D.'s admission to BCC identified active prescriptions for psychiatric medications, *Seroquel* and *Fluoxetine.* The health assessment does not include contacting collaterals for further information. The assessing RN did not take steps to obtain and offer to R.D. her prescribed medications. The RN referred R.D. to the RPN for further assessment by placing her chart along with a note on the RPN's desk and by noting the referral in the Medical Unit's communication book. The RPN testified she did not ever see R.D.'s file and the note on her desk. She somehow missed the note in the communication book; however, the communication book is not the proper way to make a referral. The Medical Unit maintains a Triage List for the purpose of referrals and R.D.'s name was never placed on the Triage List.

137. No one from BCC contacted DOCFS or SFH to request information about R.D. and no one from DOCFS or SFH contacted BCC to share information about her background, mental health challenges, or prescribed psychiatric medications. SFH delivered daily doses of medication to R.D. in the community but did not offer to do so while she was at BCC.

138. R.D. was held in the Juvenile Unit at BCC from September 20-28. BCC is an adult facility. The Juvenile Unit is intended to be a short-term placement. Not all areas of the Juvenile Unit had surveillance cameras in 2013. There are four cells in the unit and both male and female youths are housed there. Males and females are separate during free time, which may decrease

the amount of time each can be out of their cells. In 2013, communication between males and females was forbidden. Activities in the Juvenile Unit were limited. The cells do not have windows to the outside and a curtain obscured the single window in each cell door. The conditions in which youth were housed in 2013 was more akin to segregation than would be the case for most adults in BCC.

139. On September 21, R.D. and her cellmate damaged property in their cell. On September 23, R.D. flushed her underwear down the cell toilet and was disrespectful with staff prompting a shift supervisor to move her to the Admissions Unit where she was kept in a cell that smelled of urine and placed in a suicide gown because she persisted in ripping her clothing. The shift supervisor intended this as a practical measure but it was punitive.

140. Jesse Dourado contacted R.D.'s Legal Aid lawyer and twice requested that he remand R.D. in custody so that SFH and DOCFS could identify a release plan. Both the DOCFS worker and SFH management wanted to meet together and with the clinical psychiatric service providers to discuss R.D.'s release. No one from DOCFS or SFH visited R.D. at BCC. She turned sixteen on September 21 in custody. There is no evidence anyone communicated to R.D. an explanation for her continued detention or advised her that discussions to facilitate her release were taking place.

141. On September 26, R.D. asked the Literacy Officer for schoolwork so she could work on it while at the jail. She had conversations with CO's at BCC about future goals and plans.

142. On September 28, R.D. was reprimanded for trying to communicate with males in the Juvenile Unit. She was placed in her cell for a period and later allowed to resume her free time after a CO reviewed expectations with R.D.

143. At 9:30PM, twenty minutes after the previous cell check, a CO found R.D. hanging with a bedsheet knotted round her neck and tied off to the grating of a ceiling vent. It appeared she had used a stationary desk to reach the vent and as a stepping-off point. The response of Correctional Officers was excellent in terms of speed and number of responders. A rescue knife

was not readily available in the Juvenile Unit and there was likely a brief delay of less than a minute for a CO to retrieve the nearest knife. R.D. was non-responsive from the time she was discovered. Medical staff did not have radios at BCC in 2013 but responded quickly because of coincidental proximity. CO's used their training in respect of performing CPR. An AED was utilized but advised against administering any shock.

144. EMS response was timely. R.D. was intubated and intravenous application of *epinephrine* restored a pulse. EMS transported R.D. directly to BRHC. She was comatose and presented with *myoclonic jerks* indicative of serious brain injury. Doctors with relevant expertise assessed brain function and responsiveness and determined that the prognosis was very poor. R.D. was not expected to survive. If she did survive, doctors did not believe she would ever function in any meaningful way. Her condition deteriorated further when her temperature spiked and she stopped triggering the ventilator.

145. While DOCFS was the legal guardian and entitled to make medical decisions, they deferred to the family. On October 2, intensive care therapy was removed at the direction of R.D.'s family, and she died shortly thereafter.

146. Representatives of DOCFS, SFH, Probation, and Corrections who had meaningful interactions with R.D. preceding her death, all testified to a sense of shock at R.D.'s suicide. While most recognized suicide was a steady consideration with R.D., no one believed she was at acutely elevated risk for suicide in the time leading up to her death. She was future-oriented and seemed to have solid protective factors. A number of witnesses did concede they believed R.D. was at risk of ending up missing and /or murdered at the hands of someone else given her habitual running and persistent return to the sex trade.

IV. RECOMMENDATIONS

147. Finally, *The Fatality Inquiries Act* directs that I determine what, if anything, can be done to prevent similar deaths from occurring in the future. Most of the recommendations I might have considered in respect of BCC were addressed thanks to the comprehensive Divisional Review.

148. This inquest casts light on three broad issues that ought to be considered in determining whether any recommendations for change can reasonably be offered.

Availability of Secure Foster Placement Options for High-Risk Youth

149. R.D. passed through many foster homes. She had obvious issues related to trauma and specifically regarding sexual abuse and exploitation. When standard foster placements failed, she resided at a specialized foster home in Winnipeg, which had a specific program for sexually exploited youth. DOCFS' desire to try a specialized placement farther from the Winnipeg sex trade is understandable but the evidence suggests SFH did not possess expertise or programming specific to R.D.'s particular vulnerability – the sex trade.

150. SFH appears not to have had adequate structure or supervision to prevent R.D.'s continued absconding and repeated return to the perils of the sex trade and dangerous street drugs. SFH would not or could not contain R.D. Mr. Pople expressed the belief that they needed to convince R.D. that she wanted to stay at SFH. He had heard that sex trade workers returned on average seven times to the sex trade before leaving and seemed persuaded that her returns were part of a recovery process. With respect, Mr. Pople had no demonstrated expertise or higher education on the subject matter. While there may be some truth to the information, R.D. was a youth and each time she returned to the sex trade, she was potentially in grave danger.

151. R.D.'s ability to access alcohol and illicit drugs regularly while in the care of SFH is further evidence of a lack of adequate controls and supervision. The fact that SFH managers and staff knew about her ongoing abuse of intoxicants is also cause for concern. Her psychiatrist did try to offset R.D.'s resort to illicit and dangerous intoxicants with psychiatric medication. There is no evidence that SFH took meaningful steps to stop R.D.'s access to drugs, alcohol, and aerosols.

152. A number of witnesses described being fearful in the weeks leading up to R.D.'s death that she would end up dead by murder or misadventure. She died in a correctional facility but the evidence suggests she was more likely to have died on the streets while on the lam from SFH.

153. Contrary to the SFH Resident Safety Plan for R.D., as her behaviour and circumstances became more concerning, SFH with the agreement of DOCFS moved R.D. from "the farm" to a home in the City of Brandon. My impression is this happened because it seemed the best available option in the moment within SFH. Once R.D. was in custody, DOCFS and SFH representatives met and discussed a plan to seek R.D.'s release into a stand-alone SFH home, likely an apartment. The email communications tendered during the inquest suggest Jesse Dourado was advocating for release back into SFH care. He encouraged the recipients including Ms. Bjornson to focus on the number of good days and not the growing number of bad ones. Mr. Pople articulated this reasoning during his evidence as well. While there is no evidence to suggest an overt financial motive and every reason to think SFH owners and staff cared for R.D. and did their best, there is value in considering with a view to the future whether expensive "for profit" specialized foster homes are an ideal placement option for high-risk youth like R.D. or the best use of scarce public funds. That being said, I presume the primary reason SFH continued to be an option despite R.D.'s obvious decline into crisis while in their care, resulted from a lack of secure specialized placement options.

154. R.D. was at BCC for eight days. Jesse Dourado contacted R.D.'s lawyer and twice asked him to remand R.D. in custody while he and others sorted out a release plan for R.D. He referenced needing time to move another youth from "the farm" so that R.D. could move back and that this would require some time.

155. Mr. Dourado's email to Legal Aid counsel raises some concern about who was instructing legal counsel as this would be the role of R.D., not Mr. Dourado. R.D.'s lawyer did not testify but I trust he took direction from his client and not Jesse Dourado. The greater concern, however, arises from consideration of *section 29* of the *Youth Criminal Justice Act S.C. 2002, c.1,* which prohibits detention of a young person prior to sentencing as a substitute for appropriate child protection measures. BCC arguably had care of R.D. during the relevant period in the absence of a sufficiently secure foster placement. The offences with which she was charged were not crimes of violence and were not particularly serious. At sentencing, it is quite possible R.D. would not have received a custodial disposition.

156. SFH staff used their available resources and knowledge to attempt to care for R.D. but her needs exceeded what they were equipped to offer and this became particularly evident by the time her placement at “the farm” collapsed. Doctor Jenkins testified that R.D. was in crisis by September. He believed that she required a more restrictive environment with safeguards that disallowed absconding. SFH foster homes did not rise to that level.

157. The inquest did not hear opinions from experts qualified in the challenging area of child welfare nor was evidence presented as to the nature, number, and average availability of secure foster placement options in this province. Without more information, it is difficult to make a detailed recommendation but equally tough to ignore the opportunity this inquest offers to draw attention to the need for adequate safe and secure foster placement options for high-risk youth in crisis like R.D. I therefore offer the following broad recommendation recognizing its generality may limit its value.

RECOMMENDATION ONE

158. **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.**

Value of Information-Sharing Between Entities with Coexisting Responsibility for High Risk Youth in Care

159. First, everyone seems to agree that the more information and insight each entity dealing with a high-risk youth possesses, the better. When R.D. entered BCC, Corrections became her primary caregiver but she continued to be a ward of DOCFS placed with SFH. DOCFS possessed comprehensive background information and SFH had the best and most recent information about R.D.’s behaviour and medications as well as her personal and mental health challenges. Superintendent Carnegie conceded that as the primary caregiver BCC should take the initiative in seeking out collateral information. Current practices reflect BCC’s acceptance of this responsibility. This is challenging because youth are at BCC short-term and outside entities do

not always respond promptly. It makes good sense for a correctional facility to invite collateral information when a youth in the child welfare system comes into custody. It makes as much, and maybe more, sense for a specialized foster home to provide collateral information to Corrections when a child in their care goes into custody particularly where there are mental health concerns, prescribed psychiatric medications, or potential suicide concerns.

160. I appreciate SFH and DOCFS did not believe R.D. was at elevated risk for suicide but they understood suicide was always a concern with R.D. They knew she was running with greater frequency in the days leading up to her incarceration. They knew when she was absent from the placement, she was not receiving her medication and SFH medication records suggested she was not taking the medication consistently in the weeks leading up to September 20.

161. *Section 76(3)* of the *Child and Family Services Act* probably permitted the release of confidential information without a signed release but even if it did not, a signed release could have been obtained or the jail could have been alerted to the fact that there were concerns and information was forthcoming once a release was signed. SFH could have offered to deliver R.D.'s medications to BCC.

162. SFH changed their practices in these regards after the death of R.D. Prior to placement, SFH began obtaining signed releases from DOCFS so that information could be shared with Corrections if the need arose. SFH began offering to provide medications if it would be of assistance to the jail and in sufficient quantity to last until the next court date.

163. It should be noted the Government of Manitoba has enacted *The Protection of Children (Sharing Information) Act, S.M. 2016 c.17*, which is intended to provide additional authority to service providers to share information concerning supported children. This Act is awaiting royal assent. Recommendations aimed at enhancing or clarifying the existing legislation are not necessary and particularly so because of this incoming legislation.

164. Second, while there was agreement that DOCFS as guardian was responsible for bigger picture issues and decisions while SFH was responsible for R.D.'s daily care, there were

contradictions in the evidence about who was specifically responsible for what actions once R.D. entered BCC. Ms. Bjornson suggested that SFH should have been keeping in contact with R.D. by visiting her or updating her on plans for her release; that SFH should have provided collateral information about R.D. and her medications to BCC. She said they could do this without a release from DOCFS or that she would have signed a release, if asked. SFH, in reply, said they believed the guardian was responsible for visiting R.D. and providing information to the jail.

165. I attribute no blame to any individual for failing to visit R.D. or to update her on discussions about her release. It is clear that representatives of DOCFS and SFH were focussed on figuring out a safe release plan for R.D. They had her best interests at heart. The circumstances of this case offer the opportunity for reflection and consideration of best practices moving forward.

166. Hoping to encourage increased sharing of information between child welfare agencies, foster homes, and correctional facilities when a high-risk youth in care is incarcerated, I offer the following recommendation:

RECOMMENDATION TWO

167. **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.**

168. With the intention of clarifying the delineation of responsibility as between child welfare agencies and foster care providers when a child in care is in a correctional facility, I offer the following recommendation:

RECOMMENDATION THREE

169. **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.

Challenges and Limitations of Assessing and Predicting Suicide Risk

170. Significant time and attention during this inquest focussed on the suicide risk assessment and health care assessments conducted shortly after R.D.'s admission to BCC. During Superintendent Carnegie's twenty-eight years at BCC, there have been two deaths (including R.D.) by suicide. Considering the prevalence of psychiatric issues amongst residents of correctional facilities, this number is low. Psychiatrist Doctor Jenkins spoke to the challenges of accurately assessing for and predicting suicide risk. The rarity of a successful suicide at BCC and the near impossibility of accurately assessing and predicting who will attempt suicide is not offered to diminish the seriousness of R.D.'s death but both factors should be borne in mind when considering whether any recommendation herein might reasonably prevent a future suicide.

171. Doctor Jenkins testified that there is no proven medical test for determining suicide risk and his described method of assessing risk as a psychiatrist is quite similar to the assessment process conducted at BCC. It is brief and admittedly limited because it relies on the individual self-reporting. Doctor Jenkins asks the individual whether s/he is or has been thinking about suicide.

172. Interestingly, Doctor Jenkins does not assign risk levels to his patients and expressed concern that assigning a risk level may in fact make people complacent or less vigilant about continuing to monitor risk, which can fluctuate with circumstances and other factors. He seemed to endorse the notion that a person with history related to suicide is at some risk; that a person with current or very recent thoughts of suicide is at elevated risk; and an individual with a specific plan is at even greater risk. He did agree that generally the more information one has when considering suicide risk, the better.

173. A suicide risk assessment upon admission to a correctional facility is necessarily a relatively quick screening instrument intended to help identify an appropriate level of

supervision and placement within the facility. Certainly, the suicide risk assessment pertaining to R.D. could have included more anecdotal information, which would have provided a more comprehensive picture of R.D.'s background and potential risk factors. In terms of best practice, this assessment should arguably have been more detailed and more accurate. However, more anecdotal information in the case of R.D. would not, in my view, have properly motivated an override of the SUL designation. R.D. did not identify thoughts of suicide in the moment or in the preceding hours or even days. She had some history but no current thoughts or plans. The low risk designation seems appropriate.

174. Doctor Jenkins' concern about people becoming complacent once a risk designation is determined is important. There is nothing to suggest CO's were complacent in their dealings with R.D. but changes at BCC following R.D.'s death including case management for youth and increased presence of CO's in the unit interacting with the youth are valuable improvements. These types of changes increase the opportunities for CO's to interact with youth and to check-in on their well being more frequently. The case management contacts should also allow for a meaningful check-in with the youth after each court appearance that does not not result in their release from custody.

175. It was not a contributing factor in this case, but because it appears some CO's may be reluctant or averse to recommending or utilizing the override function in the suicide risk assessment and because Superintendent Carnegie expressed the view that more formalized training for staff involved with completing and reviewing suicide risk assessments including use of the override option might be beneficial, I make the following recommendation:

RECOMMENDATION FOUR

176. **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.

177. I understand that a Corrections' review with respect to this training is underway. I make the recommendation to support the work in progress and to encourage it's completion.

Other

178. The comprehensive Divisional Review recommended that BCC increase the activity options for youth in the Juvenile Unit. The evidence taken during the inquest suggested that BCC added an exercise bike to the unit but nothing more.

RECOMMENDATION FIVE

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

Additional Observations

180. J.S. was in the Juvenile Unit during the critical incident. R.D. may have disclosed to him an intention to take her own life shortly before attempting to do so. He did not call for help. To do so would have been challenging without alerting R.D. to the fact he was reporting her. Telling on another inmate violates an unwritten rule of jail culture. Increased presence of CO's in the Juvenile Unit of BCC may now better allow for disclosures of inmate-to-inmate confessions of suicidal intentions. I do not have a specific recommendation but consideration within Corrections about other ways to encourage and facilitate these types of disclosures seems prudent.

181. RPN Jennie Steel described an overwhelming workload for the 1.5 RPN's employed at BCC arising in part from changes following R.D.'s death; increasing numbers of inmates with mental health challenges; and BCC RPN's responsibilities related to inmates at Dauphin Correctional Center and The Pas Correctional Center. I do not have enough statistical or even anecdotal information to make a reasoned recommendation about staffing and I recognize the potential financial implications of doing so. Given the prevalence of mental health issues amongst inmates in correctional facilities, psychiatric resources are increasingly important.

182. *Brightscape Endeavours* replaced SFH. Given the collapse of SFH, I see no reason to make recommendations as regards its policies or practices. I do not have detailed information about *Brightscape Endeavours* including its current structure, clientele (i.e. youth in their care), policies, or practices. If high-risk youth with similarly complex vulnerabilities to R.D. continue to be placed with *Brightscape Endeavours*, investigation to ensure adequate controls, supervision, safety planning, and barriers to accessing intoxicants including illicit drugs seems prudent.

183. Finally, R.D. was a young Indigenous female. She was not murdered and is not missing but she is lost all the same. R.D.'s case is another reminder that Indigenous persons are vastly over represented in the child welfare and criminal justice systems and in correctional facility populations. *The Truth and Reconciliation Commission of Canada's Calls to Action* with respect to child welfare and justice are instructive and important.

Dated at the City of Brandon, in Manitoba, this 6th day of April, 2018.

"original signed by ACJ Hewitt-Michta"

Associate Chief Judge Shauna Hewitt-Michta
Provincial Court Judge

APPENDIX A – WITNESS LIST

December 19, 2016:
- Kyle FOUBERT
- Tasha KAYE
- Richard HLADKY
- Matt SENIUK
- James BALDWIN
- Jennifer SEITZ
- Michael BRIOL
- Monica MCLEAN (DAOUST)

December 20, 2016:
- Theresa STANICK
- Michael DIXON
- Dean ENGLISH
- Dennis HOLIAN
- Dean WERBISKI

December 21, 2016:
- Coralee HUSAK
- Denise RICHARDSON
- Erin MCLENNAN
- Bonnie CARNEGIE

December 22, 2016:
- Doctor Arturo TAMAYO
- Doctor Charles PENNER
- Bonnie CARNEGIE (continued)

December 23, 2016:
- J.S.
- Robin BJORNSON

March 9, 2017:
- Doctor Keith JENKINS
- Jennifer STEELE

March 21, 2017:
- Michael POPLE
- Jill LENNON

APPENDIX B – EXHIBIT LIST

1. Manitoba Corrections Binder of Documents
2. Manitoba Corrections – Divisional Review binder
3. Disc of scanned Documents from Dakota Ojibway Child and Family Services; Prairie Mountain Health Authority; and Brandon Fire and Emergency Services
4. Map of Brandon Correctional Center
5. Disc – Critical Incident Video
6. Suicide Risk Assessment of R.D. from BCC, September 20, 2013
7. Package of Prior Risk Assessments for R.D. from COMS
8. Manitoba Corrections Divisional Review – List of 39 Recommendations
9. Procedure for Medication Verification and Continuation (BCC)
10. Brayden Coates – Agreed Statement of Evidence (Brandon Fire and Emergency Services)
11. Curriculum Vitae for Doctor Tamayo
12. Consultation Report – Doctor Tamayo – September 29, 2013
13. Curriculum Vitae for Doctor Penner
14. Physicians Progress Notes – Doctor Penner – October 1, 2013
15. Average Length of Stay for Youth at BCC
16. Procedure for Referral to Psychiatric Services (BCC form)
17. Email from Kelly Sweeny entitled "Juvenile Psychiatric History", July 11, 2014
18. Email, Robin Bjornson, July 14, 2013
19. Specialized Foster Homes Resident Safety Plan
20. Email, Michael Pople. September 30, 2013
21. DOCFS Placement Request
22. Curriculum Vitae for Doctor Jenkins
23. Physician Notes – Doctor Jenkins
24. Specialized Foster Homes Timeline
25. Outpatient and Emergency Report Form
26. Care Conference Meeting Notes, September 25, 2013
27. BCC Psychiatric Services Triage Form
28. Specialized Foster Homes – Resident Safety Plan, April 3, 2013
29. Email Report, Michael Pople
30. Request for Release of Information Form
31. Foster Care Home Medication Records
32. Email Chain
33. Email Chain, September 24, 2013
34. Specialized Foster Homes Quarterly Reports
35. Nursing Notes – Jill Lennon
36. Letter Authored by Jill Lennon