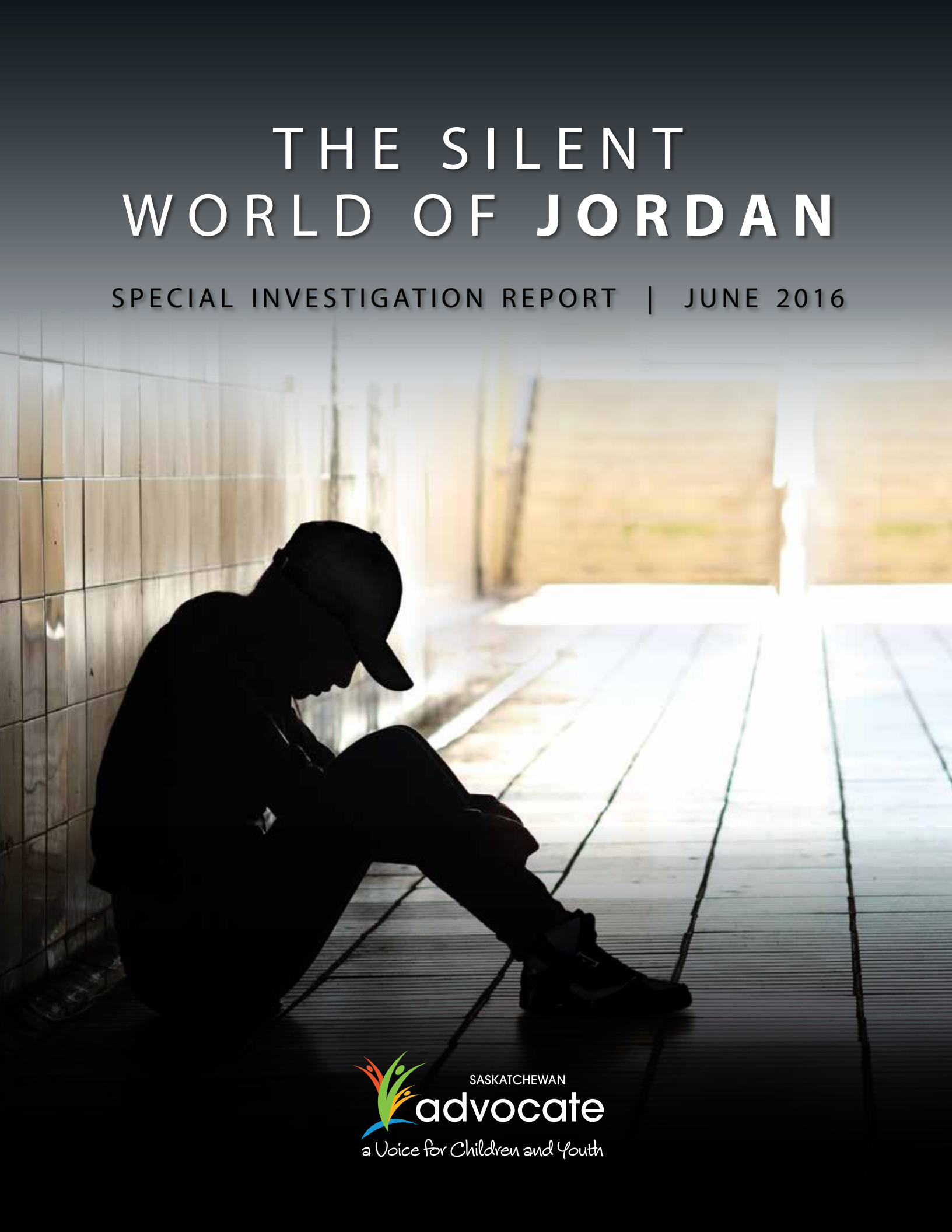
THE SILENT WORLD OF **JORDAN**

SPECIAL INVESTIGATION REPORT | JUNE 2016



SASKATCHEWAN advocate

a Voice for Children and Youth

Letter of **Transmittal**

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June 15, 2016

The Honourable Corey Tochor
Speaker of the Legislative Assembly
Legislative Building
2405 Legislative Drive
Regina SK S4S 0B3

Dear Mr. Speaker:

In accordance with Section 29 of *The Advocate for Children and Youth Act,* it is my duty and privilege to submit to you and the members of the Legislative Assembly of Saskatchewan this special investigation report: *The Silent World of Jordan.*

Respectfully,

Bob Pringle
Advocate for Children and Youth
Province of Saskatchewan

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Executive Summary

This report is an extended account of the services provided to a young First Nations person we are calling "Jordan," while he was incarcerated at a provincial youth facility. Under the legislation governing our office, we are not identifying him by his real name. The services reviewed in this report include those provided by the Ministry of Justice, Corrections and Policing, Ministry of Justice and Attorney General, Courts and Tribunals Division, and Agency Chiefs Child & Family Services Inc. We examined whether Jordan received the services he was entitled to under provincial legislation, policy and practice, in addition to the *United Nations Convention on the Rights of the Child (UNCRC).*

Before one year of age, Jordan experienced a significant hearing loss. When he reached adolescence, his ability to communicate through speech and formal sign language was limited. After accumulating a number of charges, 16-year-old Jordan was eventually remanded to the Prince Albert Youth Residence. Around this time, Jordan's family was also in receipt of support services from Agency Chiefs Child & Family Services Inc.

In spite of the communication barrier, Jordan's initial time at the Prince Albert Youth Residence was uneventful. After four days, staff noticed Jordan walking with a slight limp. He was transported to a local medical clinic and diagnosed with a soft tissue injury. Jordan's health deteriorated significantly in the days following the clinic visit to the point where 911 was called. Approximately 12 hours later, Jordan passed away in the hospital. The cause of Jordan's death was acute bronchopneumonia with associated sepsis. A Coroner's Inquest held in October 2014 identified the manner of death as Natural.

Our investigation found several findings that include:

- When Jordan was admitted to the Prince Albert Youth Residence, we found there was no process to address special or complex needs such as Jordan's. Issues with documentation were also identified, and inadequate recording of key events regarding Jordan actually increased his vulnerability and was not in his best interests.
- Our investigation found that there was no overarching provincial health policy for the Ministry of Justice, Corrections and Policing. However, while there was provincial policy pertaining to Admissions that provided some health-related guidelines, Prince Albert Youth Residence did not develop local procedures to ensure youth have access to health services. This situation was exacerbated by the lack of systematic process within the Ministry of Justice, Corrections and Policing to ensure youth facilities in Saskatchewan are in compliance with provincial policies. The Prince Albert Youth Residence did not take this opportunity to critically examine its practices, which was a barrier for Jordan to receive timely healthcare services, particularly in the period after his initial visit to the medical clinic.
- Jordan had no external symptoms of illness when he was admitted to the Prince Albert Youth Residence, and his entitlement to healthcare was secured when he was examined by a physician on September 16, 2013. However, in the following 48 hours, symptoms indicating Jordan's health was deteriorating were observed by the facility workers and were also reported to the facility by the deputy sheriffs of Court Services. We found that steps were not taken to mitigate Jordan's situation and disagreement by staff with the supervisor's decision compounded matters negatively. After recieving reports of Jordan's illness, decisions were not appropriate, and for an extended period Jordan was denied his entitlement to healthcare services.
- We found Jordan's vulnerability was also elevated when the Prince Albert Youth Residence did not provide a reasonable accommodation based on his hearing impairment. While unintentional, this lack of protection resulted in a situation that we feel was improperly discriminatory and

contributed to his disadvantage. Jordan faced a heavy burden to communicate through gesturing that areas of his body were broken. While the duty to accommodate is somewhat addressed in local procedures and in provincial policies, we found information on the duty to accommodate lacking in scope and substance to raise awareness in the youth justice system of this obligation under *The Saskatchewan Human Rights Code*.

- We found that when deputy sheriffs observed no response after reporting Jordan's illness to their supervisor, they took it upon themselves to expedite his return to the Prince Albert Youth Residence. The deputy sheriffs were operating under the assumption that the youth facility would ensure Jordan received medical attention. We noted that critical information regarding Jordan was not passed on to the Prince Albert Youth Residence supervisor and that Court Services policy lacked guidelines for effective decision making and action in situations that are serious, but not life-threatening.
- Agency Chiefs Child & Family Services Inc. was providing support to Jordan's mother and brothers, but these services did not extend to Jordan. Services were denied on two further occasions when the Agency was informed by law enforcement that Jordan was in trouble, and when the youth court issued a Section 35 referral requesting an assessment of the family home and Jordan's communication needs. The denial of support services to a young person with disabilities increased his vulnerability.

The Advocate recognizes that the Ministry of Justice, Corrections and Policing has undertaken a major re-organization which has resulted in significant changes in youth justice in Saskatchewan. In relation to Jordan's case, the Ministry conducted their own review and many improvements have been implemented as a result of this work and from the recommendations put forward by the Coroner's Inquest.

Several substantive issues with practical value emerged from our investigation. These are addressed in our recommendations which aim to improve services in a way that is more respectful of the entitlements of our young people under the UNCRC.

With this objective in mind, we recommend that:

Recommendation #1: The Ministry of Justice, Corrections and Policing amend the policy, Clinical Supervision Review of Complex, Serious Violent and Violent Offence Cases to broaden the scope of complex cases to incorporate youth with broader complex needs and/or disabilities.

Recommendation #2: The Prince Albert Youth Residence develop procedures that reflect identification, assessment, and referral for planning for the care of remanded youth with complex needs as directed in the Clinical Supervision Review of Complex, Serious Violent and Violent Offence Cases policy.

Recommendations #3: The Ministry of Justice, Corrections and Policing develop and implement a stand-alone healthcare policy to guide effective practice and safeguard the right to health services, which youth in custody are entitled to under Article 24 of the *United Nations Convention on the Rights of the Child.* The new policy should incorporate:

- a directive to facility directors to develop procedural guidelines ensuring youth in custody have access to healthcare;
- explicit guidelines for times when on-site health services are not available; and,
- guidelines for supervisors for administrative decision making, including documentation of decisions, and reporting decisions back to facility staff and to the youth.

Recommendation #4: The Ministry of Justice, Corrections and Policing establish an oversight system for monitoring, reviewing, and approving local policies and procedures to ensure alignment with Ministry policies.

Recommendation #5: The Ministry of Justice, Corrections and Policing develop and implement training for all facility staff on their roles and obligations for the effective management of health-related issues of young persons in custody. Training should incorporate:

- critical thinking skills and their application when assessing the needs of youth;
- proper documentation and reporting back when youth request medical attention, and when health-related concerns of a young person are received by external parties and the youth's parents; and,
- problem-solving when there is conflict among staff and supervisors regarding a health-related decision.

Recommendation #6: The Ministry of Justice, Corrections and Policing develop and implement a policy on its duty to accommodate that outlines the responsibilities, expectations, and processes applicable to youth in custody and youth in the community that includes training for management and staff as part of its implementation.

Recommendation #7: The Ministry of Justice and Attorney General, Courts and Tribunals Division in Prince Albert to develop procedures for non-emergency situations involving young people who are ill or injured and require medical attention. The new procedures should incorporate:

- an overarching statement regarding the right of youth to access healthcare services (UNCRC, Article 24);
- guidelines for deputy sheriffs for reporting health-related concerns regarding a young person;
- guidelines for supervisors for making effective administrative decisions, including the documentation and reporting back to the deputy sheriff and to the youth; and,
- guidelines for effective communication of events or concerns to the youth facility if applicable.

Recommendation #8: That the Prince Albert Youth Residence and Court Services in Prince Albert develop a protocol to govern the roles and responsibilities to ensure youth have timely access to healthcare services.

Recommendation #9: The Agency Chiefs Child & Family Services Inc. review its current caseload to determine the number of children ages 0 to 18 with disabilities to ensure:

- up-to-date assessments are on file;
- youth and families are connected to the necessary supports and services and provide the results of the review to our office within one year of this report.

Recommendation #10: The Agency Chiefs Child & Family Services Inc. examine its internal process when a Section 35 referral is received from the Provincial Court and make any necessary changes to ensure timely responses to meet the needs of youth involved in the youth justice system.

Jordan was a vulnerable youth when he entered into custody and this vulnerability increased when a reasonable accommodation was not provided to ensure he received equal protection under the law. While it is acknowledged that not every situation can be foreseen, it has become commonplace on a national and provincial level for organizations to have policies and practices in place to accommodate individuals with disability-related barriers. The Ministry of Justice, Corrections and Policing did not have a provincial accommodation policy in place. Furthermore, the Prince Albert Youth Residence did not develop and implement local procedures to effectively manage the healthcare needs of youth arising after the admissions process.

Jordan had the right to the highest attainable standard of health (UNCRC, Article 24). All children and youth do. Incarcerated youth are deprived of their liberty and separated from their family. Youth facilities are wholly responsible for their well-being. These circumstances entitle youth to special care and assistance by the state (UNCRC, Article 20). Therefore, the onus on youth facilities to ensure appropriate access to healthcare is high. In light of this incredible responsibility, youth facilities must act in the most protective and preventive manner possible.

1.0 Introduction

The Advocate for Children and Youth is an independent officer of the Legislative Assembly of Saskatchewan. The vision of the Advocate's office is that the rights, interests and well-being of all children and youth are honoured, respected and valued in Saskatchewan communities and in government legislation, policy, programs, and practice.

1.1 Investigative process

The authority to investigate is derived from of *The Advocate for Children and Youth Act*. The Advocate may investigate any matter concerning services provided to children and youth by a provincial ministry, agency of the government or publicly-funded health entity.

Investigations by the Advocate are approached using the principles of impartiality and fairness. Outstanding issues regarding services to children are investigated to determine if legislative, policy, or practice changes are required. In the services to Jordan, the substantive issues revolved around the duty to accommodate, the right to non-discrimination, and the right to health services.

The recommendations emerging from the investigation form the basis to advocate for service improvements. While recommendations are not binding or mandatory, the expectation is that government ministries, agencies or publicly-funded health entities will carefully consider implementing the changes necessary to enhance the safety and well-being of children and youth in Saskatchewan.

We recognize the value in viewing services to youth through a child rights lens and acknowledge that children and youth have rights under the UNCRC (Articles 1-54) until they reach the age of 18. [1] This report makes comment to several of the articles under the *UNCRC*.

The office of the Advocate has also embraced the *Touchstones of Hope for Indigenous Children, Youth, and Families: Reconciliation in Child Welfare.* [2] The principles of reconciliation encourage Aboriginal and non-Aboriginal peoples to engage in a process of acknowledging and learning from our harmful past. Through this process we can generate mutual understandings of our future direction.

Our office views the youth justice system as a critical component of reconciliation given the vast number of young people incarcerated or on community orders in Saskatchewan are First Nations and Métis youth. The Truth and Reconciliation Commission of Canada released its final report in December 2015. One of the Commission's 94 Calls to Action is directed at the youth justice system, *"…that the federal, provincial, territorial, and Aboriginal governments to commit to eliminating the overrepresentation of Aboriginal youth in custody over the next decade."* [3] Embracing the spirit and principles of the *Touchstones of Hope* is a critical step to achieving the Truth and Reconciliation Commission call for addressing the overrepresentation of First Nations and Métis youth in the justice system as a whole.

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1. United Nations General Assembly. Convention on the Rights of the Child. 1989. Available from: // www.unicef.org/crc/

2. Blackstock, C., Cross, T., George, J., Brown, I., & Formsma, J. Reconciliation in child welfare: Touchstones of Hope for Indigenous children, youth, and families. Ottawa, ON, Canada: First Nations Child & Family Caring Society of Canada / Portland, Or: National Indian Child Welfare Association, 2006. More information on the Advocate for Children and Youth's adoption of these principles is available at: http://www.saskadvocate.ca/children-youth-first/touchstones-of-hope

3. Truth and Reconciliation Commission of Canada: Calls to Action, 2015.

1.2 Reviewing services to a young person

In 2013, the Advocate was notified of 16-year-old Jordan, who died unexpectedly while on remanded status at a provincial youth facility. [4] Notification of his death was received from the Ministries of Social Services and Justice, Corrections and Policing. The Autopsy Report identified the cause of death to be acute bronchopneumonia with associated sepsis (see text box).

4 Each youth facility in Saskatchewan has detention and remand spaces which are designated for youth until their first court appearance or until they are sentenced in youth court. Ministry of Justice, Corrections and Policing, "Young Offender Programs." Accessed at http://www.justice.gov.sk.ca/Default.aspx?DN=7b77b288-fa60-40b8-9d13-02c8b4540b28 on February 10, 2016.

Sepsis-Associated Deaths

Bronchopneumonia is a type of pneumonia – an inflammation of the lungs caused by infection from viruses, bacteria or fungi. The same viruses that cause colds and flu also cause most cases of viral pneumonia. The symptoms of bronchopneumonia include fever, coughing, sweating, chills, muscle aches, and fatigue. A chest x-ray is one of the best ways to diagnose this condition.

Sepsis is a life-threatening complication of infection, which most often occurs in people who are elderly or have weakened immune systems. If not treated quickly, it can lead to multiple organ failure and death. It is estimated 30% to 50% of people who develop sepsis die from it.

According to a recent Statistics Canada study, 1 in 18 deaths involved sepsis in Canada in 2011. Sepsis can either be an underlying cause of death or a contributing cause. Sepsis contributed to more than half of all deaths from infectious diseases in Canada between 2009 and 2011. The age-standardized sepsis-associated mortality rate for 2011 was 27.5 deaths per 100,000 people. Between 2009 and 2011, deaths were highest among those 85 and over at 587.5 per 100,000. Adolescents and young adults, in contrast, were among those least likely to have sepsis contribute to their deaths, at a rate of 0.8 per 100,000 population, and just 2.2% of all deaths among those 15 to 19 involving sepsis.

Sources:

Martel, J. (2015) "Bronchopneumonia", Retrieved from: www.healthline.com/heath/bronchopneumonia?print+true

Navaneelan, T., Alam, S., Peters, P., and Phillips, O. (2016) "Deaths Involving Sepsis in Canada." Health at a Glance. Ottawa: Statistics Canada, cat no. 82-624-X.

O'Connell, K & Higuera V. (2015) "Sepsis" Retrieved from: www.healthline.com/health/sepsis?print=true

The Advocate received and reviewed the Ministry of Justice, Corrections and Policing internal review, which contained 15 recommendations. Our office was also present at the Coroner's Inquest held in October 2014. The six-person jury identified the manner of death as Natural, and an additional five recommendations were made to the Ministry of Justice.

Our office reviewed these external processes referenced above and found several issues that were not comprehensively examined. We determined that an investigation into the services provided to Jordan was warranted, and a notice was served to the Ministry of Social Services, Agency Chiefs Child & Family Services Inc., Ministry of Justice, Corrections and Policing, and Ministry of Justice and Attorney General, Courts and Tribunals Division. [5]

All files pertaining to Jordan's case were obtained and reviewed. We conducted 33 interviews with members of Jordan's family and ministry staff that had involvement in providing service to this young person. Consultations with individuals in senior management within the Ministry of Justice, Agency Chiefs Child & Family Services Inc., and individuals from other organizations occurred. It should be noted that the majority of staff in the supervisory and facility director roles in both Ministry of Justice, Court Services, and Corrections and Policing, were in an 'acting' capacity. For brevity, rather then use the term 'acting' we simply refer to the titles of supervisor and facility director as appropriate to ensure clarity of roles.

The Advocate's staff also met with members of Jordan's family, including his mother, father and younger brother. This connection with family was pivotal to our understanding of the person who was their son and brother. We are thankful for the many conversations that occurred over the course of this investigation.

5. In Saskatchewan, Court Services are part of the Courts and Tribunals Division.

2.0 Chronology of Events

2.1 Brief summary of Jordan's childhood

Jordan was a fraternal twin and one of eight children born to his parents. He was of Cree heritage and lived with his family in a First Nations community in Northwest Saskatchewan. At four months old, Jordan became ill with meningitis that left him with a hearing impairment, confirmed by a specialist at the age of one year. Jordan lacked hearing ability in one ear and had slight hearing in the other for which he used a hearing aid. Jordan's parents could not recall being connected to ongoing services for sign language or other early learning opportunities after their son's hearing loss was identified.

His mother reported that Jordan liked school, but he stopped wearing the hearing aid at school due to teasing from the other children. Jordan had limited sign language ability, and it was not until he was 10 or 11 years old that the school attempted to teach him. He learned to sign his numbers and the alphabet. However, in the absence of any systematic learning of a formal method to communicate, Jordan developed his own method of hand signals.

Jordan eventually obtained access to a teacher's aid that reportedly had formal training in American Sign Language, although the level of instruction provided to Jordan is unknown. According to Jordan's parents, he did not always understand when the teacher attempted to communicate with him, and they believed he often chose not to engage with the teacher.

In spite of his disability, Jordan's parents indicated that Jordan was an active boy who liked to play outdoors. He had a natural talent for drawing and enjoyed drawing pictures from books.

2.2 Involvement in youth justice and child welfare systems

At the time of his justice involvement, Jordan was a grade nine student. Prior to the charges he accumulated in the months before his incarceration in September 2013, Jordan had no significant involvement in the youth justice system. In May 2013, Jordan was charged with Break and Enter at the elementary school, where damage occurred and items were stolen. When he did not attend court on July 9, 2013, a warrant was issued for his arrest to ensure his attendance in court on August 13, 2013.

Due to the involvement of Jordan's brothers with youth justice and other issues within the family, Agency Chiefs Child & Family Services Inc. (thereafter called the Agency) became involved under Section 5 of *The Child and Family Services Act.* [7] A family support worker was tasked with providing support services to the family, and a Parental Services Agreement was established with Jordan's mother in July 2013. The appropriateness of the Parental Services Agreement is questionable given no Intake Report, Investigation Record, or Risk Assessment was found in the family services file, contrary to provincial policy. [7]

The Parental Services Agreement identified the separation of Jordan's parents, and other stressors in the family stemming from addictions, loss and grief, and involvement of the brothers in the youth justice system. The interventions aimed at Jordan's mother and two brothers appeared to be appropriate even though family assessment and case plans were not found in the file. Jordan is named on the Parental Services Agreement, however the interventions in the agreement were not directed at him.

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6. Section 5 of *The Child and Family Services Act* enables the Agency to provide services in the home to support the family in meeting the best interests of the child.

7. Ministry of Social Services, Family-Centred Services Manual, Sec. 2.5, 3.4, 3.11.

Parental Services Agreements

A Parental Services Agreement is a voluntary agreement between a child's parents and either the Ministry of Social Services (MSS) or the First Nations Child and Family Services Agency involved with the family, reflecting their desire to work together in the interests of the child. The agreement outlines the reason for Child and Family Services involvement and identifies the tasks and outcomes to be achieved by the parents and MSS or Agency staff. These agreements are typically 120 days in length and are renewed or amended as necessary. If the Ministry or Agency staff believe a child requires protection, either or both parents will be asked to sign a Parental Services Agreement. If parents are unwilling to sign an agreement, MSS or the Agency is required to make an application to the court for a protection hearing, for a judge to determine whether the child is in need of protection.

A contact record indicates on August 9, 2013, Jordan was arrested by the RCMP after allegedly assaulting a couple with a knife while intoxicated. He was placed in detention cells and charged with assault with a weapon.

The RCMP contacted the Agency, who advised that Jordan was not in their care and could be released to his mother. He was released on an undertaking with conditions to abstain from any contact with the victim, and from consuming alcohol or drugs. The Agency could not explain why it did not take this opportunity to provide services to Jordan in light of its involvement with his family.

Jordan attended Provincial Court in his community with his mother on August 13, 2013, and he was released with conditions. The court was adjourned to September 10, 2013 to give Jordan an opportunity to apply for Legal Aid. He did not attend court on September 10, 2013, and a warrant was issued and held until October 15, 2013.

2.3 Circumstances leading to new charges

On the evening of September 11, 2013, Jordan incurred new charges for assaulting a RCMP constable and for breaching the conditions of his previous order. The police had responded to a call regarding a fight involving some youth outside the school.

The RCMP contacted Emergency Medical Services (EMS) due to some observed injuries Jordan received. EMS determined that Jordan had minor cuts to his arms and legs, which were consistent with a physical altercation. He had no symptoms of illness or major trauma, and he refused to be transported for further medical attention. The paramedics told the RCMP to contact them if Jordan changed his mind and wanted medical treatment.

Jordan was initially transported to RCMP detention cells, held until youth court on September 12, 2013, and was remanded to custody pending his matters. Jordan was transported to Prince Albert Youth Residence (PAYR) [8] on September 12, 2013, with his next court appearance scheduled for September 13, 2013. The RCMP spoke to Jordan's mother who indicated she would attend court in Prince Albert on September 13, 2013.

2.4 Initial custodial period

Upon arrival to PAYR, the RCMP advised the remand staff that Jordan had problems with communication. At admission, the difficulty in obtaining information from Jordan due to his disability was noted in both the internal review conducted by the Ministry of Justice, Corrections and Policing, and in our interviews for this investigation. Jordan's name, birthdate and charges were extracted from the remand warrant. Historical information on file was used, as Jordan's brothers had been involved in the system before Jordan's time.

The facility staff contacted the community youth worker to obtain further

information about how to communicate with Jordan. Staff attempted to contact the Agency as another collateral source, however they were unable to reach anyone, nor were they able to reach Jordan's mother.

While the Admissions Record form was completed as comprehensively as it could be considering Jordan could not communicate, Jordan's hearing and speech impairment was not documented, nor was the form signed by the worker. The Health Screen form noted Jordan had a bruise on his right shoulder, and no present problems with illness. The bottom two-thirds of this form, requiring information on personal aids such as hearing aids or glasses was blank. There is no documentation indicating Jordan received an orientation following his admission to PAYR.

After his admission to PAYR, Jordan was assigned a primary worker and was placed in his room to serve 24 hours of building confinement as per facility practice for new admissions. Provincial policy allows for an initial period of assessment and stabilization for *up* to 24 hours. During this time, the youth is confined to their cell so facility workers can observe and monitor the youth.

Jordan appeared in court to address his charges on September 13, 2013. As he could not comprehend the court proceedings due to his hearing and speech impairment, the court was adjourned to September 18, 2013, to obtain some assistance from Jordan's teacher for translation purposes. The courts also ordered a Judicial Interim Release [9] report to be completed by a community youth worker from the Ministry of Justice, Corrections and Policing. A Section 35 child welfare referral [10] was also made to assess the suitability of the family residence for Jordan's release, and his communication needs.

Jordan was re-admitted to PAYR and required to serve a 12-hour period of building confinement. PAYR and other youth facilities refer to this as building confinement, even though youth are confined to their rooms. Documentation indicates this period of confinement was for stabilization purposes and was not a consequence of negative behavior. There was no indication that staff attempted to communicate the reason for the back-to-back periods of confinement to Jordan or his right to appeal this decision.

After his period of stabilization, Jordan participated in the regular weekend activities that included basketball in a secure outdoor space. On September 14, 2013, the primary worker and another facility worker attempted to communicate with Jordan using sign language. However, Jordan was not able to comprehend it. The primary worker was not scheduled to work after September 14, 2013, which contributed to a lack of continuity in overseeing Jordan's needs.

During the outdoor activity on the evening of September 15, 2013, Jordan motioned to the facility workers to communicate that he had been kicked in the back. During shower time, Jordan motioned that he had a rash on his chest and back and was provided ointment. A facility worker reported that Jordan had complained of a sore back later that evening, and the workers discussed that he should see a doctor. However, none of these interactions with Jordan were documented.

2.5 Identifying the need for health services

On the morning of September 16, 2013, the Director of Operations was advised of Jordan's hearing impairment and, as she knew some sign language, she attempted to communicate with him. Jordan did not respond to her in sign language. Instead, he used his fists to make a breaking motion, and pointed to his knee and his hip. Not understanding what Jordan was communicating, the Director of Operations talked to other staff and learned that Jordan had been complaining of a sore back the previous evening. At this point, she instructed the Central Communications Coordinator to monitor him.

8. Prince Albert Youth Residence is one of four youth facilities in Saskatchewan that provides both open and secure custody services.

9. Judicial Interim Release is an assessment of risk of managing the youth in the community.

10. Under Section 35 of *The Youth Criminal Justice Act,* a youth court judge may refer a young person to child welfare who will assess whether their services are necessary to meet his or her needs. The Section 35 referral may be undertaken at any stage of court proceedings.

By midday, another facility worker observed Jordan walking with a limp, and he requested to stay in his room for lunch. The worker reported he was concerned something was wrong with Jordan, and he instructed the Central Communications Coordinator to arrange for a medical transport for him. None of Jordan's complaints or the events leading up to the medical escort were documented.

2.6 Medical escort

Jordan was transported to a walk-in medical clinic.The workers advised the physician that Jordan could not hear or speak and that he was complaining of a sore back. When the physician asked Jordan about his problem, he motioned to his left side. The physician observed minor swelling on Jordan's back and had concluded that he had a soft tissue injury. He instructed the workers to give him ibuprofen 2-3 times per day as needed.

The 'Instructions for Care' form was not found on Jordan's custody file. This form is described to be a stand-alone form, developed by PAYR. After returning to the facility, Jordan was given two acetaminophen tablets, which had been recorded on the Non-Prescription Medication Chart. It is unknown why staff deviated from the physician's instructions to provide ibuprophen. No documentation relating to Jordan's condition or the outcome of the clinic visit was found in the Staff Recordings. The Ministry's internal review noted that staff had observed Jordan in pain later that evening.

2.7 Refusal by Agency to provide services

On the morning of September 16, 2013, the community youth worker called the Agency to advise of Jordan's status, upcoming court date, and to follow-up on the child welfare referral (Section 35) ordered by the court. According to file documentation, the Agency advised the community youth worker it would not be involved even though they were providing support services to his mother and brothers through the Parental Services Agreement.

To complete the Judicial Interim Release report, the community youth worker and Jordan's father met with Jordan at PAYR on the morning of September 17, 2013. The Central Communications Coordinator advised Jordan's father of Jordan's clinic visit and requested that his father determine if there were any further concerns with Jordan that the facility should know.

In our interviews with the community youth worker and Jordan's father, both stated that Jordan was limping when escorted to the interview room. Jordan gestured that he was hurting down one side, and he motioned to his hip. The community youth worker recalled that Jordan was sweating, breathing heavily, and seemed distracted at times.

After the visit, Jordan returned to his cell. The community youth worker and father had a brief visit with Jordan's younger brother who had also been remanded to the facility. The community youth worker recalled the father telling his son to monitor Jordan because he did not look good. Jordan's father stated that he asked the facility worker to take his son to the hospital as Jordan had motioned that his side was hurting. He said the worker advised him that Jordan had already been to the doctor the previous day. Jordan's father recalled that he was very concerned about his son's condition and felt dismissed by the facility worker about his concerns.

The community youth worker also communicated her observations to the facility worker that Jordan was in a lot of pain and was breathing heavy. She suggested he might need more medication. These conversations were not documented, nor did it appear any discussion occurred amongst facility staff to determine if a return visit to the medical clinic was required in light of these new observations. After the meeting, Jordan spent the majority of his time sleeping in his cell. He was not offered any ibuprofen in spite of concerns received that he appeared to be in significant pain.

2.8 Observations of deteriorating health

On the morning of September 18, 2013, a facility worker entered Jordan's cell to help him get ready for court and he noticed Jordan had urinated on himself.

He also observed Jordan as having difficulty bending over to get dressed.

Our review of the video footage of Jordan walking slowly towards the holding cell revealed that his limp was more pronounced compared to the previous day. Also noted was Jordan stumbling against the guardrail when exiting the building to get to the court van. After reviewing the video footage of Jordan at PAYR for the purpose of their investigation, the Prince Albert Police Service also concluded that Jordan's condition had progressively deteriorated. [11]

Several of the staff, including the facility director, observed Jordan limping as he left for court and had reported to our office that Jordan appeared to be in significant pain. Up to this point, there was no evidence that any discussion among staff occurred regarding Jordan returning to medical clinic for further assessment.

2.9 Second court attendance waived due to illness

Court Services deputy sheriffs arrived at PAYR at 8:25 a.m. on September 18, 2013, to transport four young offenders to Provincial Court. A facility worker advised the deputy sheriffs that Jordan had a sore hip and was hearing impaired. Based on this information, the deputy sheriffs shackled and handcuffed Jordan separately from the other youth. One deputy sheriff saw him struggling and allowed Jordan to lean on him for assistance to get into the holding compartment of the court van.

After arriving at the courthouse, the same deputy sheriff assisted Jordan to exit the van. Jordan walked to the stairs leading to the cell block but, due to his limited mobility, he was carried into the cell block entrance and into a wheelchair for assistance. At this time, the other deputy sheriffs working in the cell block were told that Jordan had a sore hip and was hearing impaired.

Jordan was escorted to an observation cell and the supervisor used hand gestures to obtain information from Jordan about his pain. Jordan motioned down the side of his leg. As per standard practice when questions emerge regarding a 'prisoner', the supervisor is required to contact the sending facility. In this case, PAYR advised that Jordan had seen a doctor earlier that week and was taking ibuprofen to control pain associated with back or leg issues.

The deputy sheriffs observed Jordan through the security camera monitors located in the control desk area. Jordan was seen constantly moving from the wheelchair to the water fountain, then lying on the concrete bench and the floor. At one point, Jordan fell to the floor as a result of not being able to get back into the wheelchair. The deputy sheriffs immediately attended to him and attempted to gain more information regarding his pain. Again, he motioned with his fists, pointing to his hip and groin area.

The deputy sheriffs informed the supervisor of their concerns regarding Jordan's condition, adding that he was noticeably shaky and pale. The supervisor reiterated that Jordan had been to the doctor and dismissed their concerns. At that point, one deputy sheriff took it upon herself to call Jordan's lawyer to inform her that Jordan was not well and needed to go to the hospital. Considering that deputy sheriffs typically do not make these kinds of calls, Jordan's lawyer spoke to the crown prosecutor, who agreed to waive his attendance in court. His lawyer recalled that Jordan did not look right, stating, *"I remember agreeing that I thought he should leave. Like it seemed evident to me he should go see a doctor."* [12]

Jordan's matter was accelerated to return him to the facility for assistance and his court appearance was adjourned to September 20, 2013. As the Agency was not in attendance, the Judge ordered their representation for the next court date stating, *"This lad has problems, to put it mildly with communication, and I'd like someone to deal with what are the prospects of teaching him sign language where he lives or elsewhere."* [13]

11. Prince Albert Police Service, Investigation Summary, December 2, 2013.

12. Interview with Legal Counsel, Legal Aid Saskatchewan, Saskatoon, SK, October 23, 2015

13. Court Transcript, Prince Albert Provincial Court, September 18, 2013.

While waiting to return to PAYR, Jordan was observed on the monitor banging the wheelchair into the cell door. When the deputy sheriffs attended his cell, Jordan motioned that he wanted to vomit, and he pointed to his hip. The supervisor was advised of Jordan's worsening condition, and he agreed to expedite his transport back to PAYR. The deputy sheriff working the control desk contacted PAYR to advise that Jordan was returning because he was not well and needed medical attention.

2.10 Return to PAYR

Jordan was not shackled or handcuffed on the transport back to PAYR as he was not believed to be a safety threat, and because he was in significant pain. Deputy sheriffs called PAYR to advise that they were en route with Jordan, reiterating that he was not well. They advised further of the need to carry Jordan into the court cells and that he had been provided the use of a wheelchair.

The deputy sheriffs then requested staff to meet them outside the remand unit with a wheelchair to assist Jordan. The Central Communications Coordinator advised the facility director that the deputy sheriffs had reported Jordan was quite sick and had requested assistance. However, according to our information and the Ministry's internal review, this request was dismissed by the facility director. The rationale for denying assistance is unknown. Our review of the PAYR video shows Jordan walking very slowly into the building using the guardrail for support just before entering the front door.

The facility director advised he could not recall details of a conversation with the Central Communications Coordinator or if he was present in the remand unit when Jordan returned from court. Our office confirmed that there was no conversation among the facility workers and facility director regarding the need to have Jordan reassessed by medical professionals. Upon receiving concerns from the deputy sheriffs regarding Jordan's health, it is apparent that the facility director's decision was that Jordan would not receive further health services.

Jordan was re-admitted to PAYR and placed in a cell beside his brother and served another 12 hours of building confinement. The Non-Prescription Medication Chart indicated he had ibuprofen at 2:00 p.m. Over 24 hours had passed since the last dosage, suggesting Jordan's condition was not adequately monitored. A facility worker reported that due to his level of pain, Jordon could not initial the Non-Prescription Medication Chart, so the worker checked it off for him.

2.11 Further deterioration and lack of response

During the shift exchange at approximately 3:00 p.m., the afternoon staff were briefed about Jordan and the pain he was experiencing. At supper, staff attended to Jordan's cell and one worker noticed Jordan was pale and trembled slightly when he moved. He motioned for more ibuprofen, but the worker indicated that he had to wait as it was confirmed his last dosage was at 2:00 p.m. that day. Ibuprofen was given to Jordan at 6:45 p.m. Facility workers entered Jordan's cell because he was too ill to sit up and swallow the medication, which he consumed while lying down.

Facility workers entered Jordan's cell again at 9:00 p.m. to serve night lunch. They noticed he was lying on the bed, trembling and whimpering quietly. All three workers agreed that not only had Jordan's health declined in the past couple of days, but there was a noticeable deterioration since they last entered the cell at 6:45 p.m. Based on this discussion, they immediately notified the supervisor.

Upon receiving concerns regarding Jordan, the supervisor immediately attended Jordan's cell accompanied by two facility workers. When she asked Jordan where he was sore, he motioned to his back. Jordan moved his clothing aside, and staff saw a red swelling approximately two inches in diameter on top of his spine. She pressed around the redness and also felt Jordan's forehead with the back of her hand and noticed he had a temperature.

The two staff and supervisor exited Jordan's cell and returned to the staff office to discuss the situation. The facility workers advised our office that they expressed their concerns to the supervisor of Jordan's worsening condition and that he should be reassessed by a doctor. The

supervisor reviewed Jordan's custody file and found no documentation about the doctor's visit or the Instructions of Care for him. She spoke to the facility worker who had escorted Jordan to the doctor and asked him to explain what happened when the doctor examined Jordan. She then instructed the worker to document the information on the Staff Recordings.

At approximately 9:30 p.m., the supervisor sent an email to two facility directors and the day supervisor explaining that Jordan had some *"…reddening on his back at the bottom of his spine"*. She also stated that Jordan had been to the doctor two days prior, and that her plan was to comply with the physician's instructions to give him ibuprofen. She then requested the day supervisor to reassess the situation in the morning. This email did not include critical observations from remand staff regarding Jordan's deteriorating health that had emerged since the doctor's visit.

The facility worker followed up with the supervisor, who advised of the plan to comply with the physician's instructions for Jordan to take ibuprofen and that no transport to the hospital would occur at that time. She explained that she sent an email to the facility directors, and was waiting for a response. The facility worker replied that she was concerned with this, as she strongly felt that Jordan needed to see a doctor.

At 10:45 p.m. Jordan motioned to the facility worker to come into the cell, and he waved his hands over his face. In the cell next door, staff reported that Jordan's brother yelled at the worker to feel Jordan's forehead, which he did and found it hot to the touch. A facility worker called the supervisor and advised that Jordan had a high fever, and he had deteriorated even further. The supervisor replied that she was briefing the night supervisor about the situation, and was maintaining the current plan to assess him in the morning.

2.12 Jordan's turn for the worse

During the shift exchange at 11:00 p.m., the afternoon staff told the night staff of Jordan's situation and stressed to call an ambulance if he showed any further signs of distress. While conducting the routine count of the youth, the facility worker noticed Jordan was lying face down on the bed and that he was sweating and shaking. Jordan motioned to his throat as if to say he could not breathe. The facility workers entered Jordan's cell, and one worker concluded that Jordan was in obvious distress. He informed his co-worker he was going to report Jordan's condition to the night supervisor, stating that, *"This boy needs to see a doctor. We have to phone for an ambulance."* [14]

The night supervisor had been told by the afternoon supervisor that she had assessed Jordan earlier and to monitor him because he was in pain, had a fever, and a swollen red mark on his back. The night supervisor reported to our office that he recalled the afternoon supervisor mentioning the doctor's visit, but she did not communicate that staff had previously requested a medical escort for Jordan, nor did she mention that she had emailed the facility directors.

The night supervisor confirmed that he was informed by the night staff that Jordan was sick and needed to go to the hospital immediately. However, due to the disruptive behavior of some youth on the open custody side of the building, he could not attend to remand until the open unit was stable. While waiting for the night supervisor, Jordan's brother yelled out that Jordan was vomiting. When they attended to his cell, the workers saw Jordan had vomited what appeared to be congealed blood. The workers returned to the staff office, called the night supervisor and advised that Jordan was vomiting, and an ambulance was needed as soon as possible.

At approximately 11:30 p.m. the night supervisor assessed the situation and observed Jordan briefly through the cell window. During the interview with our office, he stated, *"…just the kid's eyes told me he needed to go."* [15] The supervisor returned to the staff office and started calling additional staff to come in. A facility worker was helping Jordan change his clothes as he had difficulty getting to the toilet and had urinated on himself. This worker returned to the staff office and strongly advised the night supervisor

14. Incident report by Facility Youth Worker, PAYR, September 19, 2013.

15. Interview with Night Shift supervisor, PAYR, Saskatoon, SK, November 17, 2015.

that Jordan required *immediate* medical attention. The supervisor then instructed the other facility worker to call 911. Our office confirmed the call was made at 11:49 p.m.

EMS arrived at PAYR at 11:59 p.m. The paramedics decided to transport Jordan to the hospital immediately. During our investigation, our office met with the Director of Operations at Parkland Ambulance Care, who confirmed Jordan's blood pressure was lower than normal, and his heart rate was high. The only obvious injury or illness was to his abdomen. He vomited blood twice in the ambulance. He advised further that low blood pressure and a high heart rate are consistent with a diagnosis of sepsis.

A facility worker accompanied Jordan in the ambulance to the hospital, while another worker followed in the transport van. The ambulance arrived at the hospital at 12:32 a.m. on September 19, 2013. Sadly, Jordan passed away later that day.

3.0 Advocate's Findings

In the nearly three years since Jordan's death, the Ministry of Justice, Corrections and Policing have made several improvements in response to the recommendations derived from its internal review and the Coroner's Inquest. From both processes, a total of 21 recommendations were made and a work plan, documenting the actions of the Ministry to address these, was forwarded to our office in November 2015. These recommendations covered a broad range of changes required to address the issues identified, which included but are not limited to: improving documentation standards; amendments to the Admissions policy related to documentation and the collection of health information; strategies to improve communication between workers, supervisors and facility directors; consistency in assigning primary caseworkers to remanded youth; and securing a nursing position to ensure prompt access to healthcare. While our office is encouraged by the Ministry's progress in response to these recommendations, we have identified a number of potential areas of improvement requiring a further commitment by both the Ministry and the Agency.

The following findings reflect the substantive issues stemming from our investigation into the services Jordan received prior to his death. A broad scope of inquiry had been undertaken given that these services were examined through a child and youth rights lens. Our investigation found that gaps in policies and/or practices of both the youth justice *and* child welfare systems compromised the safety and security that was rightfully due to a vulnerable youth such as Jordan. We have identified a number of deficiencies in provincial policy regarding youth with complex needs, access to health services, and accommodation of youth with disabilities in youth facilities. Consequently, we have made recommendations to strengthen these service areas.

Our investigation also found the processes of monitoring and making decisions on behalf of youth in custody who require health services or an accommodation were inadequate, and we have made several recommendations to address the training requirements in these important areas. Further, Court Services has responsibility for young people in the short-term and therefore, must also take adequate steps to ensure their safety and well-being. We found procedures were insufficient for youth who require healthcare services and the communication at the supervisory levels between PAYR and Court Services in Prince Albert was lacking. Lastly, in response to findings reflecting the denial of services by the Agency, we made recommendations to ensure that children and youth with disabilities or who are in conflict with the law receive the services necessary to support them.

3.1 Poor attention to youth with special or complex needs

Finding 1: ***The documentation completed by Prince Albert Youth Residence at the time of admission until Jordan passed away lacked quality and was non-compliant with Ministry policy.***

During the difficulties encountered in admitting Jordan to PAYR on September 12, 2013, the staff took appropriate

steps in problem-solving the situation. However, none of these steps were documented. The Facility Admission form and the Health Screen form were not completed as per policy standards. [16] Furthermore, none of the documents on Jordan's custody file identified his hearing or speech impairment. Given that Jordan was a new resident, policy required that he receive an orientation at the time of admission to PAYR. No documentation was found to demonstrate this occurred.

In addition to these lapses in documentation at Jordan's admission, an overall absence of documentation was found throughout Jordan's time at PAYR to reflect crucial events regarding his health. There was no documentation that external parties had forwarded concerns that Jordan was ill and required medical attention.

The Ministry's internal review and the Jury at the Coroner's Inquest found documentation was insufficient and made several recommendations to amend this practice. These required PAYR to develop local procedures for proper documentation of medical escorts, to improve documentation of communication between workers regarding youth, and training for all PAYR staff on proper documentation. Further, an amendment to the Admissions to Youth Custody Facilities policy was made in 2015, which includes a new section entitled "Documentation of Young Persons" at the admission stage. [17] Due to the significant actions by the Ministry to address the issue of documentation, our office will not be making a recommendation in this regard.

Finding 2: ***There was an absence of policy that would trigger Jordan's case to be elevated to the Director of Clinical Services for review, which would have resulted in recommendations to address Jordan's complex needs in an expedient manner.***

There was no evidence that Jordan's circumstances were elevated to the facility director at the time of admission or that a plan was contemplated to accommodate his needs in the short-term. The admissions system at PAYR lacked direction to link Jordan to a case management process for a young person with complex needs.

Our office reviewed the Ministry's policies relating to youth with challenging circumstances and found that policy did not clearly define how staff would manage Jordan's needs. According to the Clinical Supervision Review of Complex, Serious Violent and Violent Offence Cases policy, [18] Jordan's circumstances did not invoke the application of this policy, as the definition of 'complex cases' is predominantly aimed at youth with mental health issues.

As highlighted in a Special Report for the Manitoba Office of the Children's Advocate, 'complex needs' are typically viewed as *"… a population of young people experiencing a multitude of issues that cross multiple service sectors"* (Child Welfare League of America, 2007). [19] It is arguable that Jordan fit this profile given his recent involvement in the youth justice system, and that of his family in child welfare. It was evident Jordan was facing issues with serious consequences that were impacting his well-being. He was admitted to PAYR with a limited ability to communicate, and there were no interventions provided to address this barrier. When his health began to decline, Jordan's situation eventually reached a critical state.

A more inclusive definition in the Clinical Supervision Review of Complex, Serious Violent and Violent Offence Cases policy would expand opportunities for youth facilities to utilize the Director of Clinical Services as a safeguard when youth present with particularly challenging circumstances. This change would also ensure that specialized case planning is occurring immediately upon admission when the youth's needs are identified.

16. Admission to Youth Custody Facilities, Ministry of Justice, Corrections and Policing, effective March 6, 2013.

17. Admission to Youth Custody Facilities, Ministry of Justice, Corrections and Policing, effective March 1, 2015.

18. Clinical Supervision Review of Complex, Serious Violent and Violent Offence Cases, Ministry of Justice, Corrections and Policing, effective April 25, 2012.

19. Burnside, L. Youth in Care with Complex Needs: A Special Report for the Office of the Children's Advocate, 2012, p.11.

Recommendation #1: The Ministry of Justice, Corrections and Policing amend the policy, Clinical Supervision Review of Complex, Serious Violent and Violent Offence Cases to broaden the scope of complex cases to incorporate youth with broader complex needs and/or disabilities.

Recommendation #2: The Prince Albert Youth Residence develop procedures that reflect identification, assessment, and referral for planning for the care of remanded youth with complex needs as directed in the Clinical Supervision Review of Complex, Serious Violent and Violent Offence Cases policy.

3.2 Barriers to accessing health services

Finding 3: ***The Ministry of Justice, Corrections and Policing lacked effective provincial health policies and procedural guidelines to direct staff in reporting, and decision making regarding accessing services for youth.***

Finding 4: ***The Prince Albert Youth Residence failed to develop local procedures as directed in the Ministry's Admission to Youth Custody Facilities policy that references healthcare access.***

The Ministry of Justice, Corrections and Policing advised our office that there is no provincial stand-alone healthcare policy applicable to young offenders in Saskatchewan. Instead, the Admission to Youth Custody Facilities policy is a Ministry policy with references to health services and health screening embedded in the policy. Jordan received an initial health screen on September 12, 2013, as per policy. However, subsequent health screens did not occur when he returned from court on September 13, 2013, and when deputy sheriffs reported concerns to PAYR regarding his health on September 18, 2013.

This Ministry's Admission policy instructed facility directors to establish local procedures that "*…ensure the young person is able to access health services throughout his or her incarceration.*" [20] This policy came into effect in March 2013, six months before Jordan's admission to PAYR. The PAYR Orientation and Procedures Manual covers health-related areas such as temporary health coverage, medication, and medical data. [21] However, procedures outlining access to health services could not be found. We identified this as a gap relating to the healthcare needs of youth after the admission process is complete.

Furthermore, the Ministry advised our office there was no oversight mechanism to ensure facility directors established local policies and procedures when required. The directive by the Ministry was an opportunity for PAYR to critically examine its local practices to determine if it reflected 'best practice' and if any barriers existed for youth to access healthcare services.

Although no written procedures were developed, a local practice reflecting the 'chain of command' principle was in place where facility workers would inform the supervisor when an injured or ill youth required health services. Decisions to approve a medical transport are made by the supervisor. At the time Jordan was in custody, PAYR did not provide any health services on-site and there was a total reliance on accessing these services within the larger community.

Jordan's right to health services was compromised by PAYR's non-compliance with the Ministry's directive to develop health-related procedures. This situation, coupled with inadequate oversight to ensure compliance, contributed to decision making that was not in Jordan's best interests. The goals of the recommendations below are to safeguard the right to healthcare of youth in Ministry policy and improve practice and effective decision making in all youth facilities in Saskatchewan and to align with the *United Nations Convention on the Rights of the Child* and *the Saskatchewan Children and Youth First Principles*.

20. Admission to Youth Custody Facilities, Ministry of Justice, Corrections and Policing, effective March 6, 2013.

21. Prince Albert Youth Residence, Orientation & Procedures Manual, October 2011.

Recommendations #3: The Ministry of Justice, Corrections and Policing develop and implement a stand-alone healthcare policy to guide effective practice and safeguard the right to health services, which youth in custody are entitled to under Article 24 of the *United Nations Convention on the Rights of the Child*. The new policy should incorporate:

- a directive to facility directors to develop procedural guidelines ensuring youth in custody have access to healthcare;
- explicit guidelines for times when on-site health services are not available; and,
- guidelines for supervisors for administrative decision making, including documentation of decisions, and reporting decisions back to facility staff and to the youth.

Recommendation #4: The Ministry of Justice, Corrections and Policing establish an oversight system for monitoring, reviewing, and approving local policies and procedures to ensure alignment with Ministry policies.

Finding 5: ***The Prince Albert Youth Residence did not ensure due diligence and best outcomes in their reporting and decision making when staff observed Jordan's escalating pain, disagreed with medical decisions made by superiors, and ignored concerns reported by external parties about his illness.***

When admitted to PAYR on September 12, 2013, there were no external symptoms indicating Jordan required medical attention. In fact, just before his admission to custody, an assessment by EMS did not identify any signs of illness. Jordan's entitlement to health care was met on September 16, 2013, when he was transported to a medical clinic and examined by a physician without delay.

However, indicators that Jordan's condition had worsened were forwarded to PAYR staff on September 17, 2013, from both the community youth worker and his father. These concerns were not taken seriously by staff, lacking critical thinking and accountability to follow-up on health-related concerns regarding a youth in their care, including reporting it to the supervisor.

Further aggravating factors emerged on the morning of September 18, 2013, when Jordan was seen struggling and in significant pain as he prepared to leave for court, and when he returned to PAYR from court. The following statement by a facility worker reflects a dismissive attitude underlying the lack of appropriate response to Jordan's circumstances: *"When a youth says I'm not feeling good, do you take it serious? We see so much of it, [pause] shouldn't say faking, but it's hard to believe, you know."* [22] In addition, the deputy sheriff's request for assistance on Jordan's behalf was denied by PAYR staff.

Later that evening, the staff had advised the afternoon supervisor that Jordan's health had declined since the doctor's visit, and he needed further medical attention. The afternoon staff advised our office that they fundamentally disagreed with the supervisor's decision to wait until the next morning to have Jordan reassessed. However, no additional steps were taken by the afternoon staff to break the chain of command and contact the on-call facility director, the Healthline or even 911. These steps were crucial given that the afternoon staff believed Jordan's deteriorating health warranted immediate access to healthcare services. It should be acknowledged that in a correctional environment, breaking rank could be difficult. However, all staff must have the best interests of the youth they serve as a primary consideration.

22. Interview with Facility Youth Workier for the Ministry of Justice, Corrections and Policing internal review. Prince Albert, SK. October 16, 2013.

No steps were taken by staff to mitigate the risks to Jordan's well-being at several critical points: when PAYR staff observed Jordan struggling, when external parties forwarded concerns regarding Jordan's health, and when staff disagreed with the supervisor's decision. Consequently, the inaction by staff at PAYR jeopardized Jordan's right to health services. The recommendation that follows highlights the training required to instill critical thinking to ensure effective care and management of youth in custody.

Finding 6: ***The decisions to delay access to healthcare services (UNCRC, Article 24) were inappropriate and were not in Jordan's best interest (UNCRC, Article 3). The denial of this right to health services was oppressive given that Jordan struggled in significant pain for prolonged periods of time.***

The decision to connect Jordan to medical services on September 16, 2013, was appropriate. On September 18, 2013, however, effective decision making did not occur until 911 was called at 11:49 p.m. Earlier that day, the facility director observed Jordan leaving for court. He was advised of concerns forwarded by the deputy sheriffs and was present in the remand unit when Jordan returned from court.

Our office is deeply concerned with the dismissive response by the facility director when the deputy sheriffs had requested assistance to bring Jordan into the building. The evidence suggests the facility director's decision was that Jordan would not be reassessed by medical professionals. However, this decision was not documented nor was it reported back to the deputy sheriffs who had requested medical attention for Jordan. Also, no rationale was communicated to Jordan who faced another 12 hours of building [room] confinement.

At 9:00 p.m., when the facility worker reported that Jordan's condition had deteriorated, and he required healthcare services, the actions of the supervisor to attend to Jordan's cell to see him were appropriate. However, the touching of Jordan's back and forehead, and reviewing his medical history, crossed into the realm of a medical assessment, which the supervisor was not qualified or hired to perform. Consequently, the decision to deny the medical transport appeared to be a medically driven decision. The observations of staff working with Jordan over the previous two days were not factored into this decision. In addition, the email sent to the facility directors and the briefing that was given to the night supervisor, excluded the information that a medical escort for Jordan had been requested by remand staff.

The supervisor erred in the decision that Jordan's situation could wait until the morning to be reassessed by the day supervisor. The recommendation below reflects the need for comprehensive training in critical thinking, decision making and transparency in reporting outcomes of decisions.

Recommendation #5: The Ministry of Justice, Corrections and Policing develop and implement training for all facility staff on their roles and obligations for the effective management of health-related issues of young persons in custody. Training should incorporate:

- critical thinking skills and their application when assessing the needs of youth;
- proper documentation and reporting back when youth request medical attention, and when health-related concerns of a young person are received by external parties and the youth's parents; and,
- problem-solving when there is conflict among staff and supervisors regarding a health-related decision.

3.3 Discrimination and the duty to accomodate

Finding 7: ***The Ministry of Justice, Corrections and Policing has not taken all appropriate measures to meet its obligations to protect young people from improper discrimination on the basis of disability in its provision of services.***

Finding 8: ***The Prince Albert Youth Residence did not provide a reasonable accommodation to Jordan, a youth with a sensory impairment, to ensure he received adequate care during his time in custody. As a result, the services provided to Jordan were improperly discriminatory and his rights to non-discrimination (UNCRC, Article 2), special care as a result of his disability (UNCRC, Article 23), and access to health services (UNCRC, Article 24) were not respected.***

Under Section 28(1)(a)(ii) of *The Advocate for Children and Youth Act,* the Advocate may forward recommendations if an investigation finds, *"…that a decision, recommendation act or omission…appears to have been unreasonable, unjust, oppressive, [or] improperly discriminatory."* [23] Our investigation has determined that Jordan's right to health was undermined due, in part, to discrimination, "…which is a significant factor contributing to vulnerability." [24]

In addition to the Ministry's obligations under the *United Nations Convention on the Rights of the Child,* provincial human rights principles also apply to youth facilities. The mission of the Saskatchewan Human Rights Commission is *"To promote and protect the individual dignity, fundamental freedoms and equal rights of Saskatchewan citizens."* [25] Our office confirmed that a youth facility qualifies as a public service under Section 12 of *The Saskatchewan Human Rights Code,* therefore, has a duty to accommodate young people with disabilities who are admitted to the point of undue hardship. [26] Court Services and deputy sheriffs also have this obligation under the Code as it too provides a public service.

Jordan's disability was immediately known when he was admitted to PAYR. Our office would like to acknowledge all the efforts by staff to communicate with Jordan, using sign language, gestures, note writing and pictures as a visual means of communicating. The need for accommodation should have been recognized by the leadership at PAYR in a more systematic manner to determine alternative and effective methods of communication with Jordan. Reaching out to community partners or other organizations to provide expertise, such as Saskatchewan Deaf & Hard of Hearing Services, would have been a critical step to assist with this process.

As the Executive Director of Saskatchewan Deaf & Hard of Hearing Services explained to our office, an appropriate accommodation for youth with a hearing and speech impairment would be a deaf interpreter or specialist who can conduct a language assessment. An assessment would determine language levels and whether any cognitive or any linguistic problems are evident. He cautioned that equal access does not necessarily mean hiring 'interpreters' with limited sign language capacity.

In the absence of a reasonable accommodation to assist with communication to ensure necessary access to healthcare services, a discriminatory situation emerged. Nearly all of the facility workers involved in Jordan's care at PAYR advised our office that, according to them, Jordan was treated the same as his youth counterparts. Therefore, they would argue their actions were not discriminatory towards Jordan. Yet, as explained by Hitch (1991),

"Discrimination has been defined by the Supreme Court of Canada, as cited in Law Society of B.C. v. Andrews, as: …a distinction, whether intentional or not, but based on grounds of personal characteristics of the individual or group which has the effect of imposing burdens, obligations and disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits and advantages available to other members of society. [27]"

When staff at PAYR did not take Jordan's difference into account and treated him the same as other youth, a significant burden was placed on Jordan, which rendered him more vulnerable and contributed to the delay in accessing healthcare services. Even though facility staff expressed difficulties in knowing when to trust a youth requesting medical attention, considering Jordan's barriers to communication, PAYR had a higher onus to have him reassessed by a medical professional when his condition was first observed to deteriorate.

Our office searched for Ministry or local facility policies on managing youth with disabilities. The Admission to Youth Custody Facilities policy provides no substantive direction on the duty to accommodate, and the process staff should undertake to explore reasonable accommodation. The Health Screen form, however, requires staff to identify potential areas of accommodation regarding medication, allergies, special diet, and personal aids (glasses, contact lenses, hearing aid, crutches, splint, and prosthesis).

Case Management of Young Persons is another Ministry policy which contains a broad statement cautioning that 'one size does not fit all' regarding standards that apply in the case management process.[28] Although this policy speaks to the assessment of risks and needs of young people, the language used does not fully reflect the obligations inherent in the duty to accommodate. Further, this policy is heavily focused on the management of sentenced youth and provides little direction specific to remanded youth.

Our office also reviewed the PAYR Orientation and Procedures manual which provides some guidance for young people who wish to attend religious services, including First Nations cultural and spiritual traditions. [29] Other than the areas discussed above, there is neither a stand-alone Ministry policy nor local policy or procedures respecting the duty to accommodate, something we believe to be reflected in the care Jordan received during his time at PAYR.

Our office acknowledges an amendment to the Ministry policy on Admission to Youth Custody Facilities in March 2015 resulted in a section on the collection of health information. We are making the recommendation below due to the outstanding requirement for an overarching policy on the duty to accommodate that applies to all youth facilities. In our view, the amendment to existing policy does not adequately impart the importance of the legal obligation under *The Saskatchewan Human Rights Code* in the provision of services to young people. In the spirit of this recommendation, we would suggest working with the Saskatchewan Human Rights Commission when developing any policy regarding the duty to accommodate.

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23. *The Advocate for Children and Youth Act*, Sec. 28.

24. Committee on the Rights of the Child. General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art.24), 14 January – 1 February 2013.

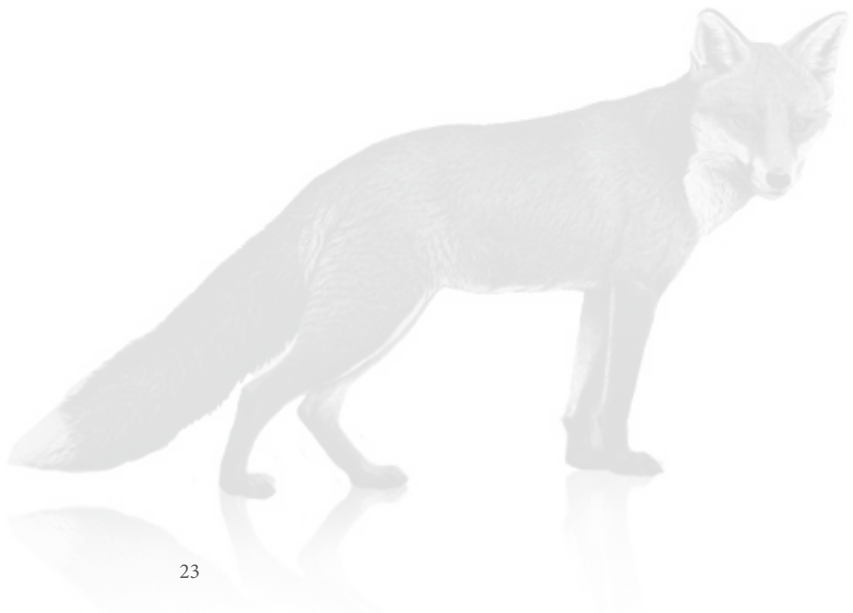
25. The Saskatchewan Human Rights Commission http://saskatchewanhumanrights.ca/about-us/about-us

26. Accommodation is required unless it would cause 'undue hardship.' What constitutes undue hardship is dependent upon the circumstances of each case, and may include such factors as cost and the effects of the accommodation upon others. The Saskatchewan Human Rights Commission http://saskatchewanhumanrights.ca/about-us/about-us

27. Hitch, L. 1991. Reasonable Accommodation and the Rights of Persons with Disabilities." Forum on Corrections Research. Vol. 3, no.2. http://www.csc-scc.gc.ca/research/forum/e032/e032k-eng.shtml

28. Case Management of Young Persons, Ministry of Justice, Corrections and Policing, effective July 22, 2005.

29. Prince Albert Youth Residence, Orientation & Procedures Manual, October 2011.



Recommendation #6: The Ministry of Justice, Corrections and Policing develop and implement a policy on its duty to accommodate that outlines the responsibilities, expectations, and processes applicable to youth in custody and youth in the community that includes training for management and staff as part of its implementation.

Hearing loss among Children and Youth

According to the most recent Canadian Health Measures Survey conducted by Statistics Canada, in 2012 and 2013, about 5% of children and youth aged 6 to 18 years have hearing loss that is considered mild or worse.

Among children and youth, hearing loss can negatively impact language acquisition, classroom learning and vocational achievement.

The inability to hear or hearing loss is a health concern that can have multiple emotional and social consequences, ranging from social isolation and depression to reduced education, income and employment opportunities (Statistics Canada, 2015).

A recent report by the Saskatchewan Human Rights Commission draws attention to a variety of gaps in programs and services for the Deaf, deaf, and hard of hearing in this province, and access to American Sign Language instruction and interpretation services is among them. As a result, the Commission proposes to strike a special stakeholder committee to address 15 systemic concerns (SHRC, 2016).

Sources:

Saskatchewan Human Rights Commission. (2016). Access and Equality for Deaf, deaf, and Hard of Hearing People: A Report to Stakeholders. Retrieved from http://saskatchewanhumanrights.ca/+pub/documents/news/2016/20160512_SHRC_DdHoH_Report.pdf.

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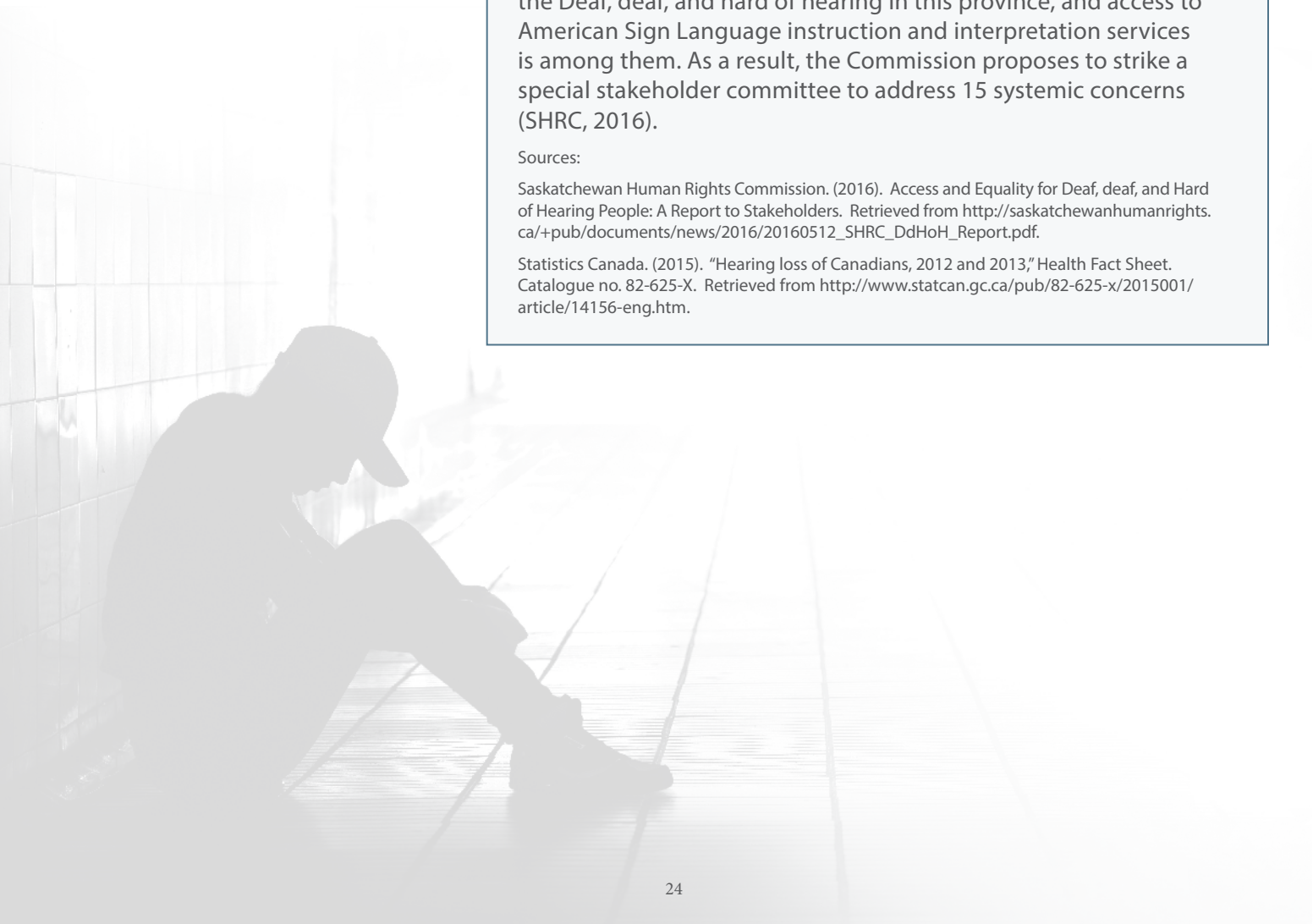


3.4 Lack of clarity in Court Services

Finding 9: ***The Ministry of Justice and Attorney General, Courts and Tribunals Division did not exercise effective decision making when health-related concerns emerged in court regarding Jordan on September 18, 2013.***

Finding 10: ***All information and events relating to Jordan were not adequately communicated by Court Services to the Prince Albert Youth Residence.***

Finding 11: ***The Court Services policy lacks clarity in non-emergency situations of youth, including agreements with the youth facility, decision-making, reporting, and conflict resolution. As a result of these lapses, Jordan did not receive his entitlement to healthcare (UNCRC Article 24) in a timely manner.***

The mandate of deputy sheriffs to provide court services is derived from both provincial and federal legislation. The transport of Jordan from PAYR to the Provincial Court on September 18, 2013, occurred as per policy. When PAYR staff advised the deputy sheriffs that Jordan had a sore hip, certain physical accommodations were provided to Jordan, and PAYR was contacted to obtain more information.

Jordan was monitored via electronic surveillance, and cell checks. The deputy sheriffs followed the chain of command and appropriately reported concerns regarding Jordan's health to their supervisor. The supervisor appeared to take the information from PAYR that Jordan had previously been examined by a doctor at face value. He did not conduct an independent assessment of Jordan's situation. Due to the inaction of the supervisor, the deputy sheriffs broke the chain of command and took steps to waive Jordan's attendance in court to prompt his return to PAYR. Our investigation found that the deputy sheriffs assumed that PAYR would ensure immediate access to healthcare on Jordan's behalf.

When the transport back to the youth facility was approved, all of the information regarding Jordan was not disclosed to PAYR: that Jordan's attendance in court was waived due to illness, that he had no appetite, and had repeatedly motioned that something was broken. Our office was advised it was extremely rare to have the attendance of a youth waived in court due to illness. There was no evidence that a supervisor at Court Services had contacted a supervisor at PAYR to advise of Jordan's health and to confirm PAYR was committed to providing Jordan with access to healthcare.

Court Services has a policy on managing medical issues, which states that, *"Any prisoner requiring emergency medical assistance shall receive immediate attention by deputy sheriffs trained in the use of first aid and/or CPR and 911 services will be called for assistance."* [30] Nearly all the deputy sheriffs advised our office that Jordan's presenting symptoms were not viewed as an emergency. A deputy sheriff assigned to cell block duty on September 18, 2013, stated that, while his situation was not an emergency, it was *"…something that needed to be dealt with as soon as possible."* [31]

30. Court Security, Policy and Procedures Manual, October 15, 2007.

31. Interview with Deputy Sheriff, Ministry of Justice, Court Services, Prince Albert, SK, September 24, 2015.

Court Services policy states that deputy sheriffs can take prisoners in non-emergency situations to a medical clinic or hospital either by ambulance or a transport vehicle. The policy is unclear for reporting, documentation, decision making, and how disagreements with decisions are resolved. The policy does not speak to who is responsible for the transport of young people if they require health services: Court Services or youth facilities. Both Court Services and PAYR have considerable responsibility for the management and care of young people required to attend court.

When health-related concerns emerged on September 18, 2013, Jordan's well-being was dependent on good communication between Court Services and PAYR, decisions based on an independent assessment of concerns, and commitments to facilitate access to healthcare services. Due to the shortfalls found in our investigation, the recommendations below are directed at Court Services to address these important areas.

Recommendation #7:
The Ministry of Justice and Attorney General, Courts and Tribunals Division in Prince Albert develop procedures for non-emergency situations involving young people who are ill or injured and require medical attention. The new procedures should incorporate:

- an overarching statement regarding the right of youth to access healthcare services (UNCRC, Article 24);
- guidelines for deputy sheriffs for reporting health-related concerns regarding a young person;
- guidelines for supervisors for making effective administrative decisions, including the documentation and reporting back to the deputy sheriff and to the youth; and,
- guidelines for effective communication of events or concerns to the youth facility if applicable.

Recommendation #8: That the Prince Albert Youth Residence and Court Services in Prince Albert develop a protocol to govern the roles and responsibilities to ensure youth have timely access to healthcare services.

3.5 Turned down by child welfare

Finding 12: ***The Agency Chiefs Child & Family Services Inc.'s denial of services to Jordan was unjust and not in his best interest (UNCRC, Article 3).***

When the Agency was providing support services to Jordan's family, Jordan had accumulated a number of charges over a short period. Our office acknowledges the Agency worked with Jordan's mother and brothers, and interventions were established to generate stability within the family. As previously mentioned, several documents were not found in the family services file, which makes it difficult to determine if these interventions were appropriate or effective.

There was no documentation to indicate services were provided to Jordan. When the RCMP contacted the Agency on August 9, 2013 to advise this vulnerable youth was in trouble, their staff did not assess Jordan's situation with a critical eye to determine if he required any supports and services.

Another opportunity to provide an assessment came from the Provincial Court through a Section 35 pursuant to *The Youth Criminal Justice Act*. Although the Agency was already involved with Jordan's family, it refused to assess Jordan's communication needs or his family residence to determine if he could be released to his mother's care. When Jordan's matter was addressed in court on September 18, 2013, the judge ordered the personal attendance of the Agency to speak to the Section 35 in court on September 20, 2013.

The Family-Centred Services Policy and Procedures Manual has policy entitled Intake and Investigation Re: Section 35 of *The Youth Criminal Justice Act.* [32] The policy indicates that referrals by a youth court should be handled according to intake and investigation procedures. Referrals from the court are to be treated in the same manner as a referral from any other agency or professional. Our office is concerned that a youth with disabilities like Jordan, was refused child welfare services on two occasions. As a result, we are requesting additional oversight of the services children and youth with disabilities receive by the Agency.

Recommendation #9: The Agency Chiefs Child & Family Services Inc. review its current caseload to determine the number of children ages 0 to 18 with disabilities to ensure:

- up-to-date assessments are on file;
- youth and families are connected to the necessary supports and services and, provide the results of the review to our office within one year of this report.

Recommendation #10: The Agency Chiefs Child & Family Services Inc. examine its internal process when a Section 35 referral is received from the Provincial Court and make any necessary changes to ensure timely responses to meet the needs of youth involved in the youth justice system.

32. Ministry of Social Services, Family-Centred Services Manual, Sec. 3.4A.

4.0 Advocate's Emerging Observations– Systemic Issues

The Advocate has the authority to provide advice and recommendations to any Minister responsible for services to youth on any matter relating to their well-being. We are taking this opportunity to shed light on possible factors contributing to the situation at PAYR in September 2013. In doing so, our intention is not to excuse shortcomings in services provided to Jordan, but rather to situate these gaps in a broader systemic context.

Our office recognizes the limitations of the physical structure of PAYR's remand unit. We understand the facility was intended to serve as a short-term resource for youth from the North awaiting trial or sentencing. However, the remand unit at PAYR mimics a traditional adult remand holding facility with a focus on static security and little space for admitting, visitation, programming, and recreation.

Further, the structure is not conducive to youth engagement, nor is it conducive to a therapeutic approach to service provision. Although difficult to provide effective services under these conditions, PAYR's past leadership and management team failed to fulfill their legal obligations to work within these limitations to foster supportive relationships with a disproportionate number of First Nations and Métis youth, many of whom have experienced significant trauma.

Under these conditions, the institutional culture that emerged at PAYR was problematic in many regards. The Ministry's internal review acknowledged this issue and put forward a recommendation that steps be taken *"…to change the PAYR culture from the non-empathetic, rigid approach…with remand unit residents, to one that is more kind hearted, caring and adaptive towards an individual's needs."* [33] Based on similar findings in our investigation, we conclude that the institutional culture at PAYR jeopardized the rights and well-being of Jordan, a vulnerable youth with significant and complex needs.

Also reflected in this culture at PAYR was evidence of the overuse of 'building confinement' or, more specifically, room confinement. During his first two days at PAYR, Jordan spent over 43 hours within a 48 hour period confined to his cell. Provincial policy sanctions the use of confinement for a 'period up to 24 hours' for new admissions to allow for observation by staff. [34] Youth, such as Jordan, who attend court soon after admission, are subject to a further 12 hours of confinement upon their return from court. The confinement of youth detracts from quality interaction with staff who monitor the youth via cell checks through a narrow window in the cell door. When PAYR receive new admissions, youth participating in programming are locked in their rooms as all remand staff must attend to the admission.

In August 2015, the Office of the Provincial Advocate for Children and Youth in Ontario released a report on the use of solitary confinement in 20 youth justice facilities in Ontario that highlighted the impact of such confinement on youth. [35] The report indicated that youth who are in developmental stages in their life may experience more detrimental effects from solitary confinement than adults. Furthermore, the majority of youth in nine facilities *"…reported no access to mental stimulation while in secure isolation."* This experience would have been even more isolating to a youth who was ill, and due to his communication barriers, may not have fully understood the purpose of this confinement. The *United Nations* Convention on the Rights of the Child forbids the use of solitary confinement for children up to age 18.

We understand the internal review had similar concerns with the use of cell confinement and recommended that the Ministry examine *"…the practice…for new admissions who are not presenting with any medical or addictions issues."* [36] The work plan stated the Ministry's position on cell confinement is currently under review, and that youth returning from court are no longer required to

serve 12 hours of confinement. Our office views this change as positive, and we anticipate receiving an update upon completion of the policy review.

In the course of our investigation, our office heard again about the persisting concern of youth from the Northern regions experiencing frequent moves due to space or programmatic limitations. While our office has been dealing with this issue on a systemic level, the dislocation of these youth from their home communities and from their service connections remains deeply troubling. While Jordan was not significantly affected in this regard, his right to a therapeutic environment in the remand unit was compromised due to these programmatic deficiencies.

As highlighted in our *2015 Annual Report,* the Facility Review commissioned by the Ministry of Justice, Corrections and Policing identified the deficiencies of the physical structure of PAYR and had recommended significant capital improvements. PAYR was identified as requiring additional space for programming, admissions and visitation. The Review stressed that, without these critical physical improvements, the environments provided to youth at PAYR were not acceptable. Moreover, the high number of First Nations and Mètis youth from the North serves to elevate the priority of providing culturally relevant interventions that are conducive to effective reintegration. Our office is anxious to learn of the Ministry's plan moving forward to deliver custodial services in Saskatchewan, apart from the previously released intentions to close certain youth facilities.

Since Jordan's death, there has been a change of leadership at PAYR. We have recently learned that several initiatives have been undertaken to cultivate a more responsive staff complement. In part, this was done through "…a realignment of existing resources to increase the contact between staff and remand residents." A number of changes have resulted in improvements to case management and intervening in a positive way with remanded youth. We also understand that the Ministry has also implemented a full-time nursing position at PAYR to ensure youth have access to health services. More programming, and a significant cultural component is presently available to First Nations and Métis youth. Naturally, the facility has encountered some internal resistance to these changes, but our office is encouraged by the commitment demonstrated by the leadership and staff at PAYR to provide quality services to young people.

33. Ministry of Justice, Corrections and Policing, Investigative Report, March 31, 2014.

34. Resident Confinement and Segregation, Ministry of Justice, Corrections and Policing, effective August 1, 2007.

35. Office of the Provincial Advocate for Children and Youth in Ontario. It's a Matter of Time: Systemic Review of Secure Isolation in Ontario Youth Justice Facilities, 2015.

36. Work Plan: Review of the Death of [name of youth]; Prince Albert Youth Residence.

37. Work Plan: Review of the Death of [name of youth]; Prince Albert Youth Residence.

5.0 Conclusion

Our office cannot claim that had Jordan received medical attention eight or 12 hours earlier, his death would have been prevented. Earlier in this report, we observed that a very low proportion of youth in Jordan's age group have sepsis as a contributing factor in their deaths. We can say with certainty that Jordan faced a life-threatening condition, and to reduce his chances of death from sepsis, he required immediate access to medical help and antibiotic therapy.

Jordan's disability put him at a disadvantage in a youth facility where he could not communicate with the staff on whom he depended. His vulnerability was elevated tenfold when he became ill and demonstrated limited mobility. He tried his best to communicate that he was in pain. Our office reviewed the PAYR video which revealed a progressive deterioration of his health and mobility. Witnesses external to PAYR, as well as his parent, described symptoms of illness that were not dealt with appropriately by PAYR leadership and staff.

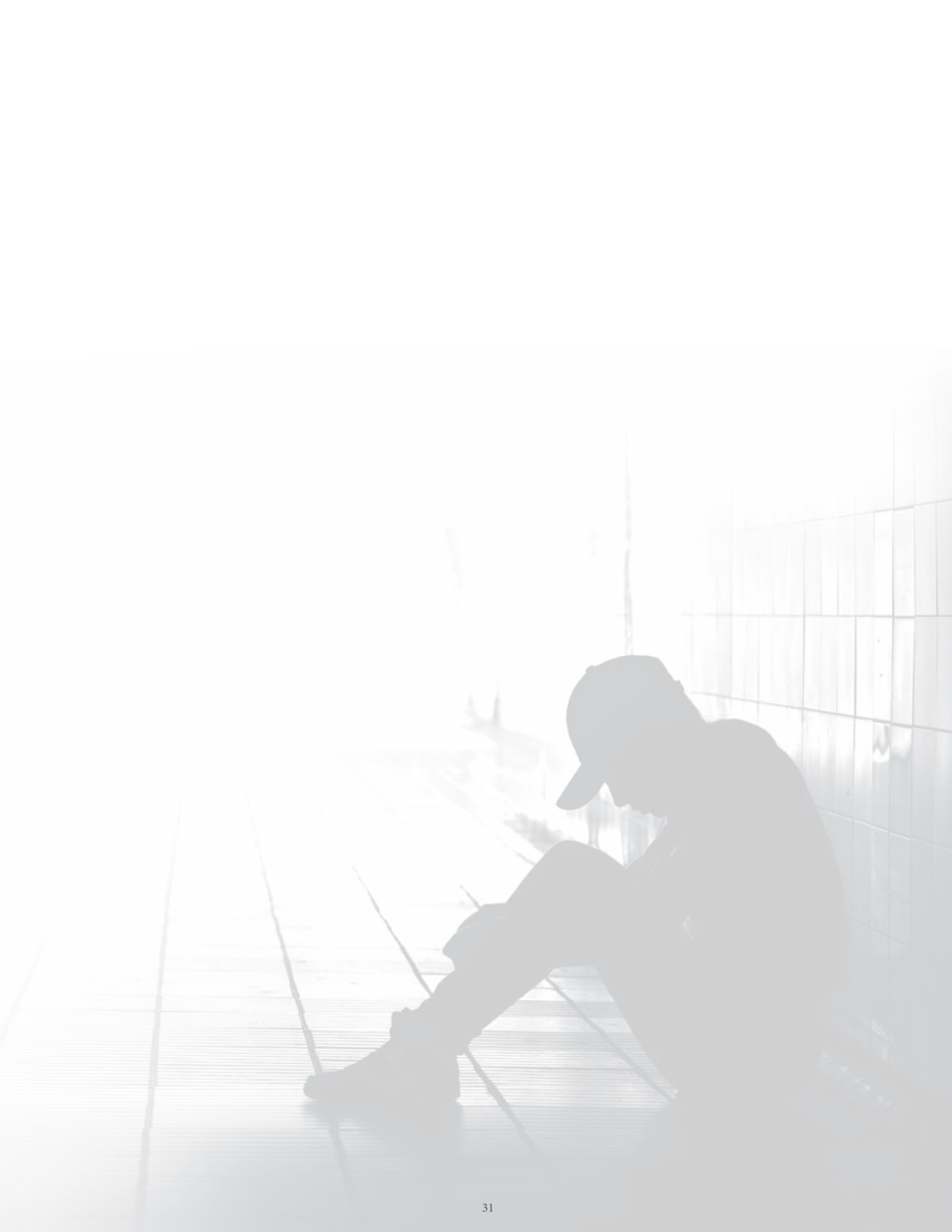
The lack of care and attention this vulnerable youth received was an aggravating factor in his death. Jordan and his family relied on a youth justice system that, while carrying out its public services effectively, would recognize and respond to the needs of youth with disabilities – with reasonable accommodation and timely access to necessary medical treatment. However, this did not occur, which resulted in a number of child rights violations. The Advocate concludes that the youth justice system failed Jordan by not accommodating his need for effective communication, not employing evidence-based decision-making processes, and not providing immediate access to healthcare.

Jordan interfaced with four systems in a short period–education, health, child welfare and youth justice. While not within our scope, we wondered how a youth like Jordan reached grade nine without an ability to communicate. Jordan was also denied appropriate services by the Agency to help him overcome any barriers to communication and to take steps to improve his life. It is time for these systems to reflect on any changes necessary to provide services that respond compassionately to children and youth with disabilities. Our office recognizes changing the culture of any system or institution is difficult, and we remain cautiously optimistic that changes in leadership at PAYR and the Agency can pave the way for healthy environments and services that meet the needs of youth who have complex needs.

Like many First Nations and Métis youth who are impacted by the legacy of residential schools, there is a need for a highly skilled and sensitive workforce in correctional facilities that is trauma informed and can deal effectively with a range of needs. Reconciliation is about addressing the past, and honoring this First Nations youth who is lost to his family and community.

Jordan's world was mostly silent. Through this report, our office wishes to project to the public issues impacting this vulnerable youth to ensure public service systems in Saskatchewan are mindful of the rights and entitlements of children and youth. Our recommendations are made with the expectation that the Ministry and the Agency will implement and do the work necessary to provide exceptional service.

> *"Institutions and individuals interacting with native people must become deeply trauma-informed."*
>
> Gabor Maté



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