



the Solicitor General
Ministère du Solliciteur général

the Chief Coroner
Bureau du coroner en chef

Verdict of Coroner's Jury / Verdict du jury du coroner

Year 1999

File - 91999-20

We
Nous soussignés,

of
de HAMILTON

of
de HAMILTON

of
de HAMILTON

of
de HAMILTON

of
de HAMILTON

the jury serving on the inquest into the death of / Jurament asssermentés, formant le jury dans l'enquête sur le décès de:

Surname / Nom de famille: LONNEE | Given names / Prénom: JAMES PRESTON

aged / âgé(e) de 16 YEARS held at / qui a été menée à HAMILTON

on the / le 02 NOVEMBER 1998 to / ~~XXXXXX~~ 23 APRIL 19 99

by / par DR. K.J.S. ACHESON Coroner for Ontario, / coroner pour l'Ontario.

having been duly sworn, have inquired into and determined the following: / avons enquêté et avons déterminé ce qui suit:

1. Name of deceased / Nom du (de la) défunt(e) JAMES PRESTON LONNEE
2. Date and time of death / Date et heure du décès 07 SEPTEMBER 1996 at 9:05AM
3. Place of death / Lieu du décès HAMILTON GENERAL HOSPITAL, HAMILTON, ONTARIO
4. Cause of death / Cause du décès COMPRESSION OF THE BRAIN AND HYPOXIC ISCHEMIC ENCEPHALOPATHY DUE TO SUBDURAL HEMATOMA DUE TO MULTIPLE BLUNT INJURIES TO HEAD.
5. By what means / Circonstances entourant le décès HOMICIDE

(Continue on reverse side if necessary / Continuer au verso si nécessaire)

This verdict was received by me this 23 day of April 19 99
Ce verdict a été reçu par moi le

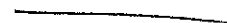
K.A. Acheson
Signature of Coroner / Signature du coroner

Distribution: Original - Regional Coroner for forwarding to Chief Coroner / L'original - coroner de la région pour transmission au coroner en chef
Copy - Crown Attorney / Copie - Procureur de la Couronne

James Lonnee Inquest Recommendations

Youth Services and The Rights of the Child

1. The Government of Ontario should establish a single ministry for all youth services which would include responsibility for child welfare, child mental health issues, and youth correction services.
A single Ministry for Youth Services would:
 - A) Ensure an integrated approach to service of young people under the age of 18 years
 - B) Provide quicker identification of high risk youth while ensuring continuity of care and/or identifications of services needed
 - C) Reduce duplication of corporate structure of services leading to the best service available for the funding provided
 - D) Facilitate easier access and exchange of information between service providers under the one youth service ministry.
2. The single Ministry for Youth Services which we recommend would be responsible for ensuring that all the youth in Ontario must have the right to benefit from the fundamental human rights outlined in:
 - A) the United Nations Convention on the Rights of the Child
 - B) United Nations Standard rules for the Administration of Juvenile Justice
 - C) The United Nation rules for the Protection of Juveniles Deprived of their Liberty
 - D) Standard Minimum rules for the Treatment of Prisoners
3. All provincial legislation that contains a definition of child should be amended to reflect a standard definition of child as a person up to the age of 18.
4. All children and young persons in detention should have the same rights of access to child welfare and mental health services as other children in Ontario.
5. Youth must be advised of their right to contact counsel, the advocate, and the ombudsman on admission, and on a regular on going basis and be provided with access to telephones in all areas of the facilities, including secure isolation. Youth must be advised of the range of interventions available, including internal and external complaint mechanisms.
6. In the event of a crisis, when a youth is in an agitated state and is requesting an Advocate, the Youth Officer must be responsible and accountable for contacting the Advocacy Office on behalf of the youth.



7. Children sixteen years of age or older who enter into a special needs agreement on their own with a Children's Aid Society, should have legal counsel to advise them of their options with respect to their status. In such circumstances the youth's capacity to sign his/her own agreement should be evaluated carefully, especially when the child has special needs. The office of the Children's Lawyer, the Child Advocate's Office, the Ministry of Community and Social Services and the Ontario Association of Children's Aid Societies should be consulted as how to make legal counsel available in such situations.
8. Early and decisive intervention by Children's Aid Societies to ensure the well being of children is imperative. In order to facilitate this task, Children's Aid Societies require resources to provide long term intensive in-home support programs in chronic cases of neglect. As part of this intensive intervention it is important that:
 - A) Every intervention be decisive and of sufficient intensity to meet the identified needs of the child.
 - B) The treatment plan for every intervention must be derived from a comprehensive need and risk assessment.
9. Early intervention and screening programs such as "Healthy Babies" should be expanded and intensified to enable support to families at the earliest possible stage before children develop deficits.
10. As soon as possible, a standardized parenting capacity assessment methodology needs to be integrated into the new case management recording system that is being implemented in the Child Welfare Sector.
11. The Child and Family Service Act should be amended so that children have access to the protection services of a Children's Aid Society until the age of eighteen and beyond, for special needs youth.
12. Children's Aid Societies should have policies in place that oblige them to consider whether a court application (society/crown wardship) should be made when a child is in care by agreement and there are long term care needs. When protection needs persist and a child cannot be provided with the necessary stability and continuity of care within his family, a plan for the child's permanent care is necessary.
13. The Ontario Child Welfare Training System should review its training curriculum on legislation and legal services to ensure there is appropriate content on the use of agreement versus the courts.
14. Until there is a Single Ministry for Youth Services, the Ministry of Community and Social Services must take immediate steps to ensure that services and programs to older youth, and youth with special needs, are not withdrawn once youth enters Phase II.

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15. The onus must be on a Children's Aid Society who is "terminating" an agreement or otherwise discharging a youth to demonstrate that the day to day safety and security needs, best interests, and long term needs of the youth are met. Furthermore, it should be mandatory for the CAS to advise a youth in person, three months before services are to be withdrawn, or before a three month landmark age is reached, of the Society proposal and the youth's range of options. The youth should also be referred for independent legal advice and to the Ontario Child and Family Services Advocate (OCFSA).
16. Further training for Children's Aid Society personnel and children services (including residential placement) is needed with respect to the duty to report when a child is in need of protection (including instances of child abuse) under the legislation.
17. Statutory amendments are required to remove privacy and confidentiality barriers to information sharing among treatment providers and Children's Aid Societies. Communication between agencies involved with children and CAS must be regular and consistent. CAS should obtain files from all agencies when taking on, maintaining, or resuming care of a child, and should have standardized information sharing and planning meetings when a child is in care and in a residential placement.
18. Ministry of Community and Social Services should develop provincial standard guidelines for the investigation and management of all child protection cases similar to existing guidelines for the investigation and management of abuse cases. These guidelines should address issues such as:
 - A) Re-enforcing to all child welfare agency workers and their supervisors that their client is the child in need of protection, not the parent or the family.
 - B) Complaints should be investigated thoroughly regardless of whether the case is an open file of a family service worker or a new file of an intake worker.
 - C) Child Welfare workers should actively seek information from community agencies for example, schools, day care and residential placement, to monitor the protection needs of children.
 - D) When investigations are made of complaints about a child in need of protection and the child can communicate, the child must be interviewed without the parent present. To ensure that very young children are interviewed effectively, child care workers should receive training for these interviews. We heard evidence that investigations into possible abuse did not always include an interview with James to illicit information.
 - E) Psycho-social histories of parents should be part of the investigation in all child protection cases. The impact of mental illnesses on the parenting ability of the parent needs to be given sufficient weight in any neglect or abuse investigation.
 - F) Home visits should be made at a time of day when parental supervision is most likely to be lacking to assess the problem or complaint effectively. If visits had been unannounced and at vulnerable times, it might have made it easier to assess Mrs. Lonnee's ability to cope safely with her child. We want to protect the child.

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19. A common system and standards for case notes, supervisory notes, file organization and file documentation across the Children's Aid Society system in Ontario is imperative.
20. All Children's Aid Society workers require training regarding assessment tools for assessment of risk, parenting capacity, the intervention spectrum, safety assessments and child development milestones, as well as training on mental and physical abuse (including patterns of injury, patterns of parental behaviour) and training regarding neglect. Training must be ongoing and comprehensive and include managers and supervisors.

Staffing

21. Staff classification should be changed from corrections officers to YOUTH WORKERS to better reflect the unique nature of their work.
22. All staff working with young offenders including casual part-time workers, shall be dedicated exclusively to young offender units.
23. Adult correctional officers should NOT be used to supervise young offenders in any circumstances. May contaminate young offender with attitudes, philosophy and culture.
24. Prospective candidates for youth workers positions should be screened to include only those who possess attitudes consistent with a prosocial outlook and who hold anti-violent beliefs.
25. All aspects of youth corrections administrative structure, system of service delivery and staffing, should have a youth-centered orientation that will maximize the development of specialized expertise, enhance the capacity to focus on youth correctional matters and establish a youth-focused system. To achieve this, the following should be implemented:
 - A) Develop competency-based hiring criteria that establish the minimum qualifications of youth worker positions, such as a B.A. or B.S.W. or, at a minimum, an appropriate diploma from a community college.
 - B) Explore mechanisms to encourage recruitment of the most qualified candidates.
 - C) Establish a clear expectation that current staff that do not meet the minimum preferred qualifications must upgrade their skills and education.
 - D) Establish a separate recruitment and basic training process for youth supervisors working within any corrections, mental health or social services institutions. This training should include a youth-centered curriculum.
 - E) Establish separate, youth-centered, multi-disciplinary, advanced training programs for youth institutional staff and youth probation officers.
 - F) Provide educational leaves, secondment to other youth programs, and tuition subsidies to staff to help them upgrade their qualifications.

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- G) Establish a consultation process with OPSEU to look at mechanisms for transferring some existing unqualified staff to other branches of the Ministry without any economic or career detriment.
- H) Provide all staff, including contractors and volunteers who deal with youth in a custodial setting, with orientation and specific training on the effects of child abuse and the prevention of peer on peer violence.
- I) Provide staff with advanced training in non-violent crisis intervention.
- J) Develop specialized advanced multi-disciplinary training programs on the dynamics and management of abuse in group living programs. All staff employed in youth custody centres should be thoroughly trained in this program.
- K) Identify one position in each centre as an in-house trainer to assist staff and youth to deal with peer on peer violence.
- L) Standards of conduct based on clearly stated principles should be developed for all personnel working with residents in youth custody centers .
26. Youth detention facilities should have managers, supervisors and superintendents with an educational background, training and experience in working with children and youth.
27. The Ministry of the Solicitor General and Correctional Services should encourage the promotion of personnel who are clinically trained or have specialized youth-related educational degrees into operational and corporate management positions throughout the structure of The Ministry of the Solicitor General and Correctional Services which relate to youth.
28. An adequate ratio of staff to youths should be established to ensure safe levels of monitoring which allow for appropriate interaction between staff and young offenders. We suggest consideration be given to Dr. Leschied's recommendations of 8:1 ratio by day, 16:1 ratio by night.
29. All facilities for youth should have a social worker, psychologist, and recreation officer on site and funding should be allocated for a child psychiatrist contract. A standard ratio of professional staff to youth should be developed for all youth detention facilities. All youth detention facilities should be reviewed to identify current levels of professional/ clinical staff. Immediate steps should be taken to remedy any shortfalls in the clinical staff complement in any of these facilities.

Staff Training

30. The training staff for youth workers/correctional officers should continue to utilize the detention care worker curriculum developed by the National Juvenile Detention Association.
31. Trainers of staff for youth detention facilities should incorporate the revised Ministry of Community and Social Service standard related to the Prevention and Management of Aggressive Behaviour Manual.



32. Staff should receive ongoing reminders through training and information to reinforce the importance of maintaining their oath of office and maintaining confidentiality concerning the youth in their care and custody.
33. Youth worker staff should be formally trained with respect to The Ministry of the Solicitor General and Correctional Services Young Offender Policy and Institutional Standing Orders.
34. Annual appraisal processes for youth correctional staff (youth workers) as well as management, should include testing designed to demonstrate the employee's comprehension of the ministry policy and procedures and their facility standing orders.
35. As part of management training, there must be the inclusion of a human resource element which teaches how to provide incentives and recognition of good staff's performance, appropriate discipline for unacceptable performance, and a shift from blaming to identifying the systemic and individual problems present.
36. A member of an institution's clinical staff should have input on performance appraisals for youth officers as well as whether the newly hired officer should be accepted past probation period. This would provide further insight as to the suitability of the youth worker.
37. Only those officers with an above average performance appraisal should be used for job shadowing and orientation of newly hired youth workers.
38. The Ministries responsible for Young Offender Services together with the Policing Services Division of the Ministry of the Solicitor General and Correctional Services should create a training syllabus in order to assist police services to conduct investigations in custody facilities.
39. The Ministries responsible for Young Offender Services should develop a clear policy on the use of the Code Blue Button.
40. All front line staff should have ready access to the Offender Management System(OMS) or the Young Offender Services Information System (YOSIS) and should receive training on its use. Until such time as there is a single Youth Service Ministry, front line and clinical staff in Phase II need to be trained how to access information from Phase I to address the youth's needs in Phase II.
41. Every young Offender Unit Manager, Deputy Superintendent and Superintendent must have clinical training and background in developmental, behavioural and youth sensitivity issues. Managers must be trained first and regularly, so ongoing on the floor supervision and evaluation can be undertaken.



42. Youth workers should be trained in cognitive behavioural intervention. Training of youth workers should include a clinical component addressing the links between psychiatric diagnoses and likely behaviours which result from them. This is particularly important for any youth worker without a background in such matters prior to entering the youth worker employment.
43. There must be ongoing regular training for staff such as child care workers, custodial staff, administration, maintenance staff, dietary staff, health care staff, volunteers, teachers, recreation staff and others, in the clinical needs of the residents in order to ensure the maintenance of a therapeutic environment.
44. In order to curb violence, a School-based Anti-violence Program (ASAP) developed by the London Court Clinic should be adopted for training purposes for detention-based educators across the Phase II system until there is a single Ministry for Youth Services.
45. Burnout Prevention Programs must be developed for youth worker staff. Without appropriate 'care for the care giver' they become exhausted, cynical and ineffective.

Assessment, Treatment and Programming

46. A comprehensive assessment and classification scheme must be put in place for all youth on admission to the young offender system. Absent a thorough assessment, all youth should be housed alone on admission to a facility in order to ensure their safety.
47. Young offenders usually have multiple problems and require a multiple disciplinary approach that provides evaluation and treatment of all identified problems concurrently. Treatment must address co-morbidities such as depression, drug and alcohol abuse, ADHD, conduct disorder and others.
48. Clinical staff must have the authority to intervene when administrative decisions about the management of a vulnerable young offender would put the youth at risk or undermine clinical treatment.
49. In the event of a Young Offender refusing mood control medication, increased observation and reporting must be made.
50. For high risk and special needs youth, Individual Placement Reviews should be conducted in consultation with the Office of the Child and Family Service Advocate and the plan of care team before a youth is placed or moved, to ensure that even a temporary move reflects optimal care and is based on a fair process.
51. The principles of treatment must be multi-modal and focus not just on behavioural control, (although this is fundamental) but also on the key deficits in cognition, moral reasoning, education or vocation and the recreational and social-interaction skills that propels much of the anti-social behaviour.

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52. In youth detention facilities, therapeutic programming must encompass the youth's entire day from dawn to dusk in order to foster pro-social behaviours.
53. Until there is a single Ministry for Youth Services, clinical resources should be supplied to the young offender Phase II system to enhance its ability to meet youth's complex and entrenched mental health needs.
54. A comprehensive review of programs in each youth custody centre should be conducted to ensure that the following types of programs are adequately and consistently available in every centre;
- A) A comprehensive orientation program for each new resident that emphasizes the centre's position on peer abuse, reporting and complaint resolution procedures.
 - B) Programs for the identification and treatment of youth who have been the victims of child abuse and neglect.
 - C) Appropriate anger management programs consistently available to all residents.
 - D) Cognitive skills training.
 - E) Programs that have demonstrated effectiveness in building positive group programs.
 - F) Programs along the lines of a peer counseling model, to support peer mentoring and orientation for centres with longer term residents.
 - G) Appropriate mental health assessment and treatment services.
 - H) Empathy training or victim awareness programs for and available to residents.
 - I) Drug and alcohol assessment and treatment.
 - J) Social skills training.
 - K) Programs for the identification and education of youth with learning disabilities.
 - L) Moral skills training.
 - M) Access to meaningful education programs for all youths including those in short term detention.
 - N) Adequate and consistent periods of physical recreation should be provided to reflect the needs of growing youths.
 - O) To eliminate boredom and its inherent risks, dawn-to-dusk programs should be enhanced.
 - P) Appropriate, individualized education must be available to all youth in detention and custody.
55. Programming must include community resources such as counseling, medical, psychiatric and mentoring programs. Parents and peer groups should be welcomed by youth facilities and incorporated into daily life in a consistent fashion across all systems.
56. The Ministry responsible for youth in custody must advise outside case workers (e.g. Children's Aid Society) immediately of any transfer of youth in their care.



57. When a Children's Aid Society has responsibility for a high risk youth who is a young offender, the Society should be involved in the development of an appropriate treatment and safety plan which is the subject of regular conferencing and that follows the youth throughout his/her progress through the young offender systems. There must be a requirement for a Notice of Request for Input to case planning to all relevant treatment and care providers. Furthermore, they should further be involved in proper after care and reintegration of the youth into the community.

Case Management and Discharge Planning

58. Practice guidelines should be developed by the Ministry of Community and Social Services and the Ministry of Correction to direct the case management relationship between the mandatory systems of child protection, child mental health and young offenders.
59. When a youth is admitted to the young offender system, a case manager should be assigned as soon as possible, and in all circumstances no later than 72 hours after admission. It is imperative that the case manager be available to meet with the youth within that 72 hours to begin the process of developing a plan of care. When a youth has received a disposition, the case manager should commence discharge planning forthwith in conjunction with the case management team responsible for the plan of care.
60. Discharge planning and care must be carefully developed upon admission in a comprehensive way addressing the needs of the youth, his family, his care givers and the community.
61. Mental health services including drug rehabilitation, reintegration programs, life skills programs, and other therapeutic interventions that commence in youth detention facilities must be continued for as long as needed, often beyond the facility and within the community, and beyond the age of 18 years.

Research and Funding

62. Programs used for young offenders should be measured and monitored for their effectiveness. Research should support the use of programs for youth offenders.
63. Funds be allocated for research into Post Traumatic Stress Disorder and Severe Attachment Disorder of youth in the care of the state with a view to establishing effective diagnosis and treatment.
64. A re-assessment should be done to determine the number of beds that are required for young offenders needing mental health therapy in the province of Ontario



65. The Ministry of the Solicitor General and Correctional Services should immediately assign resources to develop a risk assessment tool or adapt the Level of Service Inventory (LSI-OR) for use in identifying victims and perpetrators of violence within youth detention facilities. Once this risk assessment tool or modified LSI-OR is developed, its use should become standard practice and training should take place for psychologists on the use of this new measure.
66. The child and youth services system needs to conduct research to establish which interventions best serve the needs of children in the welfare, mental health and correctional systems. Once effective practices are identified, methods must be developed for wide dissemination of the information to ensure that all child and youth services are using up to date and research-based methods.
67. The Government of Ontario should affirm its commitment to children and youth by providing resources to the office of the Child and Family Services Advocate. The "on-call" after hours services of the Ontario Child and Family Service Advocate should be re-instated and additional advocates and resources be provided to fulfil its existing mandate and to fulfil any obligation arising from these recommendations.

Facilities

68. Young offender facilities need to become stand-alone centres. The operation of co-located young offender facilities can be contaminated by the attitudes, philosophy, and culture of adult corrections.
69. Absent exceptional circumstances, as outlined in the Young Offenders Act, all young persons who are subject to detention must be kept separate and apart from adult offenders.
70. In the context of other needs of the institution, wherever possible, single room accommodation should be available. Any new construction for youth facilities should be built with single cell accommodation. Single rooms should be capable of being locked from the inside by the youth, with a staff override on the locking system for security and safety purposes. Single cell accommodation facilitates privacy, time out needs, crisis management and safety. Single cells also avoid the necessity of using secure isolation for "protection" which practice can place a youth at risk when returned to the general population or at future facilities. A procedure akin to protective custody for young offenders must be explored for the safety and sense of security of all youth when single cell accommodations are unavailable.
71. The architectural design of youth detention facilities must ensure that staff have unimpeded lines of vision to allow for surveillance of all areas, especially those areas identified as high risk. Separate shower stalls and single-person washrooms should be provided.



72. Staff are responsible for supervising youth, however, for common areas that are physically difficult to supervise, consideration must be given to the use of operational video cameras with recording devices. This could serve both youth and youth workers by providing a chronological record of daily events.
73. Over-capacity operation of youth detention facilities should be monitored closely. When over-capacity situations cannot be avoided, it becomes imperative that additional staff be called in IMMEDIATELY in order to ensure safety of both residents and staff.
74. Lighting in young offender facility rooms should be at 50 foot-candles power during the day with a dimmer for provision of low light for sleep.
75. All cell doors should have windows of SUFFICIENT size to ensure a clear view of the entire cell.
76. All living units/segregation areas in facilities should have synchronized clocks. This would ensure accurate recordings of time in log books and documentation in a consistent manner throughout a facility.
77. All medical response emergency intercom calls, emergency response equipment ("red bag" first response equipment) be standardized throughout the facilities of The Ministry of the Solicitor General and Correctional Services.

Environment


78. The Ministry of the Attorney General should use all means available to implement the use of Video Remand for youth in custody. This would avoid the disruption of placement and programming of young persons. As well, this procedure will eliminate the exposure of youths to the risk of peer on peer violence during transport to and from court.
79. Increased supervision should be provided for youths while they are in transport from detention to the courts in order to ensure their safety.
80. The Government of Ontario should decrease its reliance on custody in order to reduce demands on space within the system and to meet the needs of youth through increased use of alternative measures to the court process.
81. The principle of "least intrusive to most intrusive" measures should be adopted to govern the placement of remanded youths and the use of open detention facilities should be expanded across the province.
82. The judiciary should be invited to attend to all youth detention facilities within their jurisdictions on an annual basis to familiarize themselves with the facility and its services.



83. Practice guidelines for the use of residential care facilities with respect to the laying of criminal charges against children and youth should be reviewed, updated and monitored to ensure that such intervention does not necessarily undermine the placement, security or treatment needs of the young person.
84. A standard zero tolerance to violence policy must be established for all facilities.
85. Recognizing the duty to protect youth and prevent violence, management styles must address issues of institutional violence and support a 'zero tolerance of violence' culture for managers and staff as well as for the youth. The institution and individual superintendents, staff and managers must be held accountable for institutional violence. All incidents must be investigated thoroughly with a view to examining levels of supervision, problems in physical plant and behaviours of staff. It is unacceptable to isolate the blame on the youth without regard to the culture as a whole. Measures and consequences must be put in place to ensure accountability at the institutional and Ministry level.
In the context of these recommendations, 'zero tolerance of violence' must mean that all incidents of physical and verbal violence are treated seriously and are followed up with appropriate, constructive responses (not necessarily punitive measures) for staff and youth alike. Given the importance of the zero tolerance policy in dealing with violence it is important to educate other justice partners (e.g. police) about institutional violence and special needs youth and to involve them in the development of appropriate responses.
86. Adequate and appropriate nutritional standards reflecting the needs of growing youths should be developed. Recognizing the link between restricted access to food and bullying, it is recommended that nutritious snacks be available at all times on each unit.
87. It is recommended that in cases of work stoppage resulting from strike or lockout the definition of "essential services" take into consideration the essential need of adequate youth workers to supervise young offenders. It is further recommended that when the determination of essential services is in order, a procedure be developed for speedy emergency renegotiation of such services should the need arise.

Secure Isolation

88. The use of adult segregation type cells for secure isolation of young offenders must be abolished in favor of a more appropriate temporary containment of youth in crisis. In the interim, when, under extreme circumstances such segregation cells must be used for youth in crisis, maximum supervision and observation must be used to ensure there will be no risk to a youth housed in such a cell.
89. The standards for the use of secure isolation as contained in the Child and Family Services Act must apply to all youth held in detention under the Young Offenders Act.
90. A youth in need of secure isolation must never, ever, be double bunked with another youth.



91. Whenever possible, advice of clinical staff should be obtained prior to placing a young offender in secure isolation.
92. Ministries responsible for youth corrections must redefine their definition of Crisis Management to clarify the factors and criteria that constitute a reason for using secure isolation. A directive must be issued to specify an identified range of behaviours that would warrant crisis management.
93. The use of cells such as Wellington Detention Centre Segregation Cell #6 should be prohibited immediately to ensure basic human dignity is protected.
94. Secure isolation rooms should be standardized with respect to size, dimension, lighting, colour and observation capability.
95. Video monitoring must be established within the common areas (hallway) of secure isolation facilities.
96. Secure isolation data sheets should be posted outside the individual cells within the secure isolation area. Data sheets to be discreetly posted.

Restraints, Use of Force

97. When force is required in the management of young offenders, the degree of force used must be proportionate to the resistance of the young offender whether it is verbal or physical. In either instance the use of force should be linked to de-escalation techniques. Use of force should be a last resort and only as necessary to effect control. Putting the use of force into the context of de-escalation will assist youth in understanding the resolution of conflict without peer abuse.
98. Until such time there is a Single Ministry for Youth Services, the Ministry of the Solicitor General and Correctional Services must continue to review and evaluate peer on peer violence reduction initiatives and ensure their application in secure custody facilities.
99. The office of the child advocate is encouraged to develop a process for facilitating exit interviews of young offenders to ascertain the prevalence of peer-to-peer violence and bullying. The Ministry of the Solicitor General and Correctional Services should co-operate with the Advocate in developing this process and in learning from its results.



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Stability

100. Multiple moves of children in care throughout the child welfare, child mental health and youth corrections systems are known to exacerbate the problems they already have. It is essential that all children and youth services make stability to children in care a priority. A youth oriented corrections system should ensure that youth are not subjected to frequent moves in order to maintain consistency of treatment and access to programming. Frequent moves and/or transfers particularly with respect to the hard to manage youth such as James Lonnee and Adam Trotter, is debilitating and undermines any rehabilitative gains.
101. Absent exceptional circumstances such as a very short disposition, youths who are serving dispositions should serve them in youth centers and not in detention centers. Hard to manage youth should not serve dispositions in detention centers except for very short dispositions.

Information Exchange, Access and Recording

102. Shift-change procedures in each centre should be reviewed to ensure adequate information exchange between shifts and adequate supervision during the shift change period.
103. All minutes of staff meetings at facilities must be recorded and maintained for a specified length of time.
104. Information relating to a youth who is being transferred must travel with the youth regardless of the length of stay that is anticipated in the receiving institution. Transporting officials can be provided with sealed documentation to pass on to the receiving institution. Technological supports should be put in place to facilitate communication. Information about youth at risk must be passed along on a priority basis before transfer. A case management approach, appropriate and informed transfer decisions, and reviews of placements for special needs youth will facilitate the exchange of information across ministries and service sectors.
105. A single mechanism should be developed by the Ministry of Health and the new Ministry for Youth Services to facilitate the release of essential medical/psychiatric information to care givers in the new Youth Ministry. (ages 12-18) It is essential that the care givers understand the psychiatric issues.
106. Clinical team case notes in youth detention facilities should be governed by standards with respect to timeliness, content, and retention. These notes should form part of the institutional file.
107. Data collection by care givers and treatment providers be standardized as to their minimum record keeping requirements.



108. Move toward technologically advanced recording of treatment facilities, capabilities and vacancies and a system of information sharing with protection agencies to ensure more efficient and timely access to 'best fit' treatment resources.
109. All front line youth or corrections workers should be required to complete an incident report with a narrative, whenever any violence occurs in the institution regardless of the severity of the incident. In addition to the administrative actions that such a report may require, all incident reports should be forwarded to the Ministries responsible for young offender for studies on institutional violence and on institutional responses to the violence.
110. Youth officers should record all significant behaviours and attitudes of the young offenders in their care according to prescribed guidelines which should be developed.
111. It should be mandatory that all complaints made by youths to persons in positions of authority within the ministry should be investigated and documented promptly.
112. No documents or copy of documents shall be removed from a youth detention facility without written authorization of the superintendent or his/her designate.

Audits, Investigation and Accountability

113. If the Ministries responsible for young offenders or a youth detention facility receive a complaint that a correctional officer/youth worker has released information concerning a young person, contrary to The Young Offenders Act, that complaint shall be investigated to determine whether an offence has been committed even if the correctional officer/youth worker is no longer an employee of the facility. The Ministries are responsible for the maintenance of confidentiality relating to young persons so they must also investigate such complaints to determine whether a correctional officer/youth worker or former correctional officer/youth worker has violated their oath of office, or the provisions of the Freedom of Information and Protection of Privacy Act.
114. The Ministries responsible for youth correctional services should institute a policy of annualized audits for each facility dealing with security, safety, programming, operational procedures and adherence to standards. A quality assurance overview committee, comprised of senior managers, should evaluate the audits and attend to corrections of any deficiencies. This would increase accountability of senior operational management for allocation of resources and monitoring management practices at the institutional level.



115. A force of police detectives, independent of The Ministry of Corrections, should be established with a mandate to investigate allegations of serious bodily injury or worse, that occur within the provincial corrections systems.
116. In the course of investigations by this independent force of police detectives, witness statements must be tape recorded with a copy provided to the witness upon request. The Ministry responsible for youth, should accept accountability to ensure the investigation has credibility. This would help avoid discrepancies in future testimony.
- 117 We recommend the creation of an Advisory Council to monitor and ensure increased accountability in all corporate divisions of The Ministry of the Solicitor General and Correction Services. This Advisory Council should be comprised of professionals outside the Ministry of the Solicitor General and Correctional Services to assess the facilities, staff and management at regular intervals to ensure proper policy and procedures are being followed in the Young Offender system. All incidents reported to the Assistant Deputy Ministers Office and the Information Management Unit, are to be reviewed by this Advisory Council to ensure appropriate action was taken.
118. Control of all clinical resources as allocated by the Solicitor General and Correctional Services Ministry be designated to a senior operational Corporate Manager who is a clinician; that this position not be an advisory position, but should have a scope of authority, accountability, and access to reasonable share of funding resources available to the Ministry.

Implementation

119. In order to oversee the implementation of the recommendations of this inquest, the Government of Ontario should develop a committee comprised of inter-ministerial and multi-sectorial (including staff and unions) interests. The committee shall report the progress with respect to these recommendations to the *public and the office of the Chief Coroner by the anniversary date of the verdict of this inquest, and annually thereafter.

***It is respectfully requested that individual copies of the annual report also be forwarded to each member of the jury who sat for this inquest.**

In closing I would like to stress again that this explanation is written solely for the purpose of assisting the reader to understand the verdict. The comments that I have made are my recollections of the evidence and are not put forward as actual evidence. As in all inquests, a court reporter recorded the testimony of all witnesses, the summations of persons with standing and my charge to the jury. If any party wishes to refer to actual transcripts, the court reporting service was Cindy Jones Verbatim Service Inc., 1 King St., W., Hamilton, Ontario, L8P 1A4, 905-529-3020.



Karen Acheson, M.D., C.C.F.P.
Regional Coroner, South Georgian Bay,

**Coroner's Explanation
of the Verdict of the Jury at the Inquest
into the Death of James Preston LONNEE**

Dates of Inquest : November 2, 3, 4, 5, 6, 9, 30, 1998
December 1, 2, 3, 4, 7, 8, 9, 10, 14, 15, 16, 17, 21, 22, 23, 1998
January 5, 6, 7, 8, 18, 19, 20, 21, 25, 27, 28, 29, 1999
February 1, 2, 3, 4, 5, 8, 9, 10, 11, 15, 16, 17, 19, 24, 25, 26, 1999
March 1, 5, 8, 9, 10, 11, 15, 16, 17, 18, 22, 23, 26, 29, 30, 31, 1999
April 1, 6, 7; 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 1999

Presiding Coroner: Dr. Karen Acheson

Coroner's Counsel: Mr. Al O'Marra, Counsel to the Chief Coroner

Investigating Officer: Sgt. Brian Larkin, Cst. Ian Currier, Guelph Police Service

Coroner's Constable: Cst. Larry Strange, Niagara Regional Police

Persons with Standing:

1. Cynthia Lonnee: represented by Mr. Morga
2. Adam Trotter: represented by Mr. Neuberger and Mr. Rose
3. Tracy Larraway and David French: represented by Mr. Wright, Mr. Holmes and Mr. Ryder
4. Irene Dooley: represented by Mr. Steinberg
5. Leslie Cockerline: represented by Ms. Hart
6. Justice for Children and Youth: represented by Mr. Falconer, Mr. Macklin, and Mr. Merritt
7. Essex County Children's Aid Society: represented by Mr. Harper and Ms. Oliver
8. Ministry of the Solicitor General & Correctional Services: represented by Mr. Maksimowski, Mr. Hogg and Ms. Corbold

This verdict explanation contains a brief synopsis of the evidence presented at this inquest together with some explanatory remarks about the individual recommendations made by the jury. The sole purpose of this explanation is to assist the reader to understand the jury's recommendations. It is not intended to replace the verdict. I would like to stress that this explanation is my interpretation of the evidence and the jury's reasons.

Synopsis of Events

This inquest concerns the death of James Lonnee who was born on September 13, 1979 in Windsor, Ontario. He was 16 years old on September 7, 1996, the day of his death.

James was born in Windsor. His father died before his birth. His mother was young and alone, with two children from a previous marriage, a new baby, financial difficulties and significant depression. The Children's Aid Society received notice of concerns about this baby's care from hospital staff before discharge home. The Children's Aid Society already knew the family because of abuse investigations involving James' two stepbrothers. The interventions of the Children's Aid Society at that time were not sufficient to ameliorate the neglect and abuse which he suffered at home. By the age of three, his behaviour and developmental delays led to the first in a long series of children's mental health service interventions.

He got into trouble with the law at an early age and was sentenced to secure custody in Phase I a number of times, beginning in 1993. At the age of sixteen, on conviction for another criminal offense, he was sentenced to secure custody Phase II. He was at the following institutions in Phase II: Wellington Detention Centre, then Amity Residential Treatment, then Wellington Detention Centre, then Bluevale Youth Centre, then Elgin-Middlesex Detention Centre, then Brookside Youth Centre, then Brockville Jail, then Hamilton Wentworth Detention Centre, then Brookside Youth Centre, then Brockville Jail, then Quinte Detention Centre, then Brookside Youth Centre, then Wellington Detention Centre. These transfers took place from December 2, 1995 to September 6, 1996.

James was taking psychiatric medication for significant mental health problems. He was diagnosed with Attention Deficit/Hypersensitivity Disorder and Conduct Disorder and had a significant learning disability. He was extremely impulsive, highly restless and very immature for his age. He was also small for his age and had a history of being victimized by his peers. He also had a history of acting aggressively and had committed a serious assault on another young offender at Brookside Youth Centre.

James Lonnee was transferred to Wellington Detention Centre on September 4th, 1996, from the Brookside Youth Centre in Cobourg, Ontario because he was to appear at a court hearing to face outstanding charges on the 12th of September in Goderich, Ontario.

Immediately upon his arrival at the Wellington Detention Centre, Lonnee became involved in a verbal confrontation with another young offender. He was sent to secure isolation (cell #4) by a Young Offender Unit Manager A.

At Wellington Detention Centre the adult segregation area was used for secure isolation of young offenders, and adult correctional officers, not young offender officers were used as guards for all offenders in that area regardless of age.

Sometime in the morning of September 5, he was moved from secure isolation cell #4 to secure isolation cell #5 which already housed a Young Offender "B" to make room for two other young offenders. The Young Offender Unit Manager "A" decided to put them together because she said they knew each other and James Lonnee had made a request to share a cell with the Young Offender "B" already in the cell. The reason she recorded for putting him in secure isolation was "crisis management -- can't get along with his peers".

At 2000 hours, another young offender unit manager "C" relieved "A". He and a Correctional Officer removed Lonnee and "B" from their cell so they could shower and change. They were given clean clothes. "C" described them as "happy and content" and recorded that he had "no security concerns with either youth". He did not move them from secure isolation.

That evening at 2255 hours, Shift Supervisor, "D" noticed water coming from cell #5. At 2340 hours, a Correctional Officer, "E" found the segregation area covered with water coming from a blocked toilet in cell #5. "B" and Lonnee were noted to be destroying their mattresses and throwing parts of them out the food slot of the cell door. The guards shut the water off to their cell. "B" and Lonnee continued their behaviour until 0130 hours when they fell asleep. "B" slept on the bunk with a blanket over him. Lonnee slept on the floor in the wet mess.

On September 6th, Adult Correctional Officers, "F" and "G" were assigned to supervise segregation in addition to other duties.

At 0730 hours "F" and "G" served breakfast to the segregation area inmates. Nurse "H" made medication rounds in the segregation area that morning. At about 0850 someone threw a warm liquid at her as she walked past cell #5. She complained to the guards. A decision was made to move Lonnee and "B" to cell #6 in the segregation area.

Segregation cell #6 is the smallest cell in the segregation area, measuring 6' X 7'. It has no furnishings and the only plumbing is a drain in the middle of the floor.

At 0909 hours, 9 Correctional Officers arrived at cell #5. Lonnee refused to be moved to cell #6. Correctional Officer "I" took Lonnee by the arm and pulled him out of cell #5. Correctional Officer "J" took Lonnee by the right arm and Correctional Officer "K" took Lonnee by the left arm and placed him in cell #6. "B" was searched and voluntarily walked into cell #6.

According to Correctional Officer "K", Lonnee asked to use the phone to contact the Child Advocate. This request was denied.

As the door to cell #6 was closing, CO "I" heard Lonnee say that "B" was beating him. He felt this was a joke because they were both laughing when he looked in on them. After the door to cell #6 was closed, both boys continued to yell and scream obscenities.

At 1117 hours, CO "F" went for lunch. At 1135 CO "G" served lunch to Lonnee and "B". He described the boys as quiet at that time. He collected the dishes at 1155 hours and when he looked into the cell, he saw "B" sitting on the floor and Lonnee looking out at him. Lonnee's face was red and CO "G" thought this was caused by his screaming. At 1200 hours, CO "G" went for lunch when CO "F" returned.

At 1208 hours, CO "F" made rounds in segregation. When she checked cell #6, she saw "B" staring out and heard Lonnee screaming. As "B" started to talk, Lonnee stopped screaming. Lonnee was sitting in the corner with his knees up and his arms on his knees. "B" said, "This kid is nuts. Get him out of my cell or I'll kill him". CO "F" then heard "B" laugh so she concluded that he was kidding. She left the area.

At 1221, CO "F" checked segregation cell #6. "B" was standing at the door. He was reported to have said "F", I think Lonnee is having a seizure". CO "F" looked through the food slot and could see Lonnee lying on the floor but she could not see his face. She went to the health unit to consult with the nurse.

Nurse "L" enlisted the aid of CO "T" and went to segregation cell #6 to check Lonnee. She looked through the food slot and could see Lonnee lying on the floor. He was exhibiting a "fine tremor" which would become stronger and then subside. His breathing appeared deep and regular and the nurse felt this was not a true seizure. She left to attend to another inmate with CO "T". Later, Nurse "L" and CO "F" returned to segregation. "L" saw "B" and Lonnee in the same positions. Lonnee continued to demonstrate the tremor she had seen previously. CO "F" instructed "B" to pull Lonnee away from the door so that she could see his face. When "B" did this Nurse "L" could see that Lonnee had blood coming from the top of his nose and around his mouth. She instructed CO "F" to get the door open while she went to the health unit for supplies. CO "F" enlisted the aid of a senior officer who summoned other officers and they opened cell #6. Two nurses entered cell #6 and administered first aid while the guards removed "B". The ambulance was called and transferred Lonnee to Guelph General Hospital and later to Hamilton General Hospital. He died September 7, 1996 of a head injury in Hamilton General Hospital.

On the 12th of August, 1997 "B" appeared in Ontario Court, General Division. He entered a plea of Not Guilty to the charge of First Degree Murder in connection with the death of James Lonnee but guilty to the lesser and included offence of manslaughter. The Crown Attorney filed an agreed statement of facts and "B" was convicted of manslaughter.

On the 18th of September 1997, "B" was sentenced to a term of five years in the federal penitentiary system in addition to time served.

Jury Findings

Name of Deceased: James Preston LONNEE
Date and Time of Death: 9:05 a.m., September 7, 1996.

Place of Death: Hamilton General Hospital, Hamilton, Ontario
Cause of Death: Compression of the Brain and Hypoxic Ischemic
Encephalopathy Due to Subdural Hematoma Due to
Multiple Blunt Injuries to Head
Manner of Death: Homicide

Jury Recommendations

Youth Services and The Rights of the Child

1. **The Government of Ontario should establish a single ministry for all youth services which would include responsibility for child welfare, child mental health issues, and youth correction services.**

A single Ministry for Youth Services would:

- A) **Ensure an integrated approach to service of young people under the age of 18 years**
- B) **Provide quicker identification of high risk youth while ensuring continuity of care and/or identifications of services needed**
- C) **Reduce duplication of corporate structure of services leading to the best service available for the funding provided**
- D) **Facilitate easier access and exchange of information between service providers under the one youth service ministry.**

Self Explanatory

2. **The single Ministry for Youth Services which we recommend would be responsible for ensuring that all the youth in Ontario must have the right to benefit from the fundamental human rights outlined in:**
 - A) **The United Nations Convention on the Rights of the Child**
 - B) **United Nations Standard rules for the Administration of Juvenile Justice**
 - C) **The United Nation rules for the Protection of Juveniles Deprived of their Liberty**
 - E) **Standard Minimum rules for the Treatment of Prisoners**

Self Explanatory

3. **All provincial legislation that contains a definition of child should be amended to reflect a standard definition of child as a person up to the age of 18.**

The jury heard evidence that the definition of a child varies in provincial legislation leading to inconsistency in provision of services to youth.

4. **All children and young persons in detention should have the same rights of access to child welfare and mental health services as other children in Ontario.**

The jury heard evidence that young people in detention may not have access to the services of Children's Aid because of budgetary constraints. They also heard evidence that some Phase II facilities in 1996 had extensive mental health service support for young offenders and some facilities had none.

- 5. Youth must be advised of their right to contact counsel, the advocate and the ombudsman on admission, and on a regular on going basis and be provided with access to telephones in all areas of the facilities, including secure isolation. Youth must be advised of the range of interventions available, including internal and external complaint mechanisms.**

The jury heard evidence that James Lonnee was beaten by "B" over a number of hours on September 6, 1996. He asked guards for assistance but was ignored. He also asked to be allowed to call the advocate. Guards testified that they did not allow him to call the advocate because he was too agitated to take out of his cell. No one made a call to the advocate on his behalf.

- 6. In the event of a crisis, when a youth is in an agitated state and is requesting an Advocate, the Youth Officer must be responsible and accountable for contacting the Advocacy Office on behalf of the youth.**

See explanation to recommendation #5.

- 7. Children sixteen years of age or older who enter into a special needs agreement on their own with a Children's Aid Society, should have legal counsel to advise them of their options with respect to their status. In such circumstances the youth's capacity to sign his/her own agreement should be evaluated carefully, especially when the child has special needs. The Office of the Children's Lawyer, the Child Advocate's Office, the Ministry of Community and Social Services and the Ontario Association of Children's Aid Societies should be consulted as how to make legal counsel available in such situations.**

James Lonnee had signed a special needs agreement with the Essex County Children's Aid on his own around the time of his fifteenth birthday. It was terminated about a month before it expired because the Society decided that he was likely to be incarcerated for some time. Unfortunately, James' parents wanted to have nothing to do with James who was calling them and making threats to them. When the special needs agreement was terminated, James told his lawyer that he felt like he had no one. Evidence from experts suggested that James had other options at the time that he signed the special needs agreement and that a more permanent relationship with the Society was possible and might have been suggested to him if he had legal counsel.

- 8. Early and decisive intervention by Children's Aid Societies to ensure the well being of children is imperative. In order to facilitate this task, Children's Aid**

Societies require resources to provide long term intensive in-home support programs in chronic cases of neglect. As part of this intensive intervention it is important that:

- A) Every intervention be decisive and of sufficient intensity to meet the identified needs of the child.**
- B) The treatment plan for every intervention must be derived from a comprehensive need and risk assessment.**

The jury heard evidence that James Lonnee and his family received services from the Children's Aid Society, but they were ineffective at preventing ongoing neglect and abuse.

- 9. Early intervention and screening programs such as "Healthy Babies" should be expanded and intensified to enable support to families at the earliest possible stage before children develop deficits.**

Evidence was heard that James was neglected and abused from infancy. The extent of the neglect and abuse were be inferred, by a psychiatric expert, from the deficits in development of motor skills and language and socialization that were documented from his third year of life. Evidence was heard that his mother suffered from depression and this mental illness impacted upon her ability to parent James. Healthy Babies programming is designed to support parents who are in difficulty, so that neglect/abuse is avoided or detected and acted upon expeditiously.

- 10. As soon as possible, a standardized parenting capacity assessment methodology needs to be integrated into the new case management recording system that is being implemented in the Child Welfare Sector.**

The jury heard evidence about the lack of a systematic parenting assessment to evaluate the parenting provided to James. An expert in child abuse and neglect investigations told the jury of the new case management recording system that is being implemented and pointed out the need for a standardized tool for assessing parenting capacity.

- 11. The Child and Family Service Act should be amended so that children have access to the protection services of a Children's Aid Society until the age of eighteen and beyond, for special needs youth.**

The jury heard evidence that the CFSA provides that children receive the services of a Children's Aid Society to age 16. They also heard evidence that James Lonnee was significantly handicapped with mental illness and maturational delay and was without parental contact. His special needs made it imperative that the Children's Aid Society stay involved in his life to assist him while in prison by providing personal support and advocacy and to assist him to find a residence and means of supporting himself when he was freed.

- 12. Children's Aid Societies should have policies in place that oblige them to consider whether a court application (society/crown wardship) should be made when a child is in care by agreement and there are long term care needs. When protection needs persist and a child cannot be provided with the necessary stability and continuity of care within his family, a plan for the child's permanent care is necessary.**

The jury heard evidence that the Essex Children's Aid Society did not take steps to arrange for long term care needs in James Lonnee's case and avoided going to court to apply for wardship by using "care by agreement" instead.

- 13. The Ontario Child Welfare Training System should review its training curriculum on legislation and legal services to ensure there is appropriate content on the use of agreement versus the courts.**

See explanation to recommendation #12.

- 14. Until there is a Single Ministry for Youth Services, the Ministry of Community and Social Services must take immediate steps to ensure that services and programs to older youth, and youth with special needs, are not withdrawn once youth enters Phase II.**

The jury heard evidence that until his sixteenth birthday James Lonnee received intensive intervention and mental health services in the Phase I facilities in which he resided. However, from the day that he turned sixteen and entered the Young Offender System Phase II, he did not receive mental health services, with the exception of an assessment at Bluewater Youth Centre.

- 15. The onus must be on a Children's Aid Society who is "terminating" an agreement or otherwise discharging a youth to demonstrate that the day to day safety and security needs, best interests, and long term needs of the youth are met. Furthermore, it should be mandatory for the CAS to advise a youth in person, three months before services are to be withdrawn, or before a three month landmark age is reached, of the Society proposal and the youth's range of options. The youth should also be referred for independent legal advice and to the Ontario Child and Family Services Advocate (OCFSA).**

James Lonnee's reaction to the termination of his special needs agreement was unremarkable according to the Essex Children's Aid Society worker who spoke to him on phone about this issue. However, the social worker from Quinte Detention Centre and Mr. Lonnee's lawyer testified that he was extremely upset because of the termination of this agreement and felt that he was alone and without a friend in the world.

- 16. Further training for Children's Aid Society personnel and children services (including residential placement) is needed with respect to the duty to report**

when a child is in need of protection (including instances of child abuse) under the legislation.

The jury heard evidence that staff at a residential mental health facility for children in the Windsor area heard James allege that his mother filled his mouth with cotton and taped his mouth shut with duct tape. Despite the requirements of the Child and Family Services Act for the reporting of such allegations of abuse, this staff did not report the abuse to the Children's Aid Society. When the Area Supervisor became aware that this abuse had not been reported, she chastised the staff. However, the Area Supervisor did not report the abuse to the Children's Aid Society either.

17. **Statutory amendments are required to remove privacy and confidentiality barriers to information sharing among treatment providers and Children's Aid Societies. Communication between agencies involved with children and CAS must be regular and consistent. CAS should obtain files from all agencies when taking on, maintaining, or resuming care of a child, and should have standardized information sharing and planning meetings when a child is in care and in a residential placement.**

Please see the explanation to recommendation #16.

18. **Ministry of Community and Social Services should develop provincial standard guidelines for the investigation and management of all child protection cases similar to existing guidelines for the investigation and management of abuse cases. These guidelines should address issues such as:**
 - A) **Re-enforcing to all child welfare agency workers and their supervisors that their client is the child in need of protection, not the parent or the family.**
 - B) **Complaints should be investigated thoroughly regardless of whether the case is an open file of a family service worker or a new file of an intake worker.**
 - C) **Child Welfare workers should actively seek information from community agencies for example, schools, day care and residential placement, to monitor the protection needs of children.**
 - D) **When investigations are made of complaints about a child in need of protection and the child can communicate, the child must be interviewed without the parent present. To ensure that very young children are interviewed effectively, child care workers should receive training for these interviews. We heard evidence that investigations into possible abuse did not always include an interview with James to elicit information.**
 - E) **Psycho-social histories of parents should be part of the investigation in all child protection cases. The impact of mental illnesses on the parenting ability of the parent needs to be given sufficient weight in any neglect or abuse investigation.**
 - F) **Home visits should be made at a time of day when parental supervision is most likely to be lacking to assess the problem or complaint effectively. If**

visits had been unannounced and at vulnerable times, it might have made it easier to assess Mrs. Lonnee's ability to cope safely with her child. We want to protect the child.

Self Explanatory

19. A common system and standards for case notes, supervisory notes, file organization and file documentation across the Children's Aid Society system in Ontario is imperative.

The jury heard evidence that intake workers, family service workers, and outside service workers were involved in the supervision of James Lonnee over his life time. It appeared from the testimony that workers were not aware of the findings of other workers in all cases. There also appeared to be a lack of standards regarding the information that these notes should contain. They apparently differed widely between workers and for the same worker between visits.

20. All Children's Aid Society workers require training regarding assessment tools for assessment of risk, parenting capacity, the intervention spectrum, safety assessments and child development milestones, as well as training on mental and physical abuse (including patterns of injury, patterns of parental behaviour) and training regarding neglect. Training must be ongoing and comprehensive and include managers and supervisors.

The jury heard evidence that James Lonnee suffered from both abuse and neglect from his earliest childhood. Nevertheless, the Children's Aid Society was involved in providing intensive and expensive services to the family throughout much of his life. The sad contrast between the number of services provided and the lack of recognition of the abuse and neglect and the lack of effectiveness of the service was very striking.

Staffing

21. Staff classification should be changed from corrections officers to YOUTH WORKERS to better reflect the unique nature of their work.

Self Explanatory

22. All staff working with young offenders including casual part-time workers, shall be dedicated exclusively to young offender units.

The jury heard correctional officers for adults testify that they regarded the Young Offenders Act as a terrible piece of legislation. They did not respect it or support the demands that it made of young offender correctional officers. The testimony of young offender correctional officers and adult correctional officers also revealed tension between the two groups.

- 23. Adult correctional officers should NOT be used to supervise young offenders in any circumstances. May contaminate young offender with attitudes, philosophy and culture.**

Self Explanatory.

- 24. Prospective candidates for youth workers positions should be screened to include only those who possess attitudes consistent with a prosocial outlook and who hold anti-violent beliefs.**

An expert on the prevention of peer on peer violence testified that it was essential that youth workers model and communicate problem solving without violence.

- 25. All aspects of youth corrections administrative structure, system of service delivery and staffing, should have a youth-centered orientation that will maximize the development of specialized expertise, enhance the capacity to focus on youth correctional matters and establish a youth-focused system. To achieve this, the following should be implemented:**

- A) Develop competency-based hiring criteria that establish the minimum qualifications of youth worker positions, such as a B.A. or B.S.W. or, at a minimum, an appropriate diploma from a community college.**
- B) Explore mechanisms to encourage recruitment of the most qualified candidates.**
- C) Establish a clear expectation that current staff that do not meet the minimum preferred qualifications must upgrade their skills and education.**
- D) Establish a separate recruitment and basic training process for youth supervisors working within any corrections, mental health or social services institutions. This training should include a youth-centered curriculum.**
- E) Establish separate, youth-centered, multi-disciplinary, advanced training programs for youth institutional staff and youth probation officers.**
- F) Provide educational leaves, secondment to other youth programs, and tuition subsidies to staff to help them upgrade their qualifications.**
- G) Establish a consultation process with OPSEU to look at mechanisms for transferring some existing unqualified staff to other branches of the Ministry without any economic or career detriment.**
- H) Provide all staff, including contractors and volunteers who deal with youth in a custodial setting, with orientation and specific training on the effects of child abuse and the prevention of peer on peer violence.**
- I) Provide staff with advanced training in non-violent crisis intervention.**
- J) Develop specialized advanced multi-disciplinary training programs on the dynamics and management of abuse in group living programs. All staff employed in youth custody centres should be thoroughly trained in this program.**

K) Identify one position in each centre as an in-house trainer to assist staff and youth to deal with peer on peer violence.

L) Standards of conduct based on clearly stated principles should be developed for all personnel working with residents in youth custody centres.

Self Explanatory.

26. Youth detention facilities should have managers, supervisors and superintendents with an educational background, training and experience in working with children and youth.

Self Explanatory.

27. The Ministry of the Solicitor General and Correctional Services should encourage the promotion of personnel who are clinically trained or have specialized youth-related educational degrees into operational and corporate management positions throughout the structure of The Ministry of the Solicitor General and Correctional Services which relate to youth.

Self Explanatory

28. An adequate ratio of staff to youths should be established to ensure safe levels of monitoring which allow for appropriate interaction between staff and young offenders. We suggest consideration be given to Dr. Leschied's recommendations of 8:1 ratio by day, 16:1 ratio by night.

The jury heard evidence that intensive monitoring and positive, frequent interactions between young offenders and staff prevent or reduce peer on peer violence. Dr. Leschied's recommended ratios can be found in his report entitled " Safe and Secure".

29. All facilities for youth should have a social worker, psychologist, and recreation officer on site and funding should be allocated for a child psychiatrist contract. A standard ratio of professional staff to youth should be developed for all youth detention facilities. All youth detention facilities should be reviewed to identify current levels of professional/clinical staff. Immediate steps should be taken to remedy any shortfalls in the clinical staff complement in any of these facilities.

The jury heard evidence that Wellington Detention Centre did not have a social worker, psychologist, or recreation officer on site and did not have funding for a child psychiatrist. The provision of such clinical staff to detention centres varies very widely across the province and the evidence was that Wellington Detention Centre had the fewest clinical services available although it was not the smallest detention centre.

Staff Training

- 30. The training staff for youth workers/correctional officers should continue to utilize the detention care worker curriculum developed by the National Juvenile Detention Association.**

Self Explanatory.

- 31. Trainers of staff for youth detention facilities should incorporate the revised Ministry of Community and Social Service standard related to the Prevention and Management of Aggressive Behaviour Manual.**

Self Explanatory.

- 32. Staff should receive ongoing reminders through training and information to reinforce the importance of maintaining their oath of office and maintaining confidentiality concerning the youth in their care and custody.**

The jury heard "F", a former correctional officer at the Wellington Detention Centre, admit to writing a letter to the employer of an ex-young offender, alleging that he was a young offender was committing criminal acts in the course of his employment. The provisions of the Young Offenders Act, the Oath of Office of Correctional Officers as well as the Freedom of Information and Protection of Privacy Act were violated.

- 33. Youth worker staff should be formally trained with respect to The Ministry of the Solicitor General and Correctional Services Young Offender Policy and Institutional Standing Orders.**

The jury heard evidence from the correctional officers in the young offender services at Wellington Detention Centre, including administration and management. Very few of these officers knew the Young Offender Policy of the Ministry, or the Institutional Standing Orders of Wellington Detention Centre sufficiently to recognize that young offenders were not being observed as often as required, and the observations were not recorded as required by the Policy and the Institutional Standing Orders.

- 34. Annual appraisal processes for youth correctional staff (youth workers) as well as management, should include testing designed to demonstrate the employee's comprehension of the ministry policy and procedures and their facility standing orders.**

See explanation for Recommendation #33.

- 35. As part of management training, there must be the inclusion of a human resource element, which teaches how to provide incentives and recognition of good staff's performance, appropriate discipline for unacceptable performance,**

and a shift from blaming to identifying the systemic and individual problems present.

The jury heard evidence that morale at the Wellington Detention Centre was very poor. Good performance was not recognized and unacceptable performance was not disciplined.

36. A member of an institution's clinical staff should have input on performance appraisals for youth officers as well as whether the newly hired officer should be accepted past probation period. This would provide further insight as to the suitability of the youth worker.

Self Explanatory.

37. Only those officers with an above average performance appraisal should be used for job shadowing and orientation of newly hired youth workers.

Self Explanatory.

38. The Ministries responsible for Young Offender Services together with the Policing Services Division of the Ministry of the Solicitor General and Correctional Services should create a training syllabus in order to assist police services to conduct investigations in custody facilities.

The police officers conducting the homicide investigation in this case had difficulty in conducting an investigation that would stand scrutiny at trial in a high security institution which had to continue to guard its inmates. In particular, establishing a perimeter, segregating witnesses and finding documents were very difficult when some of the very people they needed to investigate controlled their movement within the institution.

39. The Ministries responsible for Young Offender Services should develop a clear policy on the use of the Code Blue Button.

When it was recognized that James Lonnee was in significant medical distress and it was a medical emergency, two correctional officers ran past the blue buttons searching for a telephone.

40. All front line staff should have ready access to the Offender Management System (OMS) or the Young Offender Services Information System (YOSIS) and should receive training on its use. Until such time as there is a single Youth Service Ministry, front line and clinical staff in Phase II need to be trained how to access information from Phase I to address the youth's needs in Phase II.

James Lonnee arrived at Wellington Detention Centre three days before his death without his young offender records. These records did not arrive at Wellington Detention Centre until he was being taken from the Detention Centre by ambulance. These records contained information about his psychiatric diagnosis and previous difficulty with peers. Some information about him was available on the Offender Management System, but correctional officers testified that they were not accustomed to accessing the Offender Management System for information about young offenders because it was time consuming and access to a computer was not always available when they were free.

- 41. Every young Offender Unit Manager, Deputy Superintendent and Superintendent must have clinical training and background in developmental, behavioural and youth sensitivity issues. Managers must be trained first and regularly, so ongoing on the floor supervision and evaluation can be undertaken.**

Self Explanatory.

- 42. Youth workers should be trained in cognitive behavioural intervention. Training of youth workers should include a clinical component addressing the links between psychiatric diagnoses and likely behaviours which result from them. This is particularly important for any youth worker without a background in such matters prior to entering the youth worker employment.**

Self Explanatory.

- 43. There must be ongoing regular training for staff such as child care workers, custodial staff, administration, maintenance staff, dietary staff, health care staff, volunteers, teachers, recreation staff and others, in the clinical needs of the residents in order to ensure the maintenance of a therapeutic environment.**

Self Explanatory.

- 44. In order to curb violence, a School-based Anti-violence Program (ASAP) developed by the London Court Clinic should be adopted for training purposes for detention-based educators across the Phase II system until there is a single Ministry for Youth Services.**

Self Explanatory.

- 45. Burnout Prevention Programs must be developed for youth worker staff. Without appropriate 'care for the care giver' they become exhausted, cynical and ineffective.**

Self Explanatory.

Assessment, Treatment and Programming

46. A comprehensive assessment and classification scheme must be put in place for all youth on admission to the young offender system. Absent a thorough assessment, all youth should be housed alone on admission to a facility in order to ensure their safety.

Bunking young offenders together prior to a psychological assessment of a predator or victim tendency places the young offenders at risk of injury.

47. Young offenders usually have multiple problems and require a multiple disciplinary approach that provides evaluation and treatment of all identified problems concurrently. Treatment must address co-morbidity's such as depression, drug and alcohol abuse, ADHD, conduct disorder and others.

Self Explanatory.

48. Clinical staff must have the authority to intervene when administrative decisions about the management of a vulnerable young offender would put the youth at risk or undermine clinical treatment.

Self Explanatory.

49. In the event of a Young Offender refusing mood control medication, increased observation and reporting must be made.

Self Explanatory.

50. For high risk and special needs youth, Individual Placement Reviews should be conducted in consultation with the Office of the Child and Family Service Advocate and the plan of care team before a youth is placed or moved, to ensure that even a temporary move reflects optimal care and is based on a fair process.

The jury heard evidence that James Lonnee was moved many times in the months in which he was a young offender in the Phase II system. We heard evidence that conduct disorder and attention deficit/hyperactivity disorder will be significantly exacerbated by frequent moves.

51. The principles of treatment must be multi-modal and focus not just on behavioural control, (although this is fundamental) but also on the key deficits in cognition, moral reasoning, education or vocation and the recreational and social-interaction skills that propels much of the anti-social behaviour.

Self Explanatory.

52. In youth detention facilities, therapeutic programming must encompass the youth's entire day from dawn to dusk in order to foster pro-social behaviours.

Self Explanatory.

53. Until there is a single Ministry for Youth Services, clinical resources should be supplied to the young offender Phase II system to enhance its ability to meet youth's complex and entrenched mental health needs.

Self Explanatory.

54. A comprehensive review of programs in each youth custody centre should be conducted to ensure that the following types of programs are adequately and consistently available in every centre;

- A) A comprehensive orientation program for each new resident that emphasizes the centre's position on peer abuse, reporting and complaint resolution procedures.**
- B) Programs for the identification and treatment of youth who have been the victims of child abuse and neglect.**
- C) Appropriate anger management programs consistently available to all residents.**
- D) Cognitive skills training.**
- E) Programs that have demonstrated effectiveness in building positive group programs.**
- F) Programs along the lines of a peer counseling model, to support peer mentoring and orientation for centres with longer-term residents.**
- G) Appropriate mental health assessment and treatment services.**
- H) Empathy training or victim awareness programs for and available to residents.**
- I) Drug and alcohol assessment and treatment.**
- J) Social skills training.**
- K) Programs for the identification and education of youth with learning disabilities.**
- L) Moral skills training.**
- M) Access to meaningful education programs for all youths including those in short term detention.**
- N) Adequate and consistent periods of physical recreation should be provided to reflect the needs of growing youths.**
- O) To eliminate boredom and its inherent risks, dawn-to-dusk programs should be enhanced.**
- P) Appropriate, individualized education must be available to all youth in detention and custody.**

Self Explanatory.

55. Programming must include community resources such as counseling, medical, psychiatric and mentoring programs. Parents and peer groups should be welcomed by youth facilities and incorporated into daily life in a consistent fashion across all systems.

Using the testimony of a number of experts including the Child Advocate, the jury adapted this recommendation.

56. The Ministry responsible for youth in custody must advise outside case workers (e.g. Children's Aid Society) immediately of any transfer of youth in their care.

The jury heard evidence that James Lonnee was moved multiple times while he was in Phase II and although he was under a special needs agreement with the Essex County Children's Aid Society, the Children's Aid Society was not always informed of the move.

57. When a Children's Aid Society has responsibility for a high risk youth who is a young offender, the Society should be involved in the development of an appropriate treatment and safety plan which is the subject of regular conferencing and that follows the youth throughout his/her progress through the young offender systems. There must be a requirement for a Notice of Request for Input to case planning to all relevant treatment and care providers. Furthermore, they should further be involved in proper after care and reintegration of the youth into the community.

See explanation to recommendation #56.

Case Management and Discharge Planning

58. Practice guidelines should be developed by the Ministry of Community and Social Services and the Ministry of Correction to direct the case management relationship between the mandatory systems of child protection, child mental health and young offenders.

James Lonnee's life story was a tragic one. He was abused and neglected to such an extent that he developed significant developmental delays and deficits. He also had mental health difficulties presumably at least partly related to this neglect and abuse. Although he received services from all of the mandatory systems named in the recommendation, it was apparent at the inquest that these services were not in communication and were not working effectively. An example of this lack of communication was a residential children's mental health facility's failure to report James' allegation that his mother taped his mouth shut to the Children's Aid Society.

59. When a youth is admitted to the young offender system, a case manager should be assigned as soon as possible, and in all circumstances no later than 72 hours after admission. It is imperative that the case manager be available to meet with

the youth within that 72 hours to begin the process of developing a plan of care. When a youth has received a disposition, the case manager should commence discharge planning forthwith in conjunction with the case management team responsible for the plan of care.

The evidence at the inquest was that James Lonnee did not have a case manager who met with him to discuss a plan of care until he had been at Wellington Detention Centre for almost a month. There was no evidence of discharge planning after he received his disposition.

60. Discharge planning and care must be carefully developed upon admission in a comprehensive way addressing the needs of the youth, his family, his caregivers and the community.

Self Explanatory

61. Mental health services including drug rehabilitation, reintegration programs, life skills programs, and other therapeutic interventions that commence in youth detention facilities must be continued for as long as needed, often beyond the facility and within the community, and beyond the age of 18 years.

Self Explanatory

Research and Funding

62. Programs used for young offenders should be measured and monitored for their effectiveness. Research should support the use of programs for youth offenders.

Self Explanatory

63. Funds be allocated for research into Post Traumatic Stress Disorder and Severe Attachment Disorder of youth in the care of the state with a view to establishing effective diagnosis and treatment.

James Lonnee was diagnosed as suffering from attention deficit/hyperactivity disorder and conduct disorder. There were a variety of other possible diagnoses. A psychiatrist called to the inquest suggested that post-traumatic stress disorder might be a significant problem with youth who are subject to abuse and neglect as very young children. He also suggested that these children would be vulnerable to a severe detachment disorder. He recommended that research be funded to establish effective diagnosis and treatment for these young people.

64. A re-assessment should be done to determine the number of beds that are required for young offenders needing mental health therapy in the province of Ontario.

There was testimony at the inquest that twenty mental health therapy beds would be made available to young offenders in Phase II in the re-organization of Phase II services that is currently being done. Testimony from a psychiatrist about the percentage of young offenders which are suffering from severe mental health problems (above 70%) no doubt prompted the jury to say that twenty beds for mental health therapy would not be sufficient.

- 65. The Ministry of the Solicitor General and Correctional Services should immediately assign resources to develop a risk assessment tool or adapt the Level of Service Inventory (LSI-OR) for use in identifying victims and perpetrators of violence within youth detention facilities. Once this risk assessment tool or modified LSI-OR is developed, its use should become standard practice and training should take place for psychologists on the use of this new measure.**

A risk assessment tool to assist psychologists in identifying victims and perpetrators of violence in custody settings is essential in order to allow for the safe housing of young offenders. This recommendation is a variation of one made by Dr. Leschied to the Ministry in his paper "Safe and Secure". The Ministry's response, which the jury saw, was not to develop the risk assessment tool. It appears clear to me that the jury are asking them to reconsider that reply.

- 66. The child and youth services system needs to conduct research to establish which interventions best serve the needs of children in the welfare, mental health and correctional systems. Once effective practices are identified, methods must be developed for wide dissemination of the information to ensure that all child and youth services are using up to date and research-based methods.**

Self Explanatory

- 67. The Government of Ontario should affirm its commitment to children and youth by providing resources to the office of the Child and Family Services Advocate. The "on-call" after hours services of the Ontario Child and Family Service Advocate should be re-instated and additional advocates and resources be provided to fulfil its existing mandate and to fulfil any obligation arising from these recommendations.**

Self Explanatory

Facilities

- 68. Young offender facilities need to become stand-alone centres. The operation of co-located young offender facilities can be contaminated by the attitudes, philosophy, and culture of adult corrections.**

Self Explanatory

- 69. Absent exceptional circumstances, as outlined in the Young Offenders Act, all young persons who are subject to detention must be kept separate and apart from adult offenders.**

The jury made this recommendation despite the fact that it is actually provided for in the Young Offenders Act because James Lonnee and "B" were in a segregation unit used for adult offenders and there were adult offenders in the there too.

- 70. In the context of other needs of the institution, wherever possible, single room accommodation should be available. Any new construction for youth facilities should be built with single cell accommodation. Single rooms should be capable of being locked from the inside by the youth, with a staff override on the locking system for security and safety purposes. Single cell accommodation facilitates privacy, time out needs, crisis management and safety. Single cells also avoid the necessity of using secure isolation for "protection" which practice can place a youth at risk when returned to the general population or at future facilities. A procedure akin to protective custody for young offenders must be explored for the safety and sense of security of all youth when single cell accommodations are unavailable.**

Self Explanatory

- 71. The architectural design of youth detention facilities must ensure that staff have unimpeded lines of vision to allow for surveillance of all areas, especially those areas identified as high risk. Separate shower stalls and single-person washrooms should be provided.**

The evidence heard by the jury about the prevention of peer on peer violence was that surveillance is essential at all times. The design of young offender facilities must take the need for surveillance into account.

- 72. Staff are responsible for supervising youth, however, for common areas that are physically difficult to supervise, consideration must be given to the use of operational video cameras with recording devices. This could serve both youth and youth workers by providing a chronological record of daily events.**

See explanation to recommendation #71.

- 73. Over-capacity operation of youth detention facilities should be monitored closely. When over-capacity situations cannot be avoided, it becomes imperative that additional staff be called in IMMEDIATELY in order to ensure safety of both residents and staff.**

The evidence heard about prevention of peer on peer violence was strongly in support of adequate staff: young offender ratios at all times.

74. Lighting in young offender facility rooms should be at 50 foot-candles power during the day with a dimmer for provision of low light for sleep.

The jury heard evidence that the lighting in Cell #6 was so dim that it was very difficult for guards to assess whether James Lonnee was injured. It is possible that a guard who thought he had a red face was mistaken and was actually seeing blood on his face.

75. All cell doors should have windows of SUFFICIENT size to ensure a clear view of the entire cell.

See explanation to recommendation #74.

76. All living units/segregation areas in facilities should have synchronized clocks. This would ensure accurate recordings of time in logbooks and documentation in a consistent manner throughout a facility.

The jury heard evidence that the recording of time in the logbook was not consistent with times recalled by staff when James Lonnee was found to be in distress.

77. All medical response emergency intercom calls, emergency response equipment ("red bag" first response equipment) be standardized throughout the facilities of The Ministry of the Solicitor General and Correctional Services.

There was no emergency response equipment in a bag or other easily portable piece of equipment and there was no standard emergency response call at Wellington Detention Centre. A nurse had to be sent back to the Health Unit several times for equipment and guards and nurses went looking for telephones rather than using the blue button available in the segregation unit.

Environment

78. The Ministry of the Attorney General should use all means available to implement the use of Video Remand for youth in custody. This would avoid the disruption of placement and programming of young persons. As well, this procedure will eliminate the exposure of youths to the risk of peer on peer violence during transport to and from court.

Self Explanatory

79. Increased supervision should be provided for youths while they are in transport from detention to the courts in order to ensure their safety.

Self Explanatory

80. The Government of Ontario should decrease its reliance on custody in order to reduce demands on space within the system and to meet the needs of youth through increased use of alternative measures to the court process.

Self Explanatory

81. The principle of “least intrusive to most intrusive” measures should be adopted to govern the placement of remanded youths and the use of open detention facilities should be expanded across the province.

See recommendation #80.

82. The judiciary should be invited to attend to all youth detention facilities within their jurisdictions on an annual basis to familiarize themselves with the facility and its services.

Self Explanatory

83. Practice guidelines for the use of residential care facilities with respect to the laying of criminal charges against children and youth should be reviewed, updated and monitored to ensure that such intervention does not necessarily undermine the placement, security or treatment needs of the young person.

Self Explanatory

84. A standard zero tolerance to violence policy must be established for all facilities.

The jury heard evidence that when violence between peers or between young offenders and guards is tolerated, there is a tendency for the violence to spread and escalate.

85. Recognizing the duty to protect youth and prevent violence, management styles must address issues of institutional violence and support a ‘zero tolerance of violence’ culture for managers and staff as well as for the youth. The institution and individual superintendents, staff and managers must be held accountable for institutional violence. All incidents must be investigated thoroughly with a view to examining levels of supervision, problems in physical plant and behaviours of staff. It is unacceptable to isolate the blame on the youth without regard to the culture as a whole. Measures and consequences must be put in place to ensure accountability at the institutional and Ministry level. In the context of these recommendations, ‘zero tolerance of violence’ must mean that all incidents of physical and verbal violence are treated seriously and are followed up with appropriate, constructive responses (not necessarily punitive measures) for staff and youth alike. Given the importance of the zero tolerance

policy in dealing with violence it is important to educate other justice partners (e.g. police) about institutional violence and special needs youth and to involve them in the development of appropriate responses.

Self Explanatory

86. Adequate and appropriate nutritional standards reflecting the needs of growing youths should be developed. Recognizing the link between restricted access to food and bullying, it is recommended that nutritious snacks be available at all times on each unit.

Self Explanatory

87. It is recommended that in cases of work stoppage resulting from strike or lockout the definition of “essential services” take into consideration the essential need of adequate youth workers to supervise young offenders. It is further recommended that when the determination of essential services is in order, a procedure be developed for speedy emergency renegotiation of such services should the need arise.

Self Explanatory

Secure Isolation

88. The use of adult segregation type cells for secure isolation of young offenders must be abolished in favor of a more appropriate temporary containment of youth in crisis. In the interim, when, under extreme circumstances such segregation cells must be used for youth in crisis, maximum supervision and observation must be used to ensure there will be no risk to a youth housed in such a cell.

Self Explanatory

89. The standards for the use of secure isolation as contained in the Child and Family Services Act must apply to all youth held in detention under the Young Offenders Act.

The jury heard evidence that until the age of sixteen a young offender in Phase I cannot be put in secure isolation for longer than one hour without a report to the administrator of the facility. The minute the young offender turns sixteen and is in the Phase II system, that changes from one hour to twenty-four hours, and the young offender may in fact be kept in secure isolation for many days.

90. A youth in need of secure isolation must never, ever, be double bunked with another youth.

The jury also heard evidence that the Ministry of the Solicitor General and Correctional Services has issued a directive that double bunking must never be used for young offenders. I believe they included this recommendation to ensure that this policy is never reversed.

91. Whenever possible, advice of clinical staff should be obtained prior to placing a young offender in secure isolation.

The effect of secure isolation on a young offender who suffers from mental illness, is very difficult to predict, according to testimony heard at the inquest.

92. Ministries responsible for youth corrections must redefine their definition of Crisis Management to clarify the factors and criteria that constitute a reason for using secure isolation. A directive must be issued to specify an identified range of behaviours that would warrant crisis management.

Crisis management is the reason recorded by the Unit Manager for putting "B" and James Lonnee in secure isolation. In the case of James Lonnee he was placed there after a verbal confrontation with another youth. "B" was placed there after counseling another young offender to throw urine at a guard.

93. The use of cells such as Wellington Detention Centre Segregation Cell #6 should be prohibited immediately to ensure basic human dignity is protected.

Self Explanatory

94. Secure isolation rooms should be standardized with respect to size, dimension, lighting, colour and observation capability.

Self Explanatory

95. Video monitoring must be established within the common areas (hallway) of secure isolation facilities.

See the explanation to recommendation #71.

96. Secure isolation data sheets should be posted outside the individual cells within the secure isolation area. Data sheets to be discreetly posted.

Secure isolation data sheets were not available at the Wellington Detention Centre at the time of James Lonnee's death. Segregation data sheets were used instead. These data sheets were kept on a clipboard on a small counter at the end of the corridor in the segregation area. The data sheets did not include the information that was required by the Institutional Standing Orders for young offenders.

The recommendation that these data sheets be discreetly posted, addresses the testimony of adult and young offenders who said they read posted information about offenders when they could, and passed the information to other offenders.

Restraints, Use of Force

97. When force is required in the management of young offenders, the degree of force used must be proportionate to the resistance of the young offender whether it is verbal or physical. In either instance the use of force should be linked to de-escalation techniques. Use of force should be a last resort and only as necessary to effect control. Putting the use of force into the context of de-escalation will assist youth in understanding the resolution of conflict without peer abuse.

Self Explanatory

98. Until such time there is a Single Ministry for Youth Services, the Ministry of the Solicitor General and Correctional Services must continue to review and evaluate peer on peer violence reduction initiatives and ensure their application in secure custody facilities.

Self Explanatory

99. The office of the child advocate is encouraged to develop a process for facilitating exit interviews of young offenders to ascertain the prevalence of peer-to-peer violence and bullying. The Ministry of the Solicitor General and Correctional Services should co-operate with the Advocate in developing this process and in learning from its results.

Self Explanatory

Stability

100. Multiple moves of children in care throughout the child welfare, child mental health and youth corrections systems are known to exacerbate the problems they already have. It is essential that all children and youth services make stability to children in care a priority. A youth oriented corrections system should ensure that youth are not subjected to frequent moves in order to maintain consistency of treatment and access to programming. Frequent moves and/or transfers particularly with respect to the hard to manage youth such as James Lonnee and Adam Trotter, is debilitating and undermines any rehabilitative gains.

Self Explanatory

101. Absent exceptional circumstances such as a very short disposition, youths who are serving dispositions should serve them in youth centers and not in

detention centers. Hard to manage youth should not serve dispositions in detention centers except for very short dispositions.

The jury heard evidence that there is a striking difference between the services provided at youth centres in the province such as Sprucedale and the services provided at Wellington Detention Centre. They also heard that there is a plan in the re-organization of the correctional branch of the Ministry of the Solicitor General and Correctional Services to put hard to manage young offenders in Detention Centres to serve their dispositions. The jury heard evidence that hard to manage youth need more intervention and more services, not less.

Information Exchange, Access and Recording

102. Shift-change procedures in each centre should be reviewed to ensure adequate information exchange between shifts and adequate supervision during the shift change period.

Self Explanatory

103. All minutes of staff meetings at facilities must be recorded and maintained for a specified length of time.

The jury heard evidence that no one attending the staff meeting on the morning that "B" beat James Lonnee can remember the exact discussion about the plans for the management of the two young offenders who were double bunked in a segregation cell.

104. Information relating to a youth who is being transferred must travel with the youth regardless of the length of stay that is anticipated in the receiving institution. Transporting officials can be provided with sealed documentation to pass on to the receiving institution. Technological supports should be put in place to facilitate communication. Information about youth at risk must be passed along on a priority basis before transfer. A case management approach, appropriate and informed transfer decisions, and reviews of placements for special needs youth will facilitate the exchange of information across ministries and service sectors.

James Lonnee's young offender file was not transferred with him from Brookside Youth Centre to Wellington Detention Centre on September 4, 1996. James had been transferred from Quinte Detention Centre to Brookside Youth Centre for a court appearance. The jury heard evidence that a clerk in the Quinte Detention Centre decided that he would be at Brookside Youth Centre a short time and his full file would not be needed. Unfortunately he was transferred directly from Brookside Youth Centre to Wellington Detention Centre to make another court appearance, this time in Goderich. The Young Offender Unit Manager, guards and a nurse testified that although they had knowledge of James Lonnee's previous admission at Wellington Detention Centre they

did not have a full understanding of his mental health problems or his problems with peers in the institutions in Phase II that he had been to since Wellington Detention Centre.

- 105. A single mechanism should be developed by the Ministry of Health and the new Ministry for Youth Services to facilitate the release of essential medical/psychiatric information to care givers in the new Youth Ministry. (ages 12-18) It is essential that the caregivers understand the psychiatric issues.**

The jury heard evidence that medical records made by psychiatrists and psychologists can't be released to Children's Aid Societies or Phase I and Phase II facilities without the written permission of the young offender. Correctional officers and the social worker at the inquest were unclear about how to get this information.

- 106. Clinical team case notes in youth detention facilities should be governed by standards with respect to timeliness, content, and retention. These notes should form part of the institutional file.**

A social worker at a youth detention facility testified that there are no standards with respect to social worker and other clinical team case notes. These notes are also not part of any institutional file on a young offender.

- 107. Data collection by caregivers and treatment providers be standardized as to their minimum record keeping requirements.**

See explanation to recommendation #106.

- 108. Move toward technologically advanced recording of treatment facilities, capabilities and vacancies and a system of information sharing with protection agencies to ensure more efficient and timely access to 'best fit' treatment resources.**

The jury heard evidence that hard to serve youth often require referral to agencies beyond the geographic limits of the Children's Aid Society making the referral. A Children's Aid Society social worker testified about the difficulties in finding out what agencies might be available and finding out whether they have any currently available treatment facilities or vacancies.

- 109. All front line youth or corrections workers should be required to complete an incident report with a narrative, whenever any violence occurs in the institution regardless of the severity of the incident. In addition to the administrative actions that such a report may require, all incident reports should be forwarded to the Ministries responsible for young offender for studies on institutional violence and on institutional responses to the violence.**

Self Explanatory.

110. Youth officers should record all significant behaviours and attitudes of the young offenders in their care according to prescribed guidelines, which should be developed.

Self Explanatory.

111. It should be mandatory that all complaints made by youths to persons in positions of authority within the ministry should be investigated and documented promptly.

Self Explanatory.

112. No documents or copy of documents shall be removed from a youth detention facility without written authorization of the superintendent or his/her designate.

The jury heard evidence that a correctional officer took a copy of a forty-eight hour report form from Wellington Detention Centre and kept it for many months. His explanation for this action was unclear. It was clear however, that his action was in violation of his Oath of Office and Confidentiality and the Freedom of Information and Protection of Privacy Act, as well as the Young Offenders Act.

Audits, Investigation and Accountability

113. If the Ministries responsible for young offenders or a youth detention facility receive a complaint that a correctional officer/youth worker has released information concerning a young person, contrary to The Young Offenders Act, that complaint shall be investigated to determine whether an offence has been committed even if the correctional officer/youth worker is no longer an employee of the facility. The Ministries are responsible for the maintenance of confidentiality relating to young persons so they must also investigate such complaints to determine whether a correctional officer/youth worker or former correctional officer/youth worker has violated their oath of office, or the provisions of the Freedom of Information and Protection of Privacy Act.

See explanation to recommendation #32.

114. The Ministries responsible for youth correctional services should institute a policy of annualized audits for each facility dealing with security, safety, programming, operational procedures and adherence to standards. A quality assurance overview committee, comprised of senior managers, should evaluate the audits and attend to corrections of any deficiencies. This would increase accountability of senior operational management for allocation of resources and monitoring management practices at the institutional level.

Self Explanatory.

- 115. A force of police detectives, independent of The Ministry of Corrections, should be established with a mandate to investigate allegations of serious bodily injury or worse, that occur within the provincial corrections systems.**

See explanation to recommendation #38.

- 116. In the course of investigations by this independent force of police detectives, witness statements must be tape recorded with a copy provided to the witness upon request. The Ministry responsible for youth should accept accountability to ensure the investigation has credibility. This would help avoid discrepancies in future testimony.**

The jury heard evidence that the investigator from the Ministry of the Solicitor General & Correctional Services who prepared statements from witnesses did so by including the material that he thought the statements should include, not including everything that the witness said.

- 117. We recommend the creation of an Advisory Council to monitor and ensure increased accountability in all corporate divisions of The Ministry of the Solicitor General and Correction Services. This Advisory Council should be comprised of professionals outside the Ministry of the Solicitor General and Correctional Services to assess the facilities, staff and management at regular intervals to ensure proper policy and procedures are being followed in the Young Offender system. All incidents reported to the Assistant Deputy Ministers Office and the Information Management Unit are to be reviewed by this Advisory Council to ensure appropriate action was taken.**

Self explanatory.

- 118. Control of all clinical resources as allocated by the Solicitor General and Correctional Services Ministry be designated to a senior operational Corporate Manager who is a clinician; that this position not be an advisory position, but should have a scope of authority, accountability, and access to reasonable share of funding resources available to the Ministry.**

I believe this recommendation arises from the evidence the jury heard about the high percentage of young offenders with psychiatric illnesses and from the evidence given by a psychiatric expert about the importance of ensuring that clinicians have authority so that clinical needs could not be ignored.

Implementation

119. In order to oversee the implementation of the recommendations of this inquest, the Government of Ontario should develop a committee comprised of inter-ministerial and multi-sectorial (including staff and unions) interests. The committee shall report the progress with respect to these recommendations to the *public and the office of the Chief Coroner by the anniversary date of the verdict of this inquest, and annually thereafter.

*It is respectfully requested that individual copies of the annual report also be forwarded to each member of the jury who sat for this inquest.

In closing I would like to stress again that this explanation is written solely for the purpose of assisting the reader to understand the verdict. The comments that I have made are my recollections of the evidence and are not put forward as actual evidence. As in all inquests, a court reporter recorded the testimony of all witnesses, the summations of persons with standing and my charge to the jury. If any party wishes to refer to actual transcripts, the court reporter was Sandra Richardson, 261 John St., Weston, Ontario. M6N 1K1, 416-243-3085.



Karen Acheson, M.D., C.C.F.P.
Regional Coroner, South Georgian Bay,
Presiding Coroner.