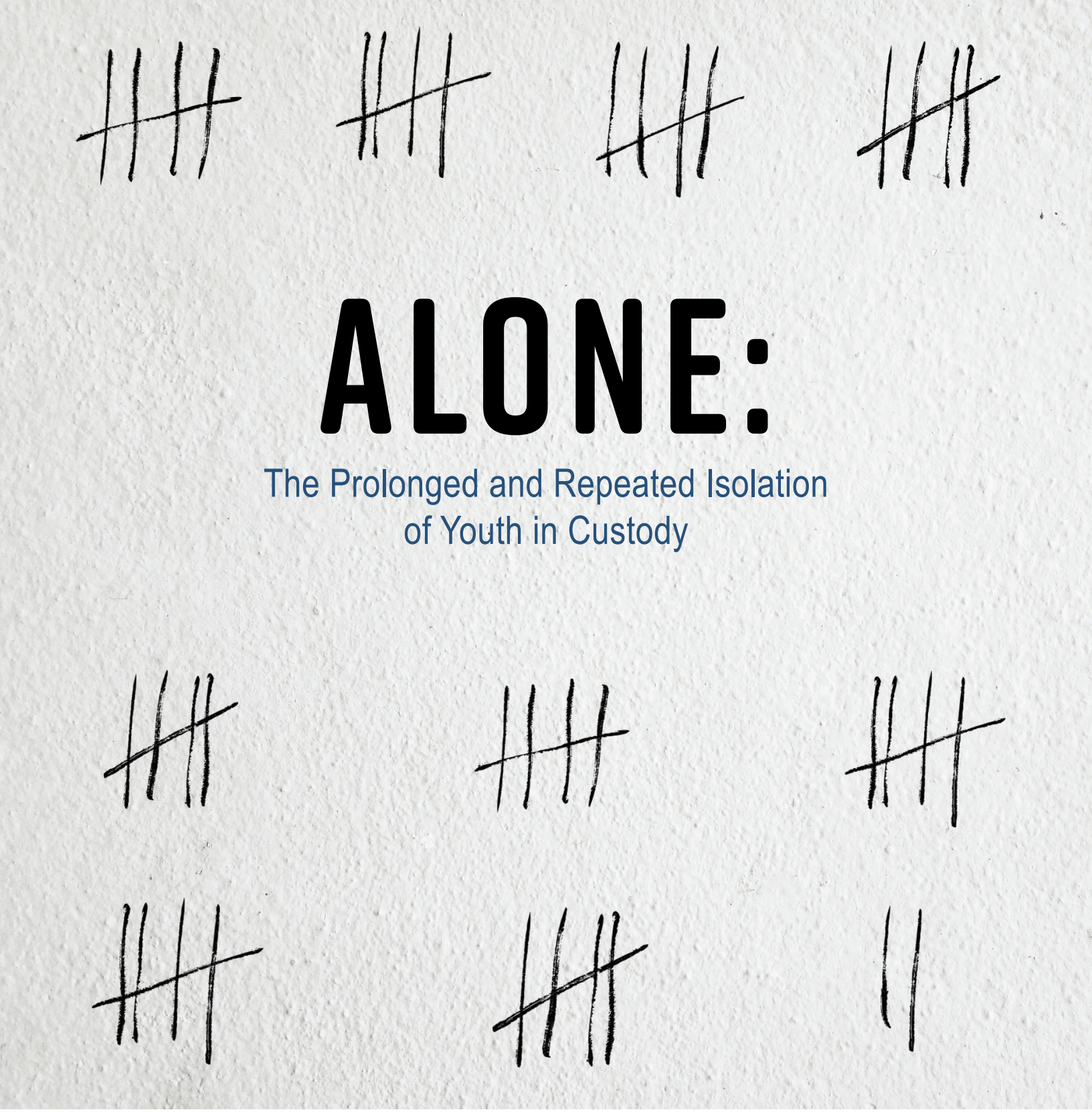

# ALONE:

## The Prolonged and Repeated Isolation of Youth in Custody

OMBUDSPERSON
BRITISH COLUMBIA

Special Report No. 48

June 2021

As an independent officer of the Legislature, the Ombudsperson investigates complaints of unfair or unreasonable treatment by provincial and local public authorities and provides general oversight of the administrative fairness of government processes under the *Ombudsperson Act*. The Ombudsperson conducts three types of investigations: investigations into individual complaints; investigations that are commenced on the Ombudsperson's own initiative; and investigations referred to the Ombudsperson by the Legislative Assembly or one of its Committees.

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OMBUDSPERSON
BRITISH COLUMBIA

June 2021

The Honourable Raj Chouhan
Speaker of the Legislative Assembly
Parliament Buildings
Victoria BC V8V 1X4

Dear Mr. Speaker,

It is my pleasure to present the Ombudsperson's Special Report No. 48, *Alone: The Prolonged and Repeated Isolation of Youth in Custody*.

The report is presented pursuant to section 31(3) of the *Ombudsperson Act*.

Yours sincerely,

Jay Chalke
Ombudsperson
Province of British Columbia

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## A caution to readers

This report discusses topics related to separate confinement and use of force in youth custody that may be upsetting for some people. For those who have been involved in the criminal justice system, the content of this report may recall or surface memories of traumatic personal experiences or experiences of family or friends.

This report examines how separate confinement is used in youth custody and makes recommendations to significantly reduce the separate confinement of youth and to support the trauma-informed and culturally safe care of youth in custody.  However, the content may trigger unpleasant feelings or thoughts.

If you require emotional support, you can contact:

- BC Crisis Centre: phone 1-800-784-2433 or online chat: https://www.crisislines.bc.ca/
- First Nations, Métis and Inuit peoples who require emotional support can contact the First Nations and Inuit Hope for Wellness Help Line and On-line Counselling Service, available toll-free at 1-855-242-3310 or through https://www.hopeforwellness.ca/
- the KUU-US Crisis line is available 24/7 toll-free at 1-800-588-8717 to provide support to Indigenous people in B.C. For more information, visit: https://www.kuu-uscrisisline.com/
- the Métis Crisis Line, available 24 hours a day toll-free at 1-833-MétisBC (1-833-638-4722)

## Acknowledgement of youth

We acknowledge the young people who are and have been in custody, especially those who have experienced and survived the harms caused by separate confinement. We have learned from their experiences and we hope that telling part of their stories in this report will help lead to long-term structural and systemic changes that will prevent other youth from experiencing the psychological harms cased by separate confinement and other forms of physical and social isolation.

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# FROM THE OMBUDSPERSON

Imprisonment is the most serious sanction permitted in Canadian criminal law. And, especially for young people in conflict with the law, placement in custody is reserved for the most serious matters. But once a young person is placed in custody, further deprivation of liberty is possible when they are isolated, physically and socially, from their peers. The courts have described such confinement as "a prison within a prison."

This report shines a light on this critically important issue in youth custody – the use of separate confinement. The practice of isolating young people is authorized by the provincial *Youth Justice Act* and *Youth Custody Regulation*, but carries significant risks of psychological harm to the youth who are subject to it. Courts examining the analogous practice of segregation in adult correctional institutions in Canada have determined that because of the harms it causes, segregation violates prisoner's rights under the *Canadian Charter of Rights and Freedoms* and as a result, the law must be reformed to impose limits on duration and to ensure independent oversight. The courts' decisions have been informed by international standards for the treatment of people in custody, known as the Mandela Rules, that seek to strictly limit the isolation of people in custody.

Youth – children aged 12 to 17 – are particularly vulnerable to the harms of physical and social isolation when they are in custody. In recognition of this vulnerability, the law affords them additional protections. The federal *Youth Criminal Justice Act* requires a custody system that is "safe, fair and humane" and that respects the rights afforded children and youth under the United Nations Convention on the Rights of the Child. The Mandela Rules prohibit the isolation of youth and people living with a mental illness for more than 22 hours. These domestic rules and international standards establish a framework within which my office investigated the isolation of youth in custody.

Over a period of three years, we examined how separate confinement is being used in the two youth custody centres in B.C. What we found is troubling. While overall, the number of instances of separate confinement has declined, the average duration of separate confinement increased three-fold at Burnaby Youth Custody Services Centre from 2017 to 2019. When we took a closer look at who was separately confined, we found that prolonged periods of separate confinement – those over 72 hours – were most commonly used to respond to youth who were self-injuring or suicidal. These prolonged periods of separate confinement in response to self-injury were experienced almost exclusively by female youth and mostly by Indigenous and racialized female youth. Three youth in particular were confined for long periods of time – 38 days, 41 days and 47 days. One youth was separately confined for 78 days over an 81-day period. The existing review and approval processes did not limit any of this prolonged and repeated isolation.

The conditions in which these youth were separately confined were neither supportive nor therapeutic. The separate confinement space posed risks and youth had limited and inconsistent access to mental health support, schooling and other programs. These youth did not have effective access to cultural or spiritual supports. Separate confinement was often accompanied by the repeated use of force, including forced clothing removal. These measures diminished the youth's sense of autonomy and privacy, and it is very likely that they

retraumatized youth who had significant, known, histories of trauma. Not surprisingly, youth struggled in this environment, and the isolation they faced contributed to a deterioration of their mental health over time. Youth who were separately confined rarely accessed the custody centre's complaints process, although it was clear from the records that they often strongly disagreed with their isolation.

The decisions to separately confine these youth – and the ways in which they were treated during their isolation – reflected a profound gap between the ministry's policy commitment to trauma-informed practices and the lived reality of youth in custody.

While I made a number of findings as a result of my investigation, the key point is this: youth in custody should not be isolated from other youth in custody except as a last resort when all other options have failed. And in those cases, strict time limits and effective, independent oversight is necessary to prevent the serious harms that this practice can cause.

I have recommended significant law reform to address the shortcomings in the current legislative and regulatory framework. I have recommended that the amount of time a youth is isolated be capped in the Regulation at 22 consecutive hours, without exception, and that rules be established to prohibit repeated separate confinement. I have recommended the establishment of an independent oversight body that can act quickly to review all separate confinement decisions and ensure that the law is being followed. I have recommended that the Regulation be amended to prohibit entirely the separate confinement of youth who are particularly vulnerable to its harms, including those under the age of 16 and youth with complex mental health needs.

All of this must be accompanied by a renewed commitment to, and implementation of, trauma-informed and culturally safe practices for all youth in custody. This will require a fundamental shift in the way that the youth custody system in B.C. responds to youth with complex mental health needs, including youth who are self-injuring or suicidal and youth who have experienced trauma. The ministry must establish meaningful alternatives to separate confinement so that when youth are in crisis, those alternatives exist and are used.

I am optimistic about the Minister's commitment to, in her words, "endeavour to implement every recommendation" in this report but I am concerned that for many recommendations the ministry has preferred timelines for this work that extend years into the future rather than responding to the more urgent call to action embodied in our recommendations. As the ministry has recognized, this work will require consultation with Indigenous leadership and communities to determine the best way forward. At the same time, I expect that the ministry will make this work a priority recognizing the disproportionate impact of separate confinement on Indigenous youth.

As we note in the report, the overall number of youth in custody has declined over the past few years. Thus, the ministry has an opportunity to devote its significant resources to quickly make a real difference in the lived experience of these youth – to ensure that a youth's experience in custody is truly, in the words of the *Youth Criminal Justice Act*, "safe, fair and humane."

We will monitor the ministry's implementation of these recommendations including whether it has given this matter the priority it needs.

Sincerely,

Jay Chalke
Ombudsperson
Province of British Columbia

# INTRODUCTION

Youth in custody in British Columbia are subject to indeterminate, prolonged periods of isolation from their peers, with potentially significant consequences for their mental health and well-being.[1]

> In this report "youth" or "young person" are defined as people aged 12 to 17. Children cannot be held criminally responsible for alleged offences if under 12 and those 18 or over are subject to the adult corrections system.

The practice of isolating youth in custody – known in B.C. as "separate confinement" – occurs with few meaningful safeguards and little effective oversight.[2] Youth in custody, who almost always have histories of trauma and abuse and are disproportionately Indigenous or racialized, are some of the most vulnerable people in our society. When youth in custody are separately confined, they have little recourse to assert or protect their rights.

It is well documented that separate confinement can cause or exacerbate mental illness. For this reason, numerous domestic and international bodies have recommended that separate confinement be significantly restricted in scope or abolished altogether, particularly for youth and people living with mental illness.[3] Canadian courts have issued decisions limiting the use of separate confinement in adult corrections, ruling that in certain circumstances it is contrary to the rights enshrined in the *Canadian Charter of Rights and Freedoms*. In 2019, the B.C. Court of Appeal found that provisions of the federal legislation governing adult correctional centres

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1 The federal *Youth Criminal Justice Act* and the provincial *Youth Justice Act* apply to people aged 12 to 17 who are in custody while awaiting trial or after being sentenced. *Youth Justice Act*, S.B.C. 2003, c. 85, s. 1 and 2; *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 2(1).

2 In this report, we primarily use the term "separate confinement" to describe the practice of isolating youth in custody from their peers, as that is the term used in s. 15.1 of the *Youth Custody Regulation*, which authorizes the practice.

3 A small sampling of relevant domestic and international reports includes the following: United Nations Office on Drugs and Crime, *The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, December 17, 2015, (http://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6_Rev1/ECN152015_L6Rev1_e_"V1503585.pdf); Correctional Investigator of Canada, *A Preventable Death*, June 20, 2008, https://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20080620-eng.pdf; New Brunswick, Office of the Ombudsman and Child and Youth Advocate, *The Ashley Smith Report*, June 2008, https://www.ombudnb.ca/site/images/PDFs/AshleySmith-e.pdf; Louise Arbour, Commissioner, *Commission of Inquiry into Certain Events at the Prison for Women in Kingston*, 1996, http://publications.gc.ca/collections/collection_2017/bcp-pco/JS42-73-1996-eng.pdf; Manitoba Advocate for Children and Youth, *Learning from Nelson Mandela: A Report on the Use of Solitary Confinement and Pepper Spray in Manitoba Youth Custody Facilities*, 2019, https://manitobaadvocate.ca/wp-content/uploads/MACY-2019-Learning-from-Nelson-Mandela-FINAL.pdf.

were unconstitutional because they authorized the "prolonged, indefinite administrative segregation" of incarcerated individuals.[4] Most recently, the Ontario Court of Appeal found that placing prisoners with a serious mental illness in administrative segregation for any length of time was similarly unconstitutional.[5]

B.C.'s *Youth Custody Regulation* allows youth to be confined separately from other youth within a custody centre.[6] According to the Regulation, youth can be separately confined if they pose a risk to health or safety and no alternatives are reasonably available. The Regulation also states that separate confinement should continue for no longer than necessary.

This report outlines our investigation into the use of separate confinement at the two youth custody centres in B.C., located in Burnaby and Prince George.[7] We initiated our investigation because our experience investigating individual complaints gave rise to concerns about whether the custody centres were properly following the law and policy in documenting separate confinement decisions. We obtained and analyzed records related to each use of separate confinement in youth custody over a three-year period, from January 1, 2017, to December 31, 2019. These records allowed us to examine how often, and for how long, youth had been separately confined and whether each use of separate confinement was authorized in accordance with the statutory scheme that governs its use.

Over the three years of our investigation, we saw overall improvements in the extent to which the centres were complying with their obligation to document separate confinement decisions. However, we also found systemic problems with the use of separate confinement in youth custody.

First, we found that the number of instances of documented separate confinement declined over the three years of our investigation at both provincial youth centres. However, we found that the number of hours of separate confinement increased at Burnaby Youth Custody Services Centre (BYCS) during the same period.

Second, we looked closely at *who* is primarily affected by the use of separate confinement in youth custody. We found that different groups of youth were disproportionately subject to separate confinement. We found that Indigenous youth were separately confined more frequently and experienced more hours of separate confinement than non-Indigenous youth. We examined the circumstances of the youth who were most often subject to prolonged periods of separate confinement and observed, based on the records, the conditions and the effects of separate confinement on these individual youth.

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4 *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2019 BCCA 228. The B.C. Court of Appeal cited the Mandela Rules with approval in its decision. Canada withdrew its appeal of this decision to the Supreme Court of Canada on April 21, 2020, and cross-appeals by the B.C. Civil Liberties Association, the John Howard Society of Canada and the Canadian Civil Liberties Association (CCLA) were withdrawn on May 28, 2020. See Supreme Court of Canada Docket 38814, https://www.scc-csc.ca/case-dossier/info/dock-regi-eng.aspx?cas=38814. The federal legislation at issue in this decision was amended in June 2019 to create "structured intervention units" as a replacement for administrative segregation: Bill C-83, *An Act to amend the Corrections and Conditional Release Act and another Act*, First Session, Forty-Second Parliament, https://parl.ca/DocumentViewer/en/42-1/bill/C-83/royal-assent.

5 *Francis v. Ontario*, 2021 ONCA 197. The Court found that the administrative segregation of mentally ill inmates violated their rights to life and to be free of cruel and unusual punishment under the *Canadian Charter of Rights and Freedoms*. In addition, the Court found that Ontario was liable for systemic negligence for breaching the duty of care owed to inmates subjected to administrative segregation in provincial prisons. The Court concluded that the award of aggregated damages in the amount of $30,000,000 was appropriate.

6 *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1.

7 The former Victoria Youth Custody Centre also operates as an "interim holding unit" for youth awaiting transfer to BYCS. Operationally, this unit is part of BYCS.

We found that prolonged periods of separate confinement were most commonly used to respond to youth who were self-injuring or suicidal, and these prolonged periods of separate confinement in response to self-injury were experienced disproportionately by female youth, and mostly by Indigenous and racialized female youth. These youth were separately confined more often and for significantly longer periods than any other youth in custody. Their experience of often prolonged periods of separate confinement in response to their mental illness disproportionately exposed them to the risk of psychological harm caused by separate confinement.

Third, we examined closely the effectiveness of the various oversight mechanisms that currently exist: reviews of separate confinement decisions, internal and external complaint processes, and inspections.

Based on our investigative work, we drew four key conclusions about the use of separate confinement in youth custody.[8] We found that the regulation that allows youth to be separately confined is unjust because it allows for prolonged and indefinite isolation. We found that the practice of separate confinement is also unjust because Indigenous youth, female youth and youth living with a mental illness are disproportionately separately confined for prolonged periods lasting days or weeks at a time. We found that separate confinement was used as a way to manage self-injuring and suicidal behaviour of youth with complex mental health needs.This use of separate confinement is not culturally safe and is fundamentally inconsistent with the Ministry of Children and Family Development's commitments to use trauma-informed practice. As a result, we found that the use of a practice known to cause harms is oppressive. We also found that the existing oversight is insufficient to limit the use or duration of separate confinement in youth custody.

Our findings about how separate confinement is used in B.C. youth custody, and which youth are most affected by its use, form the basis of our recommendations for change. These recommendations include significant reforms to the legal and policy framework that allows for separate confinement, the establishment of trauma-informed and culturally safe alternatives, and changes to practices within the youth custody centres, with the goal of eliminating the prolonged and repeated isolation of youth in custody, along with the psychological harms caused by that isolation.

[8] As we will describe in later sections of the report, these conclusions are made in accordance with the *Ombudsperson Act*, R.S.B.C. 1996, c. 340, s. 23.

# 2. BACKGROUND: SEPARATE CONFINEMENT OF YOUTH IN B.C.

## 2.1 Defining separate confinement

Youth in custody in B.C. are normally housed in living units that allow them to interact with others, including by eating meals, going to school, playing sports and games, and attending other programs together. These housing arrangements provide many opportunities for voluntary, meaningful social interaction between young people in custody, which is essential for psychological well-being. As one physician has written:

> Human beings are social creatures. We are social not just in the trivial sense that we like company, and not just in the obvious sense that we each depend on others. We are social in a more elemental way: simply to exist as a normal human being requires interaction with other people.[9]

Creating and maintaining opportunities for meaningful social interaction for young people in custody is critical to supporting their well-being and, in turn, their prospects for rehabilitation and reintegration.[10]

Separate confinement in B.C.'s youth custody centres is the confinement of an individual youth in a location that isolates them, physically and socially, from other youth in the centre. B.C.'s *Youth Custody Regulation* allows youth to be confined separately from other youth within a custody centre.[11] In our investigation, we found that youth who were separately confined are generally housed in a dedicated separate confinement unit, isolated from other youth, where their voluntary social interactions were significantly restricted and minimized. For example, while separately confined, youth were largely restricted from attending school or participating in

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[9] Atul Gawande, "Hellhole," *New Yorker*, March 30, 2009, https://www.newyorker.com/magazine/2009/03/30/hellhole.

[10] Jessica Feierman et al., *Unlocking Youth: Legal Strategies to End Solitary Confinement in Juvenile Facilities*, Juvenile Law Center, 2017, 12, http://jlc.org/sites/default/files/publication_pdfs/JLC_Solitary_Report-FINAL.pdf. As we will discuss in section 5.1, rehabilitation is one of the primary goals of Canada's youth justice legislation.

[11] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1.

programs with other youth. During separate confinement, youth ate all their meals alone. Separately confined youth had little to no contact with family and were not provided with cultural, religious or spiritual supports. Operational and health care staff were the separately confined youths' primary source of human interaction but this interaction was inconsistent and primarily occurred in the course of normal administrative tasks such as receiving meals, gaining access to washroom facilities, safety check-ins or practical conversations.

## 2.2 The harmful impacts of isolation

Originally conceived in 19th-century American prisons as an "enlightened and humane" reform that was intended to "inspire penitence and foster rehabilitation," the practice of isolating an individual prisoner from the general prison population has persisted in the Canadian correctional system.[12] Despite significant and mounting evidence of its detrimental psychological effects, this practice of isolating individual prisoners continues to be used across the globe as a behaviour management tool for both adult and youth prisoners.[13]

> Solitary confinement, segregation, separate confinement, secure isolation, room time, administrative segregation, restricted housing and secure de-escalation are some of the terms used in the prison context to describe the practice of confinement where prisoners are separated from the general prison population and housed by themselves.[14]

Regardless of the term used, the "central harmful feature" of this isolation is that it "reduces meaningful social contact to a level that many will experience as insufficient to sustain health and well-being."[15] This social isolation is known to cause significant, sometimes irreversible, psychological harms, which can include "such clinically significant symptoms as hypertension, uncontrollable anger, hallucinations, emotional breakdowns, chronic depression, and suicidal thoughts and behavior."[16] The UN Special Rapporteur on Torture lists the effects of solitary confinement as including anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia and psychosis, and self-injury.[17] Placing a person in solitary confinement dramatically increases the likelihood that they will self-injure.[18]

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[12] *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2018 BCSC 62 at para. 17. See paras. 15–49 for a detailed history of the use of segregation in the adult correctional system in Canada.

[13] UN General Assembly, *Interim Report of the Special Rapporteur of the Human Rights Council on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, UN General Assembly Official Records, 66th Session, UN Doc A/66/268 (2011), https://digitallibrary.un.org/record/710177?ln=en.

[14] Organization for Security and Co-operation in Europe, Office for Democratic Institutions and Human Rights and Penal Reform International, *Guidance Document on the Nelson Mandela Rules: Implementing the United Nations Revised Standard Minimum Rules for the Treatment of Prisoners*, 2018, 104 https://www.osce.org/odihr/389912.

[15] UN General Assembly, *Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN General Assembly Official Records, 63rd Session, UN Doc A/63/175 (2008) https://documents-dds-ny.un.org/doc/UNDOC/GEN/N08/440/75/PDF/N0844075.pdf?OpenElement, cited in *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2019 BCCA 228, para. 73; https://studiesonsolitary.files.wordpress.com/2016/10/istanbul_expert_statement_on_sc.pdf. Statement adopted by a working group of 24 international experts at the International Psychological Trauma Symposium, Istanbul.

[16] Craig Haney, "Mental Health Issues in Long-Term Solitary and '"Supermax"' Confinement," *Crime and Delinquency* 49, no. 1 (January 2003): 131., www.gwern.net/docs/psychology/2003-haney.pdf.

[17] UN General Assembly, *Interim Report of the Special Rapporteur of the Human Rights Council*, 66th Session, 26–27.

[18] Haney, "Mental Health Issues," 131.

Criticism of the use of isolation in prison is not new. In the Canadian context, Justice Louise Arbour's 1996 report, *Commission of Inquiry into Certain Events at the Prison for Women in Kingston,* recommended an end to long-term segregation.[19] Many Canadian reports since then have echoed and expanded on those recommendations. Of particular relevance are the three reports issued following the 2007 in-custody death of 19-year-old Ashley Smith, by the Ontario Coroner, the Correctional Investigator of Canada, and the New Brunswick Ombudsman and Child and Youth Advocate. Ms. Smith was an "identified mentally ill, high risk, high needs"[20] young woman who died of self-strangulation while in a segregation cell in a federal penitentiary centre, after not being provided with appropriate care, treatment and support. All of the reports identified Ms. Smith's repeated, prolonged isolation as a significant contributing factor in her mental deterioration.[21] Most recently, judicial decisions informed by a significant body of evidence-based research have focused increasing attention on the harmful effects of segregation and the consequent need for changes to the law and correctional practices.[22]

The Ontario Court of Appeal has found that prolonged segregation of adults in correctional facilities – defined in this context as segregation for any continuous period of more than 15 days – causes "foreseeable and expected harm" and concluded that the legislative scheme that permitted prolonged segregation amounted to cruel and unusual punishment.[23] The B.C. Court of Appeal cited with approval similar findings by the B.C. Supreme Court about the harm caused by segregation in the prison context:

> Administrative segregation places all federal inmates subject to it at significant risk of serious psychological harm, including mental pain and suffering, and is associated with an increased incidence of self-harm and suicide… while acute symptoms often subside upon termination of segregation, many inmates are likely to suffer permanent harm as a result of their confinement in segregation. That harm is most commonly manifested in an intolerance to social interaction which negatively affects the ability of some inmates to successfully readjust to the general prison population and to the broader community upon release from custody…the risk of harm is intensified in the case of mentally ill inmates… the indeterminacy of administrative segregation is a particularly problematic feature that exacerbates its harmful effects and intensifies the depression and hopelessness that is often generated in the restricted environment that characterizes segregation.[24]

The negative consequences of social isolation can develop after only a few days and increase the longer an individual is segregated from their peers.[25] The likelihood that an individual will experience these effects

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19 Arbour, *Commission of Inquiry*.

20 Correctional Service Canada, "Coroner's Inquest Touching the Death of Ashley Smith," Verdict of Coroner's Jury, December 19, 2013, Recommendation 1, https://www.csc-scc.gc.ca/publications/005007-9009-eng.shtml.

21 Correctional Service Canada, "Coroner's Inquest, Ashley Smith"; Correctional Investigator of Canada, *A Preventable Death*; New Brunswick, Ombudsman and Child and Youth Advocate, *The Ashley Smith Report*.

22 *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2019 BCCA 228; *Canadian Civil Liberties Association v. Canada*, 2019 ONCA 243.

23 *Canadian Civil Liberties Association v. Canada,* 2019 ONCA 243, paras. 71, 119 and 126.

24 *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2019 BCCA 228, para. 90.

25 UN General Assembly, *Interim Report of the Special Rapporteur*, 63rd Session, 23; see also *Canadian Civil Liberties Association* v. *Canada*, 2019 ONCA 243, paras. 73 and 76, citing findings made by the trial judge.

increases with each day a prisoner is isolated from others.[26] This practice of isolation in the prison environment can give rise to mental illness among prisoners who were previously healthy and exacerbate existing mental illness.[27] Craig Haney[28] reviewed research on solitary confinement and concluded, "there is not a single published study of solitary confinement…in which non-voluntary confinement lasted for longer than 10 days, where participants were unable to terminate their isolation at will, that failed to result in negative psychological effects."[29]

Individuals who have been isolated from others may have difficulty reintegrating into social groups, either inside prisons or within the broader community.[30] This is because individuals who are separated from their peers develop various strategies to cope with this isolation. On release, these strategies are often incongruent with dominant social and behavioural norms, and manifest as destructive social pathologies.[31] Moreover, many facilities do not prepare inmates for reintegration in any meaningful way, making it exceptionally difficult for prisoners who have been isolated to adapt to the organic set of social norms, cues and expectations that characterize life outside the isolated environment.[32] As a result, these practices of isolation can create a self-reinforcing cycle in which the harmful effects of isolation make it harder for a person to be in a non-isolated environment, and so isolation is more likely to continue.

## 2.3 Expert opinions on the impacts of isolation on youth

Experts are generally of the view that young people are particularly likely to experience negative health outcomes from social isolation in custody. As a starting point, it is important to recognize that youth are especially vulnerable to the negative effects of traumatic experiences, including those that are induced by the youth custody system.[33] This is because young people's brains, and by extension their intellectual, emotional and psychological capacity, continue to develop into their mid-20s. Brain structures responsible for executive functioning and self-regulation – including judgment and impulse control – are not fully mature until this time. Limited social interaction impairs this development.[34] Social interaction is therefore essential to the long-term psychological well-being of young people.

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[26] Diane Kelsall, "Cruel and Unusual Punishment: Solitary Confinement in Canadian Prisons," *Canadian Medical Association Journal* 186, no. 18 (2014): 1345. See also *British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para. 250; this finding was not challenged on appeal: *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2019 BCCA 228, para. 90.

[27] UN General Assembly, *Interim Report of the Special Rapporteur of the Human Rights Council*, 66th Session.

[28] Craig Haney's research, writing and testimony have been cited in the United States, including state courts, Federal District Courts, Circuit Courts of Appeal, and the United States Supreme Court (described in BCSC 2018 62, paras. 178–179). He was an expert witness for BC Civil Liberties Association in *British Columbia Civil Liberties Association v. Canada*, 2018 BCSC 62, in which the BCCLA challenged the constitutionality of administrative segregation in federal penitentiaries.

[29] Haney, "Mental Health Issues," 132.

[30] *British Columbia Civil Liberties Association* v. *Canada (Attorney General),* 2018 BCSC 62, para. 249.

[31] Haney, "Mental Health Issues," 138.

[32] Haney, "Mental Health Issues," 138.

[33] Ministry of Children and Family Development, *Healing Families, Helping Systems: A Trauma-Informed Practice Guide for Working with Children, Youth and Families*, January 2017, 4 and 6, https://www2.gov.bc.ca/assets/gov/health/child-teen-mental-health/trauma-informed_practice_guide.pdf.

[34] Alison S. Burke, "Under Construction: Brain Formation, Culpability, and the Criminal Justice System," *International Journal of Law and Psychiatry* 34, no. 6 (2011): 381, doi.org/10.1016/j.ijlp.2011.10.001.

The connection between age, brain development and social isolation is so significant that the two strongest predictors of suicidal behaviour in prison are time spent in isolation and being under the age of 19.[35] A joint position paper on solitary confinement of children and young people, published by the British Medical Association, the Royal College of Paediatrics and Child Health, and the Royal College of Psychiatrists, summarizes the nature of the concerns:

> As children [and youth] are still in the crucial stages of developing socially, psychologically, and neurologically, there are serious risks of solitary confinement causing long-term psychiatric and developmental harm. There is also clear evidence that it is counter-productive. Rather than improving behaviour, solitary confinement fails to address the underlying causes, and creates problems with reintegration.[36]

The paper condemns solitary confinement and concludes that children and youth should never be subjected to this practice.[37] In support of this conclusion, the British Medical Association wrote that "there is clear evidence that solitary confinement can have a profound, and lasting, adverse impact on health and well-being. As a result, we do not believe that its use can ever be sanctioned on children and young people."[38]

Other physician groups have also called for a prohibition on the isolation of youth in custody. For example, the College of Family Physicians of Canada's 2016 position statement on solitary confinement makes seven recommendations, including the following:

> 2. Abolish solitary confinement for youth. Due to the more fragile brains, the negative effects of solitary confinement will have a greater impact on youth.
>
> 4. Solitary confinement for mental illness (including those with post-traumatic stress disorder) is inappropriate. These persons require care in a specialized setting that will address the mental health needs rather than exacerbate them in solitary confinement.
>
> 6. Until solitary confinement is abolished, correctional facilities should develop and implement independent review procedures of all those in solitary confinement, to address both legality of the confinement and also to ensure the health (mental and medical) of persons in solitary confinement.
>
> 7. Until solitary confinement is abolished, correctional facilities should assure that the health care needs of persons in segregation are met. Persons in solitary confinement should be assessed in person by medical and nursing staff at least daily, in addition to regular assessment by correctional staff. If the person requires health care, then the patient should be seen in a health care setting that maintains confidentiality and dignity.[39]

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35 Lindsay M. Hayes, *Juvenile Suicide in Confinement: A National Survey,* U.S. Department of Justice, February 2009, www.ncjrs.gov/pdffiles1/ojjdp/213691.pdf.

36 Royal College of Paediatrics and Child Health, Royal College of Psychiatrists, and British Medical Association, *Joint Position Statement on Solitary Confinement of Children and Young People,* 2018, www.rcpch.ac.uk/sites/default/files/2018-04/solitary_confinement_position_statement.pdf.

37 Royal College of Paediatrics and Child Health et al., *Joint Position Statement*.

38 British Medical Association, "Solitary Confinement and Children and Young People," updated 2020, www.bma.org.uk/collective-voice/policy-and-research/equality/the-medical-role-in-solitary-confinement.

39 College of Family Physicians of Canada, *Position Statement on Solitary Confinement*, August 7, 2016, https://portal.cfpc.ca/resourcesdocs/uploadedFiles/Directories/Committees_List/Solitary%20Confinement_EN_Prison%20Health.pdf.

These recommendations are echoed in a 2012 statement of the American Academy of Child and Adolescent Psychiatry:

> The potential psychiatric consequences of prolonged solitary confinement are well recognized and include depression, anxiety and psychosis. Due to their developmental vulnerability, juvenile offenders are at particular risk of such adverse reactions. Furthermore, the majority of suicides in juvenile correctional facilities occur when the individual is isolated or in solitary confinement.
>
> [The Academy] opposes the use of solitary confinement in correctional facilities for juveniles. In addition, any youth that is confined for more than 24 hours must be evaluated by a mental health professional, such as a child and adolescent psychiatrist when one is available.[40]

Despite this body of research on the detrimental effects of social isolation, and both domestic and international calls by medical professionals for the practice to be strictly limited or abolished, youth in B.C. custody centres continue to be separately confined on a regular basis.

## 2.4 How youth end up in custody

Most youth involved in the youth criminal justice system in B.C. do not spend time in custody.[41] Youth charged with an offence are generally not detained in custody before adjudication and sentencing, and most who are found guilty receive sentences that can be served in the community.

However, some youth charged with or found guilty of an offence are detained in youth custody centres by order of a provincial court judge. The federal *Youth Criminal Justice Act* (YCJA) provides legal authority for a court to impose a custodial sentence on a youth after making a finding of guilt related to a federal statute, including the *Criminal Code*.[42] In addition, the YCJA provides the authority to place a youth in remand custody, which means that they are detained in a designated "place of temporary detention" while they await trial or sentencing.[43] B.C.'s youth custody centres are so designated. Finally, the provincial *Youth Justice Act* provides legal authority to detain, in a designated facility, youth who have been found guilty of a provincial statute offence.[44]

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40 American Academy of Child and Adolescent Psychiatry, "Solitary Confinement of Juvenile Offenders," policy statement, April 2012, https://www.aacap.org/aacap/policy_statements/2012/solitary_confinement_of_juvenile_offenders.aspx.

41 Statistics Canada, Canadian Centre for Justice Statistics, "Table 7: Average Daily Counts of Youth in Correctional Services, by Type of Supervision and Jurisdiction, 2017/2018," *Youth Corrections Key Indicator Report and Canadian Correctional Services Survey, 2017/2018*, https://www150.statcan.gc.ca/n1/pub/85-002-x/2019001/article/00010/tbl/tbl07-eng.htm.

42 *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 42(2)(n), (o), (q) and (r). Section 42(2)(p) authorizes custody for breach and suspension of deferred custody and supervision, and s. 76 authorizes placement in a youth custody centre when subject to an adult sentence.

43 *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 30(1). Remand custody is defined as the court-ordered custody in a designated youth custody centre arising from a detention order made while the youth is awaiting trial, preparation of an in-custody medical or psychological report or sentencing. Remand custody may also continue after a youth is granted bail that is unable to be perfected. Judges must consider two factors when deciding whether to hold a young person in remand. First, judges may not detain youth in remand custody as a social measure, such as for child protection or mental health reasons. Second, judges may only detain a youth in remand custody if they are charged with a "serious offence," or are charged with a non-serious offence but have a history of outstanding charges or findings of guilt: *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 28.1 and s. 29(2)(b)(iii)(D).

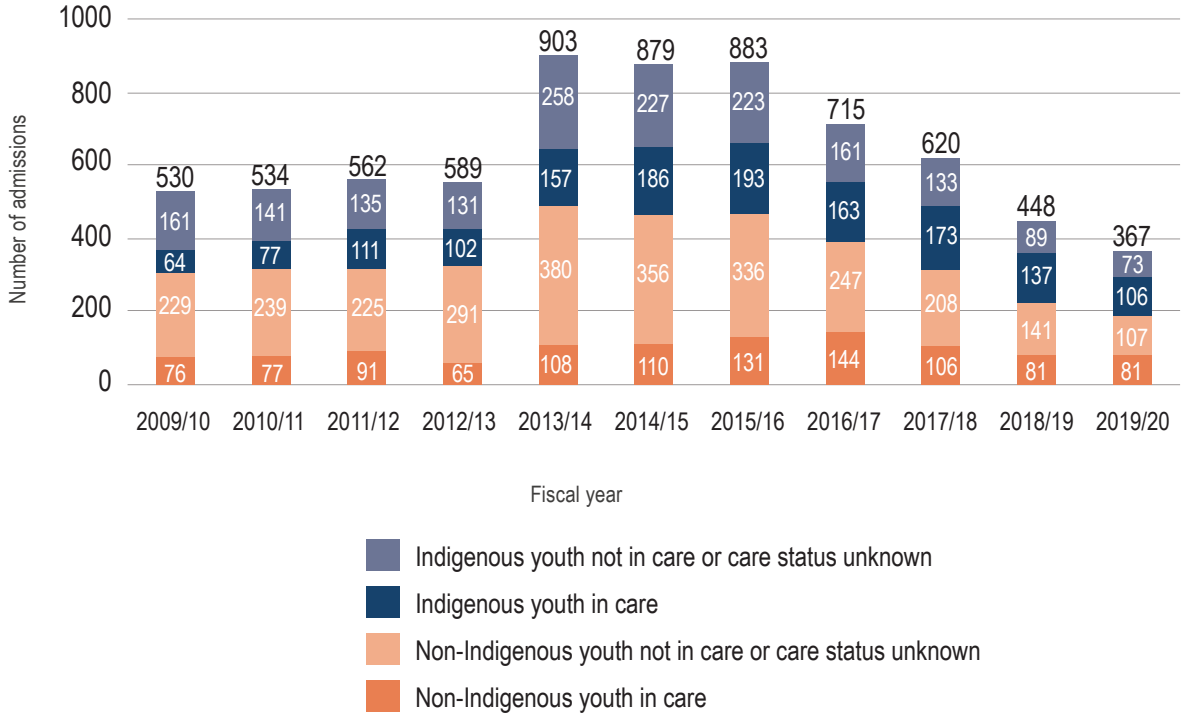
44 *Youth Justice Act*, S.B.C. 2003, c. 85, s. 13.

Custody is the most serious consequence in the criminal justice system and is intended to be used primarily for youth who are charged with or convicted of violent offences, youth who are repeatedly convicted of violent offences, or youth who fail to comply with the conditions of non-custodial sentences.[45]

When a youth is admitted to custody, they become subject to the care, control and custody of the government until released from custody.[46] The youth custody system in B.C. is the responsibility of the Ministry of Children and Family Development.

The number of youth who are detained in custody in B.C. has fluctuated over the past decade. As shown in Figure 1, the number of youth admitted to custody increased between 2009 and 2014.[47] Since then, the number of

**Figure 1: Admissions to youth custody, by Indigeneity and care status, 2009/10–2019/20**




[45] This is reflected in the requirement that "the least restrictive measures consistent with the protection of the public" be used in relation to custody and supervision of youth: *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 83(2)(a). Similarly, when the *Youth Justice Act* was debated in the British Columbia Legislative Assembly, then-Minister of Children and Family Development Gordon Hogg said: "In this provincial legislation, custody has been maintained only for those most serious of the provincial statutes and is in fact not available for less serious crimes. There is a distinction and a line drawn between those to reflect the role of custody as a consequence." Hansard, November 4, 2003, 7786, https://www.leg.bc.ca/content/hansard/37th4th/H1104pm-02.pdf.

[46] *Youth Justice Act*, S.B.C. 2003, c. 85, s. 30.

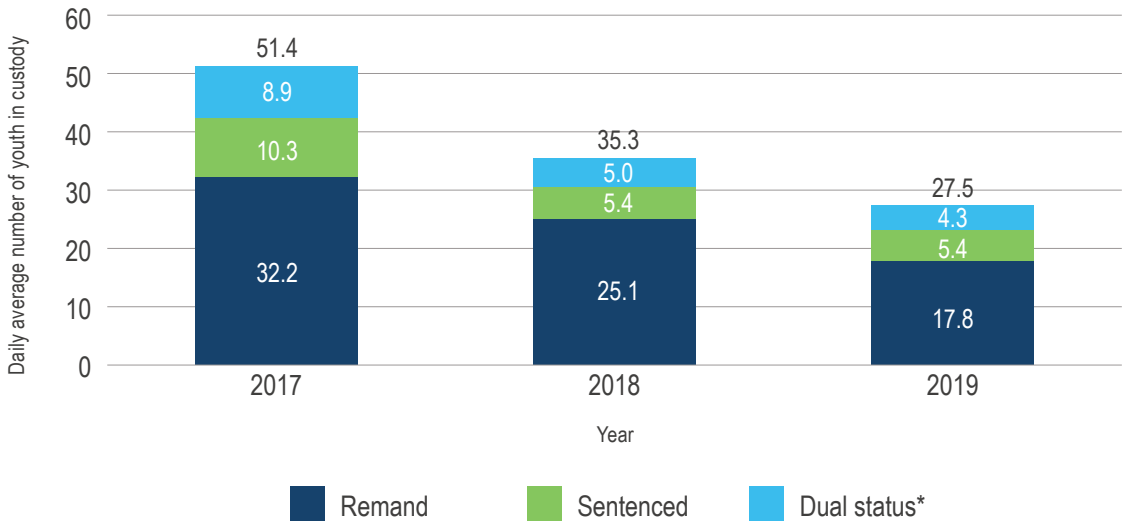
[47] The figures we present in Figure 1 are based on data provided by Branch Practice and Service Manager, Specialized Intervention and Youth Justice Branch, Ministry of Children and Family Development, email to the Office of the Ombudsperson, January 7, 2021.

youth admitted to youth custody has declined steadily.[48] In 2017, there were an average of 52 youth in custody on any given day.[49] In 2019, there were an average of 28 youth in custody in the province on any given day.[50]

Over the three years of our investigation, 582 individual youth were admitted to B.C. custody centres. Some youth were admitted multiple times; as a result, there were 1,513 total admissions over this three-year period. The number of youth in custody is very small relative to the total youth population in the province. As of July 1, 2019, there were an estimated 357,455 youth aged 12–18 in B.C.[51]

A significant number of youth in custody in B.C. are in remand. Statistics produced by the ministry, shown in Figure 2, confirm the relatively high proportion of youth in remand during the time of our investigation.[52] As Figure 3 shows, remanded youth made up 62 percent of the daily average number of youth in custody in 2017. While the number of individual youth in custody has declined over the years, remanded youth represented 65 percent of the daily average of youth in custody in 2019.

**Figure 2: Daily averages of youth in custody, by status (sentenced, remand or dual status), 2017–2019**




*Dual status refers to youth who are held in custody on both a sentence and remand order.

[48] This decline is consistent with national statistics. The national youth incarceration rate in 2017/18 decreased by 12 percent from the previous year and 29 percent from 2013/14. See Jamil Malakieh, *Adult and Youth Correctional Statistics in Canada, 2017/2018*, Statistics Canada, Canadian Centre for Justice Statistics, May 9, 2019, 6, https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2019001/article/00010-eng.pdf?st=UI3FwMKW.

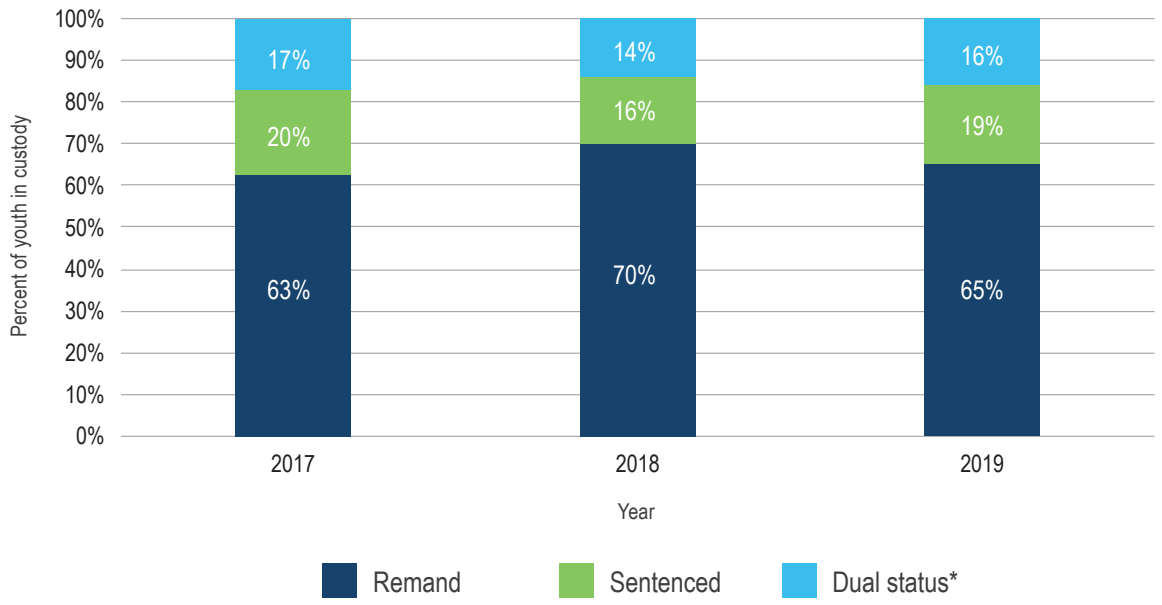
[49] Daily averages based on data provided by the ministry in the form of quarterly "provincial quality improvement" (PQI) reports. These reports provide the daily average number of youth in custody per month, quarter and fiscal year-to-date: Ministry of Children and Family Development, Youth Custody Services, PQI Report, FY 16/17 Q4–FY 19/20 Q3. These numbers have been rounded to the nearest whole number.

[50] Ministry of Children and Family Development, Youth Custody Services, PQI Report, FY 16/17 Q4–FY 19/20 Q3.

[51] This number was obtained using the tool available at BC Stats, "British Columbia – Population Estimates," https://bcstats.shinyapps.io/popApp/

[52] The numbers presented in Figure 2 and Figure 3 are based on data provided by the ministry in quarterly PQI reports. Ministry of Children and Family Development, Youth Custody Services, PQI Report, FY 16/17 Q4–FY 19/20 Q3.

**Figure 3: Proportions of youth in custody by status (sentenced, remand or dual status), 2017–2019**




*Dual status refers to youth who are held in custody on both a sentence and remand order.

## 2.5 Characteristics of youth in custody

An extensive study across numerous national contexts, including Canada, found that many youth in custody live with a range of health and developmental difficulties, including neurodevelopmental disabilities, traumatic brain injuries, mental health difficulties and adverse childhood experiences.[53] A report by the B.C. Representative for Children and Youth (RCY) and the Provincial Health Officer (PHO) noted that many youth in custody in B.C. have experienced childhood trauma and adversity.[54] A 2011 study found that almost all youth in custody in B.C. (91.9 percent of males and 100 percent of females) lived with at least one mental disorder; the majority of those youth were living with more than one mental disorder.[55] Further, a 2013 report found that 67 percent of youth in custody in B.C. reported having been diagnosed with a specific mental disorder, and 65 percent of youth reported having at least one health challenge (including behavioural problems and mental or emotional health conditions).[56] Indeed, the Ministry of Children and Family Development states:

[53] Nathan Hughes et al., "Health Determinants of Adolescent Criminalisation," *Lancet Child and Adolescent Health* 4, no. 2 (2002): 153, https://doi.org/10.1016/S2352-4642(19)30347-5.

[54] Representative for Children and Youth and Office of the Provincial Health Officer, *Kids, Crime and Care: Health and Well-Being of Children in Care: Youth Justice Experiences and Outcomes*, Joint Special Report, February 23, 2009, https://rcybc.ca/reports-and-publications/reports/monitoring-reports/kids-crime-and-care-youth-justice-experiences-and-outcomes/. See also Hughes et al., "Health Determinants," 153.

[55] Heather M. Gretton and Robert J.W. Clift, "The Mental Health Needs of Incarcerated Youth in British Columbia, Canada," *International Journal of Law and Psychiatry* 34 (2011): 111.

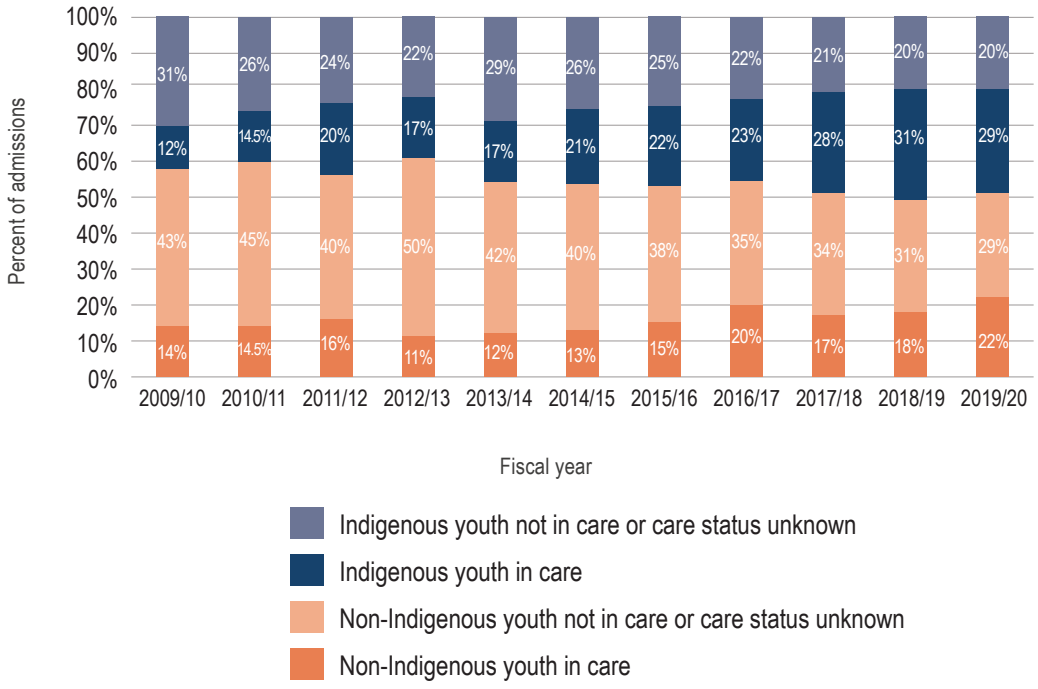
[56] Annie Smith et al., *Time Out III: A Profile of BC Youth in Custody*, The McCreary Centre Society, 2013, 4 and 24, http://www.mcs.bc.ca/pdf/Time_Out_III.pdf.

Research findings, external reviews and the general observations and assessment by staff and service providers confirm that youth in custody have typically suffered significant trauma, are impacted by physical and mental health issues, have experienced multiple placements resulting in limited family and community connectedness and disrupted educational achievement, have witnessed violence and have histories of extensive exposure to and use of a variety of substances.[57]

The health and developmental difficulties experienced by youth in custody are exacerbated by experiences of societal marginalization, structural disadvantage and inequality.[58] The link between youth living with histories of trauma and mental illness and their involvement with the youth justice system in B.C. is described in the 2009 report by the RCY and PHO.[59] That report also acknowledged the overrepresentation of Indigenous youth and youth in care in the youth justice system.

While the overall number of youth in custody has declined, Indigenous youth and youth in care of the ministry's child welfare system continue to be overrepresented in B.C.'s youth custody system, as shown in Figure 4.[60]

**Figure 4: Proportions of admissions to youth custody, by care status and Indigeneity, 2009/10–2019/20**



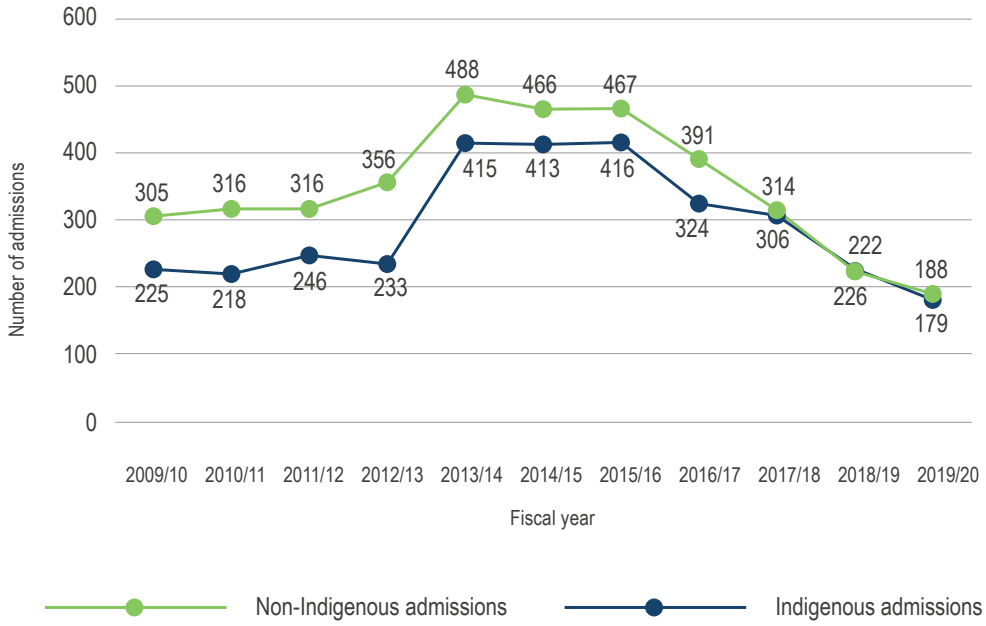

[57] Ministry of Children and Family Development, Youth Custody Services, *Strategic Plan 2017/18–2019/20*, December 2017, 8.
[58] Hughes et al., "Health Determinants," 151.
[59] RCY and PHO, *Kids, Crime and Care*.
[60] Figure 4, Figure 5 and Figure 6 are based on data provided by Branch Practice and Service Manager, Specialized Intervention and Youth Justice Branch, Ministry of Children and Family Development, email to the Office of the Ombudsperson, January 7, 2021. Note that "in care" is defined in the records received from the ministry as the following: "Voluntary Care, Continuing Care, and Temporary Care."

## Indigenous youth

The decline in the number of youth in custody in B.C. includes a decline in the number of Indigenous youth in custody. However, Indigenous youth continue to be overrepresented in youth custody. In 2016, almost 10 percent of youth in B.C. (ages 10–19) identified as Indigenous (First Nations, Métis or Inuit).[61]

The proportion of youth in custody in B.C. who are Indigenous has been increasing for at least two decades. The proportion of youth in custody who the ministry identifies as Indigenous was 27 percent in 2000/01; this grew to 42 percent in 2009/10,[62] and in 2019/20 Indigenous youth accounted for 49 percent of all youth admitted to custody in B.C. (see Figure 6).[63] These proportions are the same for male and female youth[64] – that is, approximately half of all male and half of all female admissions to youth custody are currently Indigenous youth. This is consistent with broader social patterns described by the RCY and PHO in their 2009 report, finding that Indigenous youth in B.C. were five times

**Figure 5: Admissions to youth custody, by Indigeneity, 2009/10–2019/20**




[61] Statistics Canada, *British Columbia, Aboriginal Population Profile*, 2016 Census, July 18, 2018, https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/abpopprof/details/page.cfm?Lang=E&Geo1=PR&Code1=59&Data=Count&SearchText=British%20Columbia&SearchType=Begins&B1=All&C1=All&SEX_ID=1&AGE_ID=1&RESGEO_ID=1.

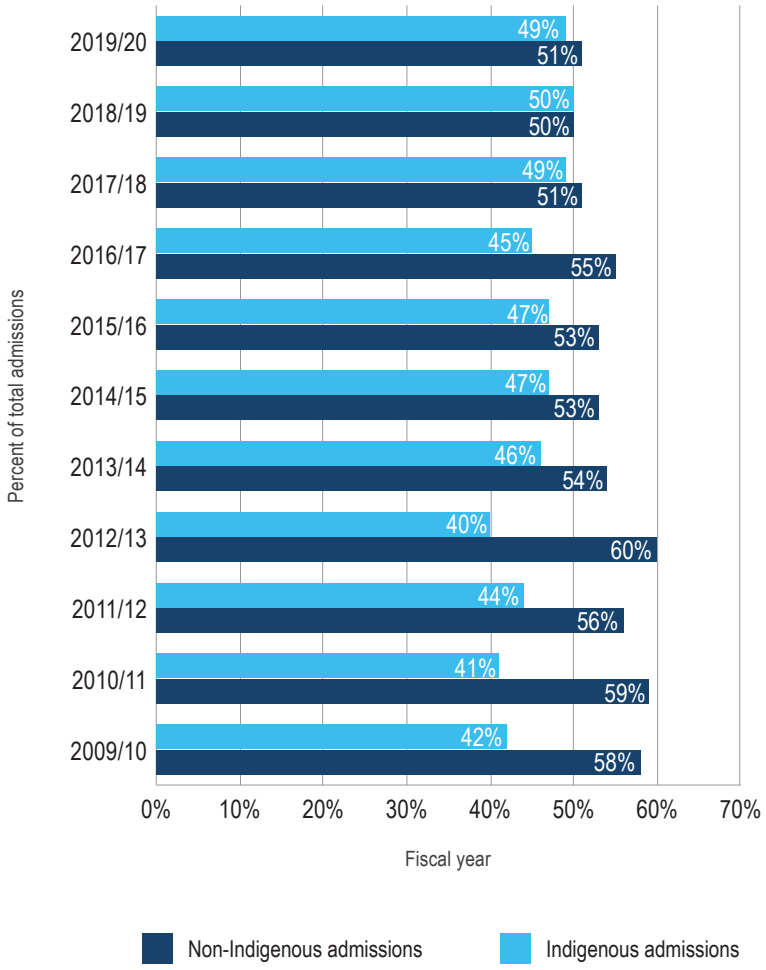
[62] Statistics Canada, Canadian Centre for Justice Statistics, *Youth Custody and Community Services Data Tables, 2000–2001*, October 2002, 18, 22, 27, https://www150.statcan.gc.ca/n1/en/pub/85-226-x/85-226-x2001000-eng.pdf?st=MEkMF4BN.

[63] Branch Practice and Service Manager, Specialized Intervention and Youth Justice Branch, Ministry of Children and Family Development, email to the Office of the Ombudsperson, January 7, 2021.

[64] The ministry's admission data does not identify gender-diverse youth, so any such youth would have been labelled as either male or female in this data set.

more likely than youth in the general study population to be incarcerated.[65] Similarly, data from 2016/17 showed that Indigenous youth in B.C. were incarcerated at an estimated rate of approximately 6.9 per 1,000 youth, while non-Indigenous youth were incarcerated at an estimated rate of approximately 0.9 per 1,000 youth.[66]

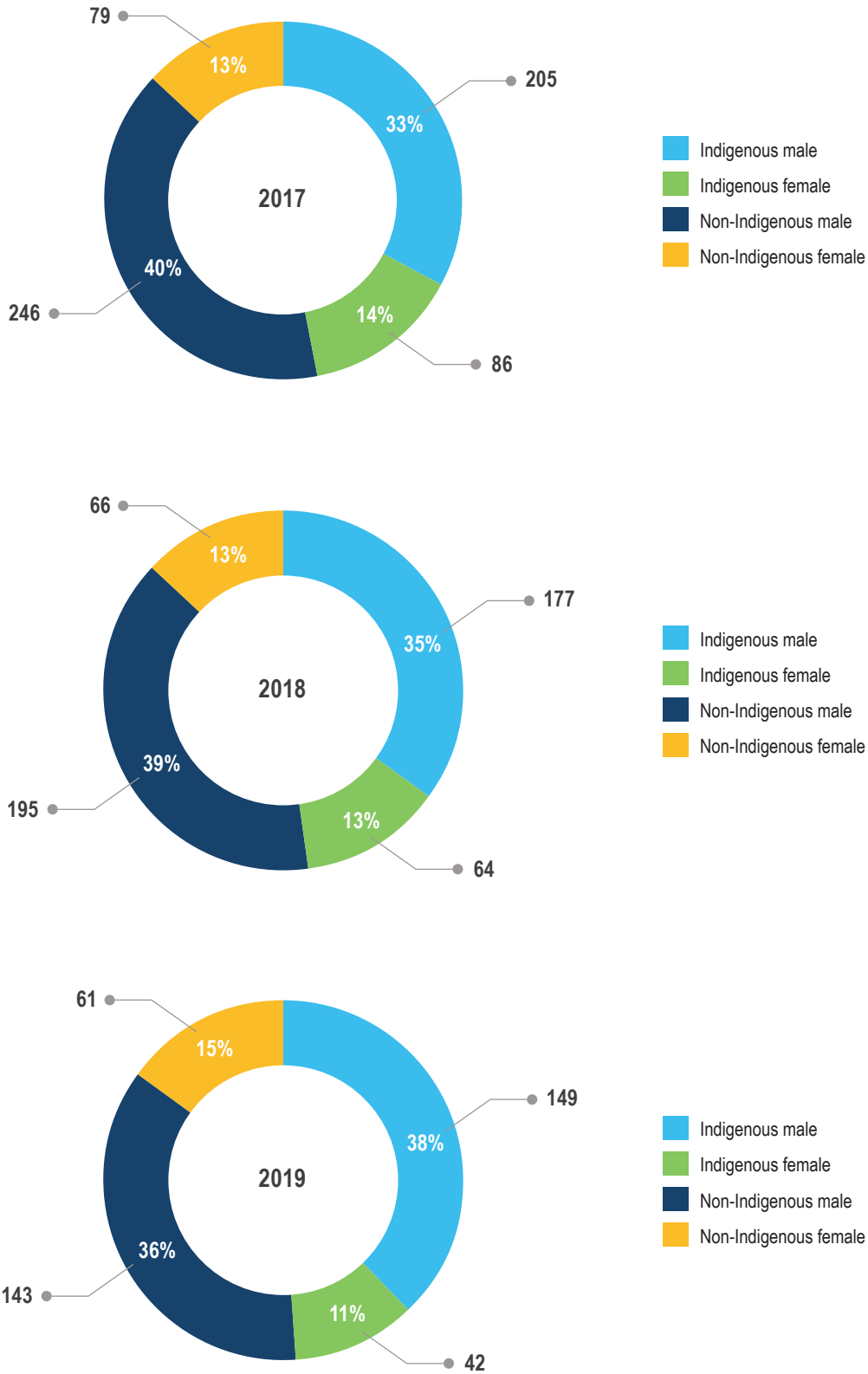
**Figure 6: Proportions of youth custody admissions, by Indigeneity, 2009/10–2019/20**




[65] RCY and PHO, *Kids, Crime and Care*, 7 and 38.

[66] Statistics Canada, *British Columbia, Aboriginal Population Profile*, 2016 Census. Note that the population figures provided by Statistics Canada are for youth aged 10–19. No youth under 12 can be held criminally responsible and, as a result, cannot be admitted to custody.

**Figure 7: Annual admissions to youth custody, by sex and Indigeneity, 2017–2019**[67]




[67] Branch Practice and Service Manager, Specialized Intervention and Youth Justice Branch, Ministry of Children and Family Development, email to the Office of the Ombudsperson, February 19, 2020.

The overrepresentation of Indigenous people in the Canadian criminal justice system has been well-documented for decades.[68] In its 2015 report, the Truth and Reconciliation Commission of Canada discussed the complex causes of Indigenous overrepresentation in Canadian prisons, including the intergenerational legacy of colonialism and systemic discrimination in the criminal justice system:

> The causes of the over-incarceration of Aboriginal people are complex. The convictions of Aboriginal offenders frequently result from an interplay of factors, including the intergenerational legacy of residential schools. Aboriginal overrepresentation in prison reflects a systemic bias in the Canadian justice system. Once Aboriginal persons are arrested, prosecuted, and convicted, they are more likely to be sentenced to prison than non-Aboriginal people.[69]

The commission called for the elimination of the overrepresentation of Indigenous youth in custody by 2025 and the development of realistic alternatives to imprisonment that respond to the underlying causes of offending behaviour, including cognitive vulnerabilities and intergenerational trauma.[70] This approach is consistent with the goals of the *Youth Criminal Justice Act*, discussed in further detail in section 5.1.[71]

The ministry acknowledges the overrepresentation of Indigenous youth in the youth custody centres. The *Manual of Operations – Youth Custody Programs* contains the following statement in relation to Indigenous youth in custody:

> Youth Justice Services' policies and programs acknowledge:
>
> 1. The overrepresentation of Indigenous youth involved in the criminal justice system and contributing historical and systemic factors.
>
> 2. The unique position of Indigenous youth, the role of the family, the role of extended families, and the distinctive values, traditions and processes of Indigenous communities for resolving harm.
>
> 3. The obligation to consult with Indigenous communities and invite Indigenous community participation in making services more relevant and responsive to Indigenous youth.[72]

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[68] See, for example, *Report of the Royal Commission on Aboriginal Peoples: Looking Forward, Looking Back, Vol. 1,* August 26, 1991, http://data2.archives.ca/e/e448/e011188230-01.pdf; A.C. Hamilton and C.M. Sinclair, *Report of the Aboriginal Justice Inquiry of Manitoba*, 1991, http://www.ajic.mb.ca/volumel/toc.html; Royal Commission on Aboriginal Peoples, *Bridging the Cultural Divide: A Report on Aboriginal People and the Criminal Justice System in Canada*, 1996, http://publications.gc.ca/collections/collection_2016/bcp-pco/Z1-1991-1-41-8-eng.pdf; Truth and Reconciliation Commission of Canada, *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada*, July 23, 2015, 170, http://nctr.ca/assets/reports/Final%20Reports/Executive_Summary_English_Web.pdf; *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*, 2019, https://www.mmiwg-ffada.ca/final-report/.

[69] Truth and Reconciliation Commission, *Honouring the Truth,* 170.

[70] See TRC Calls to Action 31, 36, and 38: Truth and Reconciliation Commission, *Honouring the Truth,* 173–174, 176–177 and 178–179.

[71] The YCJA states that "measures taken against young persons who commit offences should…respond to the needs of aboriginal young persons": *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 3(1)(c)(iv).

[72] Ministry of Children and Family Development, Office of the Provincial Director of Youth Justice, *Manual of Operations – Youth Custody Programs*, April 1, 2018, B.1.08.

However, the operations manual does not explain how these acknowledgements can or should be operationalized in the context of day-to-day decision making. Similarly, the *Youth Justice Act* does not establish an obligation for the ministry to respond to the special needs of Indigenous youth in custody in making decisions under that Act or the *Youth Custody Regulation*.

The overrepresentation of Indigenous youth admitted to custody is largely beyond the control of the ministry's custody services. Ultimately, the decision to commence criminal law processes rests with the police and Crown through the charge approval process.[73] The decision to sentence or remand Indigenous youth to custody is made by the court.

The role of police, Crown counsel and the courts in the overrepresentation of Indigenous people in custody has been the focus of jurisprudence and legislative initiatives aimed at ameliorating the over-incarceration of Indigenous people and mitigating historical disadvantage and systemic discrimination.[74] Recently, the B.C. Prosecution Service announced policy changes that specifically target the overrepresentation of Indigenous people in the B.C criminal justice system, including amendments to the *Crown Counsel Policy Manual* that provide more specific guidance to Crown counsel in considering the use of extrajudicial measures for young people who are Indigenous.[75]

More broadly, the February 2020 *BC First Nations Justice Strategy*, jointly developed by the BC First Nations Justice Council, B.C. First Nations communities and the provincial government, envisions the creation of a First Nations youth justice prevention and action plan aimed at addressing the overrepresentation of First Nations youth in the justice system.[76]

## Youth in care under the *Child, Family and Community Service Act*

Youth who were in the care of the Ministry of Children and Family Development under the *Child, Family and Community Service Act* prior to their admission are also overrepresented in custody.[77] As Figure 9 shows, the proportion of youth admitted to custody who are in care

[73] In B.C., Crown counsel are responsible for laying charges. The charge approval process is set out in provincial policy. British Columbia Prosecution Service, *Crown Counsel Policy Manual*, Charge Assessment Guidelines, CHA 1, January 15, 2021, https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/prosecution-service/crown-counsel-policy-manual/cha-1-charge-assessment-guidelines.pdf.

[74] Section 718.2(e) of the *Criminal Code* came into force in 1996, requiring judges to pay "particular attention to the circumstances of aboriginal offenders" in the consideration of "all available sanctions other than imprisonment" in making sentencing decisions for adults and youth. See *Criminal Code*, R.S.C. 1985, c. C-46, s. 718.2(e). In 1999, the Supreme Court of Canada in *R. v. Gladue* directed judges to look at alternative sentencing options, and to consider broad systemic and background factors that affect Indigenous people generally and the offender in particular: *R. v. Gladue*, [1999] 1 SCR 688.

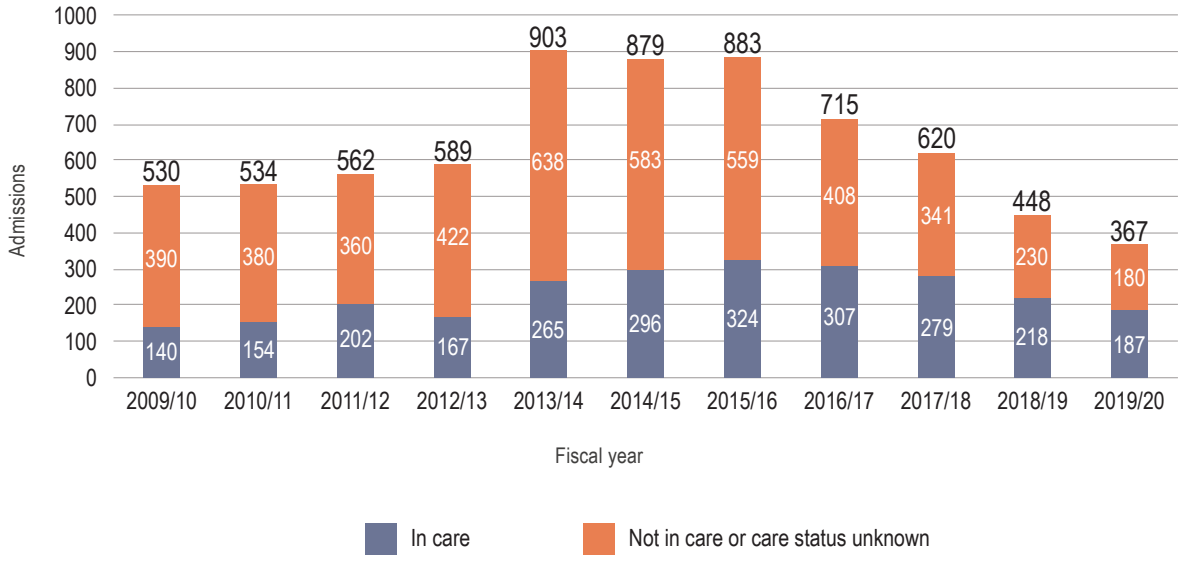
[75] The *Crown Counsel Policy Manual* was amended on January 15, 2021, directing Crown counsel to consider whether bias, racism or systemic discrimination as well as the factors discussed in *R. v. Gladue* have played a part in the Indigenous person coming into contact with the criminal justice system. The amended policy directs Crown counsel to specifically consider whether traditional or culturally based Indigenous practices or programs are appropriate and available extrajudicial measures in the community. Finally, the policy supports the use of extrajudicial measures for Indigenous youth whenever the public interest could reasonably be satisfied, even when the youth has been previously referred for or dealt with by an extrajudicial measure or has been previously convicted of a criminal offence and sentenced, including to a sentence of imprisonment. See B.C. Prosecution Service, *Crown Counsel Policy Manual*, Youth Criminal Justice Act – Extrajudicial Measures, YOU1.4.

[76] BC First Nations Justice Council, Ministry of Attorney General, and Ministry of Public Safety and Solicitor General, *BC First Nations Justice Strategy*, February 2020, 37–38, https://news.gov.bc.ca/files/First_Nations_Justice_Strategy_Feb_2020.pdf.

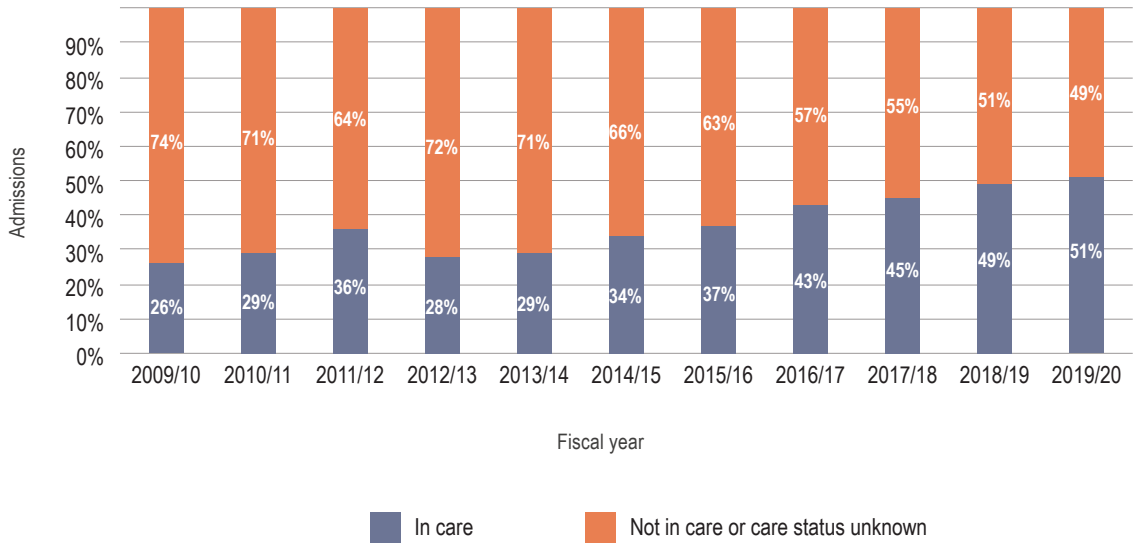
[77] *Child, Family and Community Services Act*, R.S.B.C. 1996, c. 46.

increased from 26 percent in 2009/10 to 51 percent in 2019/20.[78] Youth in care are more likely than the general population to end up in custody: a 2009 study found that one in six youth in care in B.C. had been in youth custody, compared with one in 50 youth in the general study population.[79]

### Figure 8: Admissions to youth custody, by care status, 2009/10–2019/20




### Figure 9: Proportions of youth admitted to custody, by care status, 2009/10–2019/20




[78] Branch Practice and Service Manager, Specialized Intervention and Youth Justice Branch, Ministry of Children and Family Development, email to the Office of the Ombudsperson, January 7, 2021. "In care" is defined in the records received from the ministry as the following: "Voluntary Care, Continuing Care and Temporary Care." "Other status" includes youth tagged in the ministry's database as "Not in care," as well as youth whose care status is tagged as "Not stated" or "Unknown." In some cases the care status of youth was unknown or undocumented at the time the data was entered into the database and that data was not subsequently added. As a result, the numbers of youth in custody who are in care may have been undercounted. Source: Ministry of Children and Family Development, Youth Custody Services, PQI Report, FY 16/17 Q4–FY 19/20 Q3.

[79] RCY and PHO, *Kids, Crime and Care*, 7 and 13.

In 2018, Indigenous children (from birth to age 18) were in the care of the ministry at a rate more than 15 times higher than non-Indigenous children.[80] Almost two-thirds (63 percent) of children in care in the province are Indigenous.[81] Indigenous youth in care are increasingly overrepresented in custody. As shown in Figure 4, in 2009/10, 12 percent of youth admitted to custody were Indigenous and in the care of the ministry. This rate has increased over time. In 2019/20, 29 percent of youth admitted to custody were Indigenous youth in the care of the ministry.

The overrepresentation of Indigenous children in the child welfare system is the result of a long history of colonialism that has supported the ongoing removal of Indigenous children from their families and communities.[82] To this day, the majority of Indigenous children are removed for reasons broadly characterized as "neglect" but which have been identified more accurately as structural risk factors beyond the control of individual parents and guardians, such as "poor housing, poverty, substance misuse and, in many cases, lack of access to safe drinking water and adequate health care."[83] Along with these structural risks, there is a dire lack of support services within many Indigenous communities that would help children and youth to thrive.[84] These risk factors are a direct result of colonialism, chronic underfunding of services, and the legacy of intergenerational trauma rendered through residential school experiences.[85]

Apprehension by the child welfare system increases a child's vulnerability to sexual abuse and exploitation, especially for Indigenous girls.[86] In addition, Indigenous children in the child welfare system experience high rates of isolation, physical, emotional and sexual abuse, and death.[87]

There is also a significant overlap of youth in care involved with the criminal justice system and youth living with mental illness. Almost 72 percent of youth in care involved with the criminal justice system (which includes youth in custody and those under community supervision) have been reported to be living with serious behavioural problems or mental illness.[88]

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80 Ministry of Children and Family Development, "Performance Indicators: Children and Youth in Care (CYIC)," https://mcfd.gov.bc.ca/reporting/services/child-protection/permanency-for-children-and-youth/performance-indicators/children-in-care.

81 Ministry of Children and Family Development, "Performance Indicators."

82 Truth and Reconciliation Commission, *Honouring the Truth,* 135.

83 Melisa Brittain and Cindy Blackstock, *First Nations Child Poverty: A Literature Review and Analysis*, First Nations Children's Action Research and Education Service, 2015, 12; National Collaborating Centre for Aboriginal Health, *Indigenous Children and the Child Welfare System in Canada*, 2017, 9, https://www.nccih.ca/docs/health/FS-ChildWelfareCanada-EN.pdf; Bruce MacLaurin et al., *A Comparison of First Nations and Non-Aboriginal Children Investigated for Maltreatment in Canada in 2003*, Centres of Excellence for Children's Well-Being, 2008, 2–3, https://cwrp.ca/sites/default/files/infosheets/FNvsnonFN66E.pdf.

84 West Coast LEAF, *Pathways in a Forest: Indigenous Guidance on Prevention-Based Child Welfare*, September 2019, 38–40 and 88–91, http://www.westcoastleaf.org/wp-content/uploads/2019/09/Pathways-in-a-Forest.pdf.

85 West Coast LEAF, *Pathways in a Forest*, 38–40 and 88–91; Truth and Reconciliation Commission, *Honouring the Truth*, 144, 178, 180, 182 and 377.

86 Representative for Children and Youth, *Too Many Victims: Sexualized Violence in the Lives of Children and Youth in Care*, 2016, https://rcybc.ca/reports-and-publications/reports/general-reports/too-many-victimssexualized-violence-in-the-lives-of-children-and-youth-in-care/.

87 Brittain and Blackstock, *First Nations Child Poverty*; Kenneth Jackson, "Death as Expected: Inside a Child Welfare System Where 102 Indigenous Kids Died over 5 years," *APTN News,* September 25, 2019, https://www.aptnnews.ca/national-news/inside-a-child-welfare-system-where-102-indigenous-kids-died-over-5-years/; Representative for Children and Youth, *Illuminating Service Experience: A Descriptive Analysis of Injury and Death Reports for First Nations Children and Youth in B.C., 2015 to 2017*, 2020, 16-26, 34 and 35, https://rcybc.ca/wp-content/uploads/2020/12/IlluminatingServiceExperience.pdf.

88 RCY and PHO, *Kids, Crime and Care*, 4.

We describe these factors to emphasize that while fewer youth are detained in custody now than has historically been the case, those youth who are in custody have complex needs and vulnerabilities caused by structural inequalities within broader society. As the 2009 joint report by the Representative for Children and Youth and Provincial Health Officer highlighted, "The youth remaining in the [youth justice] system are those for whom many systems may have failed and many adults may have rejected or failed to support."[89] When youth enter custody, they become "subject to the care, control and custody of the government."[90] The ministry has an obligation to ensure that the ways in which all youth experience custody do not cause further harm but are, as required by the *Youth Criminal Justice Act*, "safe, fair and humane."[91]

## 2.6 Youth custody centres in B.C.

There are currently two youth custody centres in B.C., located in Burnaby and Prince George.

Burnaby Youth Custody Services Centre (BYCS) first opened in its current location in 2007. Originally built in 1990 as the B.C. Correctional Centre for Women, and later renovated to accommodate youth, BYCS has a maximum capacity of 142 beds and houses male, female and gender-diverse youth.[92] In 2012, BYCS became the central custody location for all female and gender-diverse youth in custody. It also continues to house the majority of male youth who are in custody in B.C.

Prince George Youth Custody Services Centre (PGYCS) was designed and built specifically as a youth facility. It opened in 1989 and has a maximum capacity of 60 beds. Historically, it housed male and female youth from the northern and interior regions of the province. Since 2012, PGYCS has primarily housed male youth. It will sometimes also house female and gender-diverse youth for periods of up to seven days prior to their release or transfer to BYCS.

BYCS is the primary centre for youth custody in the province. Total annual admissions and daily average numbers of youth in custody are much higher for BYCS than for PGYCS. There were 536 admissions to BYCS in 2017, 436 in 2018 and 328 in 2019, for a total of 1,300 admissions during the three years of our investigation (see Figure 10).[93] In contrast, there were 80 admissions to PGYCS in 2017, 66 in 2018 and 67 in 2019, for a total of 213 admissions during the three years of our investigation. This means that 86 percent of admissions to youth custody over this three-year period were to BYCS.

89 RCY and PHO, *Kids, Crime and Care*, 5.

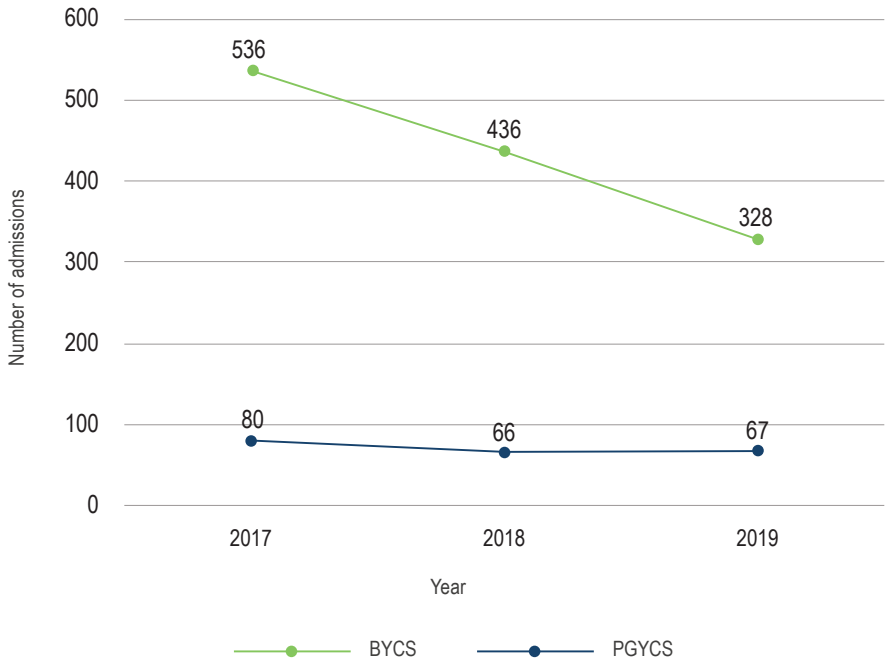
90 *Youth Justice Act*, S.B.C. 2003, c. 85, s. 30.

91 *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 83(1)(a). This provision of the *Youth Criminal Justice Act* acknowledges that a "safe, fair and humane" custody system contributes to the protection of society.

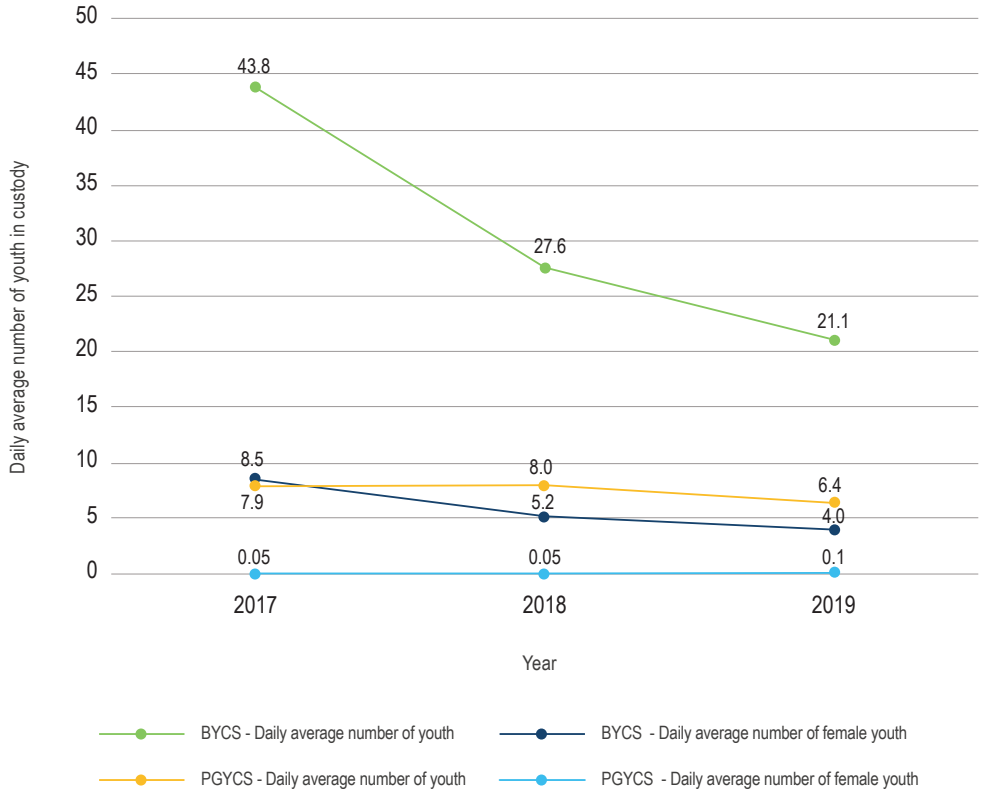
92 The precise number of youth admitted to custody who identify as gender-diverse is unknown, as the ministry does not record diverse gender identity on admission. The demographic data provided by the ministry categorizes youth based on biological sex, male or female.

93 Branch Practice and Service Manager, Specialized Intervention and Youth Justice Branch, Ministry of Children and Family Development, email to the Office of the Ombudsperson, February 24, 2020.

## Figure 10: Annual admissions, BYCS and PGYCS, 2017–2019




## Figure 11: Average daily numbers of youth in custody, BYCS and PGYCS, 2017–2019



BYCS housed a daily average of 43.8 youth in 2017, 27.6 youth in 2018 and 21.1 youth in 2019 (see Figure 11[94]). In contrast, PGYCS averaged 7.9 youth each day in 2017, 8 youth in 2018 and 6.4 youth in 2019. Female youth are a tiny fraction of the daily average of youth in custody at PGYCS.

Until September 2014, the ministry operated a third youth custody centre in Victoria. This facility originally had a maximum capacity of 60 beds. Currently, a small area (four beds) of the centre operates as an interim holding unit that is a satellite facility of BYCS. It functions as a short-term, temporary, overnight housing unit for youth on Vancouver Island who are awaiting transfer to or from court or to BYCS. The use of the Victoria facility has declined over time. In 2017/18, there were 40 individual admissions (41 total nights), in 2018/19, there were 22 admissions (21 total nights), and in 2019/20, there were 21 admissions (23 total nights).

## Female youth

In response to a significant decline in the number of female youth in custody, the ministry centralized services for female youth at BYCS in 2012. Since then, female youth have been housed primarily in all-female units at BYCS.

Female youth account for approximately 26 percent of all youth admitted to custody on an annual basis.[95] Despite representing 26 percent of all admissions over the course of a year, female youth make up a significantly smaller proportion of the average daily population in custody. This is because female youth tend to spend less time in custody per admission than male youth. For example, in 2017, female youth accounted for an average of 17 percent of the youth custody population on any given day. In real numbers, there was a daily average of 8.6 female youth in custody in 2017. In 2019 there was a daily average of 4.1 female youth in custody, representing 15 percent of the population on any given day.[96]

## Youth Forensic Psychiatric Services and the Maples Adolescent Treatment Centre

The Ministry of Children and Family Development also provides services to youth involved in the justice system, whether they are in custody or not, through Youth Forensic Psychiatric Services (YFPS) and the Maples Adolescent Treatment Centre. This includes forensic assessment and mental health treatment. For example, YFPS may conduct court-ordered assessments of youth to assist the court in determining whether they are fit to stand trial or in determining an appropriate sentence. YFPS also delivers mental health treatment services to youth in custody at BYCS and PGYCS.

YFPS has a six-bed facility, called the Inpatient Assessment Unit, located adjacent to BYCS. The Inpatient Assessment Unit is administratively, operationally and physically separate from BYCS, and is staffed by a multidisciplinary team of health care professionals. It provides assessment and treatment services for youth when a court orders assessment and treatment. In addition,

[94] Ministry of Children and Family Development, Youth Custody Services, PQI Report, FY 16/17 Q4–FY 19/20 Q3. Figure 11 is based on the total number of admissions over the three-year period, not the number of unique individuals admitted over this period.

[95] Female youth represent 23 percent of the total number of unique individuals admitted over the three years of our investigation.

[96] Ministry of Children and Family Development, Youth Custody Services, PQI Report, FY 16/17 Q4–FY 19/20 Q3.

it is a designated mental health facility under the *Mental Health Act*.[97] If a youth in custody at BYCS is certified under the *Mental Health Act*, they may be transferred to the Inpatient Assessment Unit for the certification period.

YFPS also provides short-term care and custody for young people found not criminally responsible by reason of a mental disorder, or who are not fit to stand trial.[98] As a designated hospital under the *Criminal Code*, the Inpatient Assessment Unit is designated as a place of temporary custody for the purpose of housing youth who are remanded in custody while undergoing a medical or psychiatric assessment ordered by a judge.

The Maples Adolescent Treatment Centre provides specialized assessment and treatment programs for youth aged 12–18 who are living with significant mental health, emotional or behavioural challenges that impact many aspects of their lives.

The Maples is designated under the *Mental Health Act* as a provincial tertiary mental health facility.[99] It also acts as the provincial forensic hospital treatment facility for youth found not fit to stand trial or not criminally responsible by reason of a mental disorder.[100]

[97] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 3(1); Ministerial Order M393/2016.
[98] Ministerial Order M213/2003; *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 141(11); *Criminal Code*, R.S.C. 1985, c. C-46, s. 672.1
[99] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 3(1); Ministerial Order M076/2019 amending Ministerial Order M393/2016.
[100] Ministerial Order M213/2003; *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 141(11); *Criminal Code*, R.S.C. 1985, c. C-46, s. 672.1.

# 3. INVESTIGATIVE FOCUS AND METHODOLOGY

An investigation into complaints we received in 2016 from youth who were separately confined raised concerns that some of the institutional practices at Burnaby Youth Custody Services Centre were inconsistent with the regulatory and policy framework that governs the use of separate confinement for youth in custody in B.C.[101]

In light of these concerns, we began to monitor the use of separate confinement at Burnaby Youth Custody Services Centre, and later at Prince George Youth Custody Services Centre. In this monitoring work, we obtained and reviewed the records associated with every instance of separate confinement over a three-year period from January 1, 2017, to December 31, 2019. The different types of records we received are described in Appendix C. These records are created and maintained by staff, except for complaint forms, which may be completed by youth.

We initiated our investigation because our experience investigating individual complaints gave rise to concerns about whether the custody centres were properly following the law and policy in documenting separate confinement decisions. In reviewing the records, it became clear that compliance with legal requirements was just one aspect of a much larger issue.

This report describes our investigation into three aspects of separate confinement in youth custody centres in B.C.:

- how often separate confinement is used, and the length of time that youth are separately confined
- the conditions of separate confinement, and which youth are primarily affected by its use
- the effectiveness of mechanisms for overseeing the use of separate confinement

[101] See Office of the Ombudsperson, "Separate Confinement of Youth in Custody," case summary, https://bcombudsperson.ca/case_summary/separate-confinement-of-youth-in-custody/.

# 4. FREQUENCY AND DURATION OF SEPARATE CONFINEMENT

As we have described, the harmful effects of separate confinement are significant and well understood. This made it essential for us to look closely at *how often* separate confinement is used in B.C. and *who* is primarily affected by its use.

Our investigation examined how often youth were separately confined at both Burnaby Youth Custody Services Centre (BYCS) and Prince George Youth Custody Services Centre (PGYCS). We also investigated how long individual youth were separately confined, as well as the conditions of their separate confinement. We investigated whether the longest instances of separate confinement had been authorized in accordance with the statutory scheme that governs the use of separate confinement, and we examined how these authorizations, when they existed, were documented.

We also looked at why the longest instances of separate confinement occurred, whether they were authorized or not. We observed, based on the records, the conditions and effects of separate confinement for some of the youth who experienced it. We examined the circumstances of the youth who were most often subject to prolonged separate confinement. In doing so, we recognized that the experiences of youth in custody arise from and are interwoven with their unique social positioning, social histories and identities.

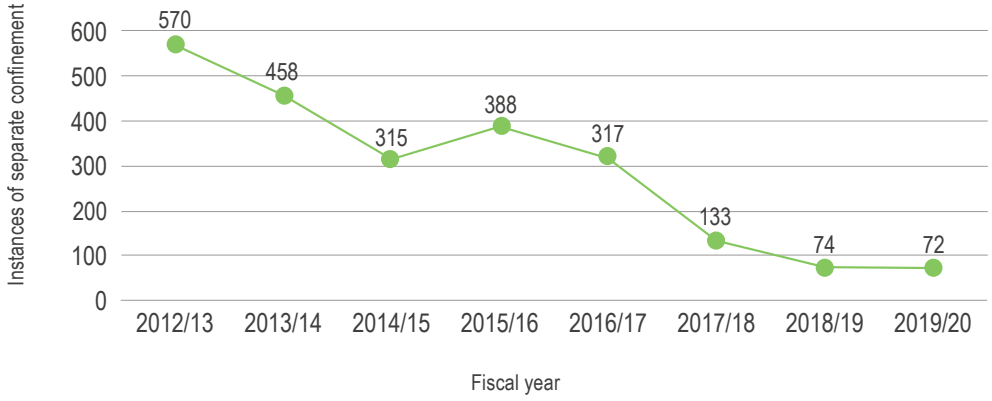
Our investigation sought to be attentive to the way that the intersections of race (Indigeneity), gender, sex and mental health shaped the experience of separate confinement.

## 4.1 How often youth are separately confined

Based on the records from BYCS and PGYCS, we determined how often separate confinement was used at each centre from January 1, 2017, to December 31, 2019.

The number of instances of documented separate confinement declined over the three years of our investigation at both BYCS and PGYCS. As Figure 12 shows, the number of instances of separate confinement has decreased sharply since 2012 – from 570 instances in 2012/13 to 72 in 2019/20.

**Figure 12: Instances of separate confinement in youth custody, 2012/13–2019/20***

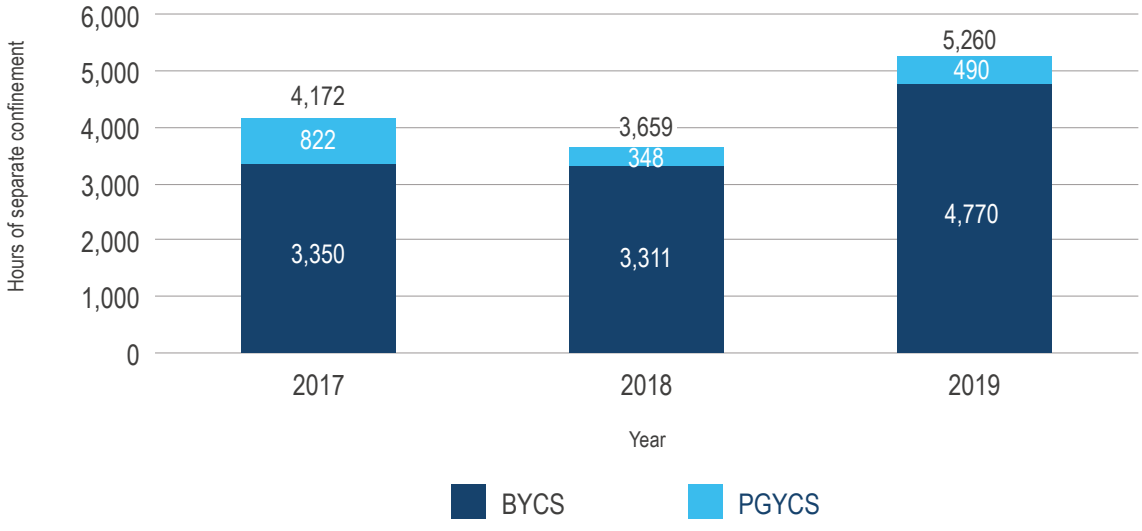



*Figures for 2012/13 – 2016/17 are based on PQI report data. Figures for 2017/18 – 2019/20 are based on separate confinement documentation our office received from the ministry.

## 4.2 How long youth are separately confined

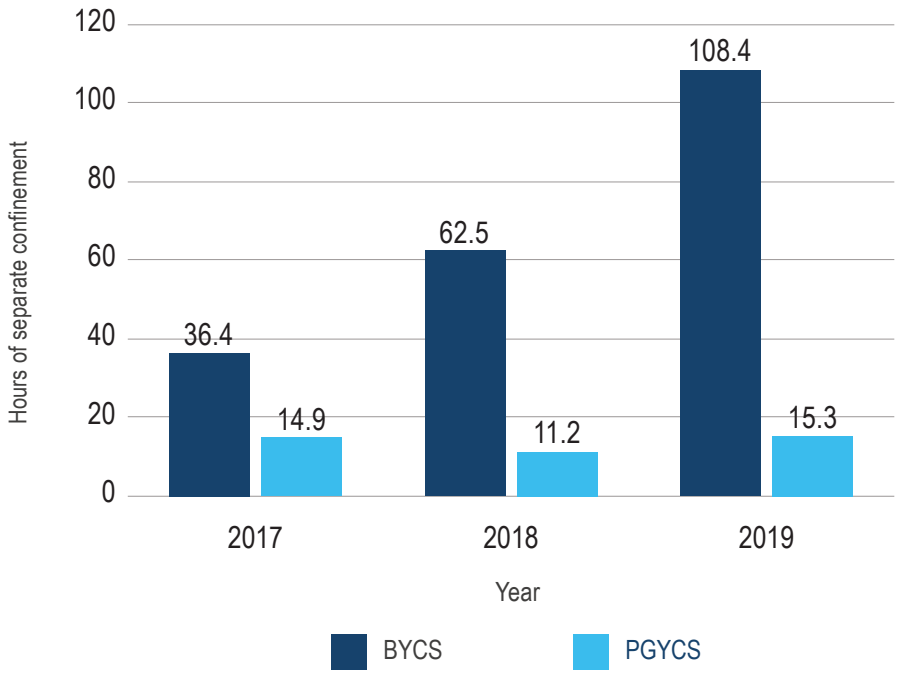
We examined the duration of each instance of separate confinement at BYCS and PGYCS between January 1, 2017, and December 31, 2019. We found that, as shown in Figure 13, there was an increase in the total number of hours that youth were separately confined over that three-year period. In 2017, youth were separately confined at BYCS and PGYCS for a total of 4,172 hours, while in 2019, youth were separately confined at BYCS and PGCYS for a total of 5,260 hours.

**Figure 13: Hours of separate confinement, BYCS and PGYCS, 2017–2019**



As Figure 14 shows, from 2017 to 2019, there was an almost threefold increase in the average duration of separate confinement at BYCS. Over the same three-year time frame, the average duration of each instance of separate confinement at PGYCS remained more or less the same.

**Figure 14: Average duration of separate confinement, BYCS and PGYCS, 2017–2019**




Through our investigation, we tried to understand how different groups of youth were exposed to the risk of harm caused by separate confinement. We reviewed disaggregated demographic data provided by the Ministry of Children and Family Development that identified gender and racial identities of all youth separately confined between January 1, 2017, and December 31, 2019. [102]

[102] In the data provided by the ministry, there were five instances of separate confinement for which the disaggregated demographic data regarding the racial or ethnic identities of the youth involved either was not available in CORNET or was unavailable because the youth's record was sealed. These five instances related to different youth, three of whom were male and two of whom were female. The separate confinement of one of these youth lasted 137.58 hours. The remaining four instances were all shorter than 22 hours in duration. Combined, these instances totalled 184 hours of separate confinement. Although these instances and related hours of separate confinement are presented in Figures 15-18, we have excluded them from our analysis of the instances and hours of separate confinement we know to have been experienced by Indigenous youth and non-Indigenous youth.

## Terminology

### *Race and racialization*

In her September 2020 report on the collection and use of disaggregated demographic data, the B.C. Human Rights Commissioner discussed the concepts of race and racialization. Race is a socially constructed category tied to histories of colonization, social values, politics and culture.[103] Race can be understood as a process of racialization: groups of people are racialized over time according to shifting political, economic, social and national values.[104]

Ontario's anti-racism strategic plan defines racialization as

> the process by which societies construct races as real, different and unequal in ways that matter to economic, political and social life. (Commission on Systemic Racism in the Ontario Criminal Justice System; 1995). Racial categories are not based on science or biology but on differences that society has chosen to emphasize, with significant consequences for people's lives. People can be racialized not only based on skin colour but also other perceived characteristics such as their culture, language, customs, ancestry, country or place of origin or religion as is the case with Islamophobia and antisemitism.[105]

In this report, we use the term "racialized youth" to refer to youth who are not Indigenous or white.

We use the term "white" consistent with the Statistics Canada definition,[106] to refer to people who are Caucasian in race or white in colour.

### *Indigeneity*

As noted by Mary-Ellen Turpel-Lafond, Aki-Kwe in her independent review of Indigenous-specific racism in B.C.'s provincial health care system, "The lexicon of Indigeneity is dynamic and complex, spanning individual and nation preferences, government legislation, policy and practices, and emerging social norms and understandings."[107]

In this report, we use the term "Indigenous" as the overall descriptor for youth who are First Nations, Métis or Inuit. B.C.'s *Declaration on the Rights of Indigenous Peoples Act* defines "Indigenous peoples" the same way as the federal Constitution defines "Aboriginal peoples."[108]

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[103] B.C. Human Rights Commissioner, *Disaggregated Demographic Data Collection in British Columbia: The Grandmother Perspective*, September 2020, 44, https://bchumanrights.ca/wp-content/uploads/BCOHRC_Sept2020_Disaggregated-Data-Report_FINAL.pdf.

[104] B.C. Human Rights Commissioner, *Disaggregated Demographic Data*, 44.

[105] Government of Ontario, *A Better Way Forward: Ontario's 3-Year Anti-Racism Strategic Plan*, 2017, 11, https://files.ontario.ca/ar-2001_ard_report_tagged_final-s.pdf.

[106] Statistics Canada, "Visible Minority," *Dictionary, Census of Population, 2016*, https://www12.statcan.gc.ca/census-recensement/2016/ref/dict/pop127-eng.cfm.

[107] Mary Ellen Turpel-Lafond (Aki-Kwe), *In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in B.C. Health Care* (full report), November 2020, 9, https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf.

[108] *Declaration on the Rights of Indigenous Peoples Act*, S.B.C. 2019, c. 44, s. 1. Section 35(2) of the *Constitution Act, 1982* defines "aboriginal peoples of Canada" to include "the Indian, Inuit and Métis peoples of Canada."

We note that the provincial *Child, Family and Community Service Act* defines a First Nations child as a child who is a member of or entitled to be a member of a First Nation, and an Indigenous child as including all children who are of Indigenous ancestry including First Nations, Métis and Inuit and – if over age 12 – consider themselves to be Indigenous.[109] In our investigation, we found that ministry records variously and inconsistently used the terms "Indigenous," "Aboriginal," "First Nations" and "Métis" to identify and describe Indigenous youth in custody. Given the extent of the inconsistency of terminology in the original records and data, we use the term "Indigenous" in this report to encompass all youth who were identified in ministry records as Indigenous, Aboriginal, Métis or Inuit.

From a data perspective, we note that the term "Aboriginal" is used in the federal census data and we have carried over this term to accurately identify the data's original descriptor. We have also used the term "Aboriginal" where it appears in legislation, policy or court decisions.

We acknowledge that these aggregate terms do not reflect the linguistic, cultural and social diversity of self-determining Nations.

We cross-referenced the disaggregated data we received from the ministry with the ministry's separate confinement records. In doing so we observed inconsistencies and limitations with the information provided by the ministry. For example, we found that the ministry did not record a youth's gender identity on admission, but categorized youth exclusively by biological sex. We also found that the ministry's approach to recording racial identities did not clearly identify all racialized youth. As noted above, the ministry's records inconsistently identified youths' specific Indigenous identity.

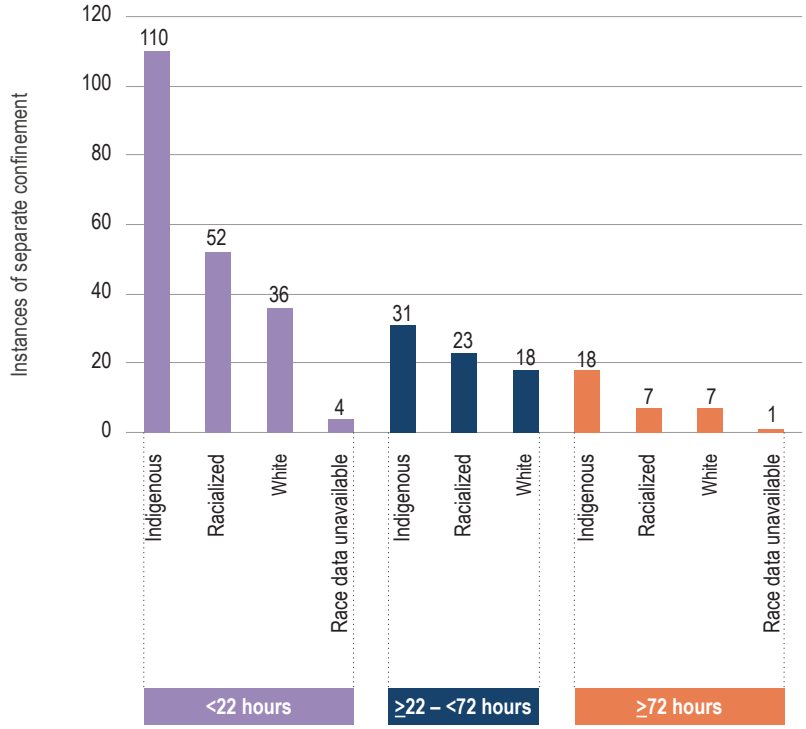
Despite limitations of the data we received from the ministry, we found that Indigenous youth were separately confined more frequently than other youth. Between 2017 and 2019, Indigenous youth were separately confined 159 different times - see Figure 15. This represents 52 percent all of instances of separate confinement in this period.

In addition, Indigenous youth experienced more hours of separate confinement than non-Indigenous youth. Overall, Indigenous youth were separately confined for 7,057 hours, which represents 55 percent of all hours of separate confinement between 2017 and 2019. Moreover, as Figure 16 shows, Indigenous youth experienced far more of this time in prolonged periods of separate confinement (periods of separate confinement more than 72 hours).

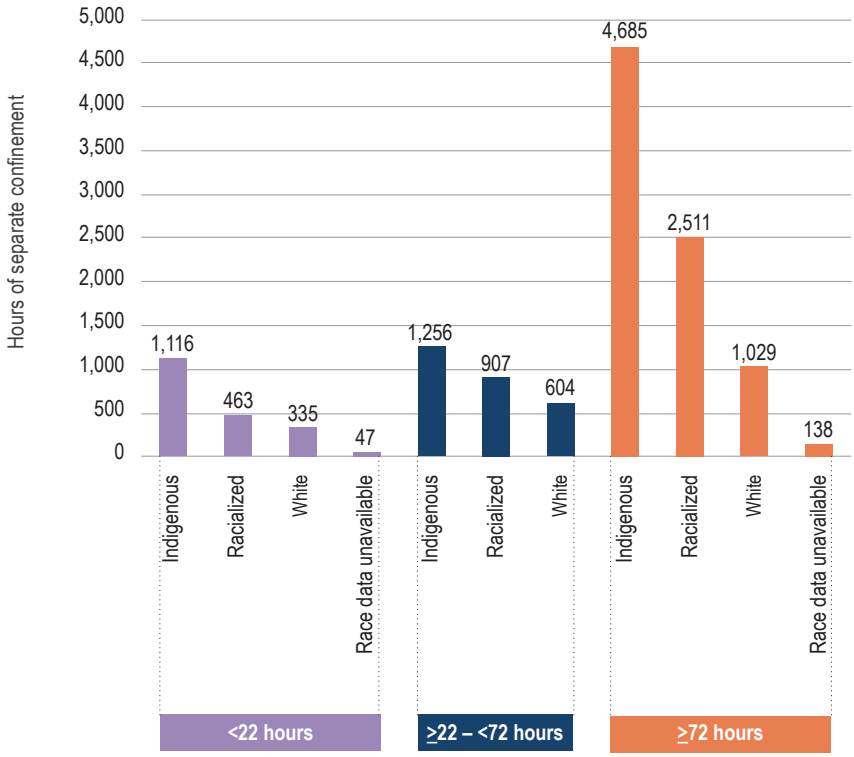
We also found that other racialized youth were separately confined. While not a focus of this report, racialized youth in custody may also be disproportionately impacted by separate confinement decisions.

[109] *Child, Family and Community Service Act*, S.B.C. 1996, c. 46, s. 1.

## Figure 15: Instances of separate confinement, by race, BYCS and PGYCS, 2017–2019




## Figure 16: Total hours of separate confinement, by race, BYCS and PGYCS, 2017–2019

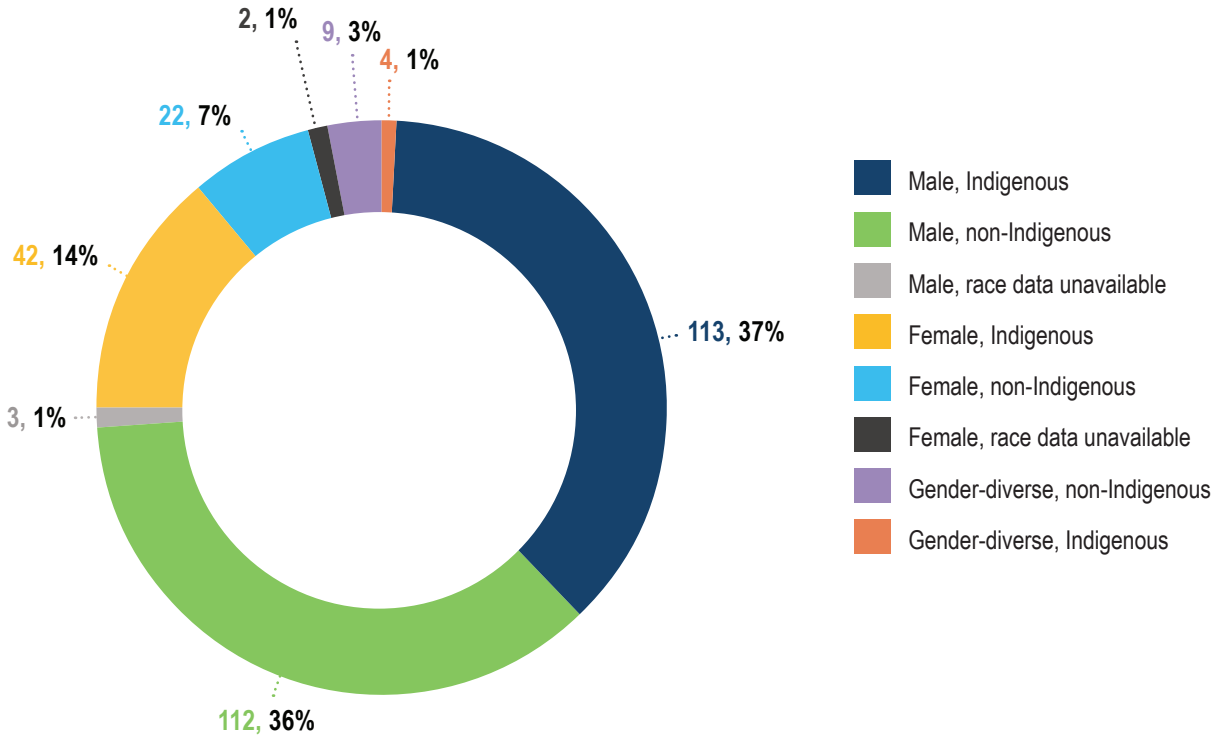


We also looked at the gender of youth who were separately confined. This is illustrated in Figures 17 and 18. We found that male youth were separately confined most frequently. Between 2017 and 2019, male youth were separately confined 228 times, which represents 74 percent of all instances of separate confinement in that period. Indigenous males experienced approximately half of the instances of separate confinement of male youth.

Conversely, female youth were separately confined less frequently. As shown in Figure 17, female youth were separately confined 66 times between 2017 and 2019, which represents 22 percent of all instances of separate confinement in that period. Indigenous female youth experienced 64 percent of these instances of separate confinement.

Youth identified as gender-diverse were separately confined 13 times between 2017 and 2019, which represents 4 percent of all instances of separate confinement.[110]

**Figure 17: Instances of separate confinement, by gender and Indigeneity, BYCS and PGCYS, 2017–2019**

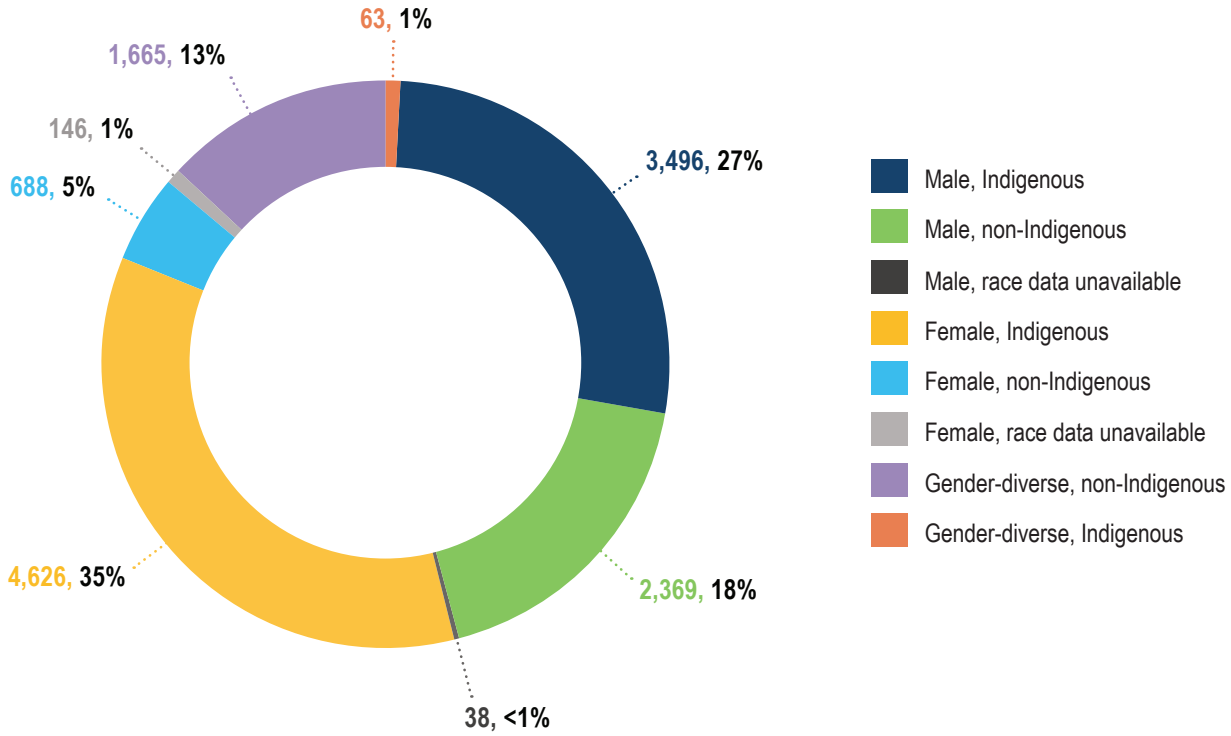



[110] As noted above, the ministry's demographic data did not include diverse gender identity but categorized youth exclusively by biological sex. However, we found that staff identified gender-diverse youth in the separate confinement records. The gender analysis set out in Figures 17 and 18 is based on the information included in these records.

While male youth were separately confined most frequently, female and gender-diverse youth were separately confined for much longer periods of time. Female youth were separately confined for 5,460 hours, which represents 42 percent of all hours of separate confinement used between 2017 and 2019. Indigenous female youth experienced 87 percent of this time.

Gender-diverse youth also experienced a greater amount of time in separate confinement. Gender-diverse youth were separately confined for 1,728 hours, which is 13 percent of all hours of separate confinement between 2017 and 2019. While not a focus of this report, gender-diverse youth in custody may also be disproportionately impacted by separate confinement decisions.

**Figure 18: Hours of separate confinement, by gender and Indigeneity, BYCS and PGCYS, 2017–2019**




We also examined each instance of separate confinement to better understand why it was being used, and whether and how its use changed over time.

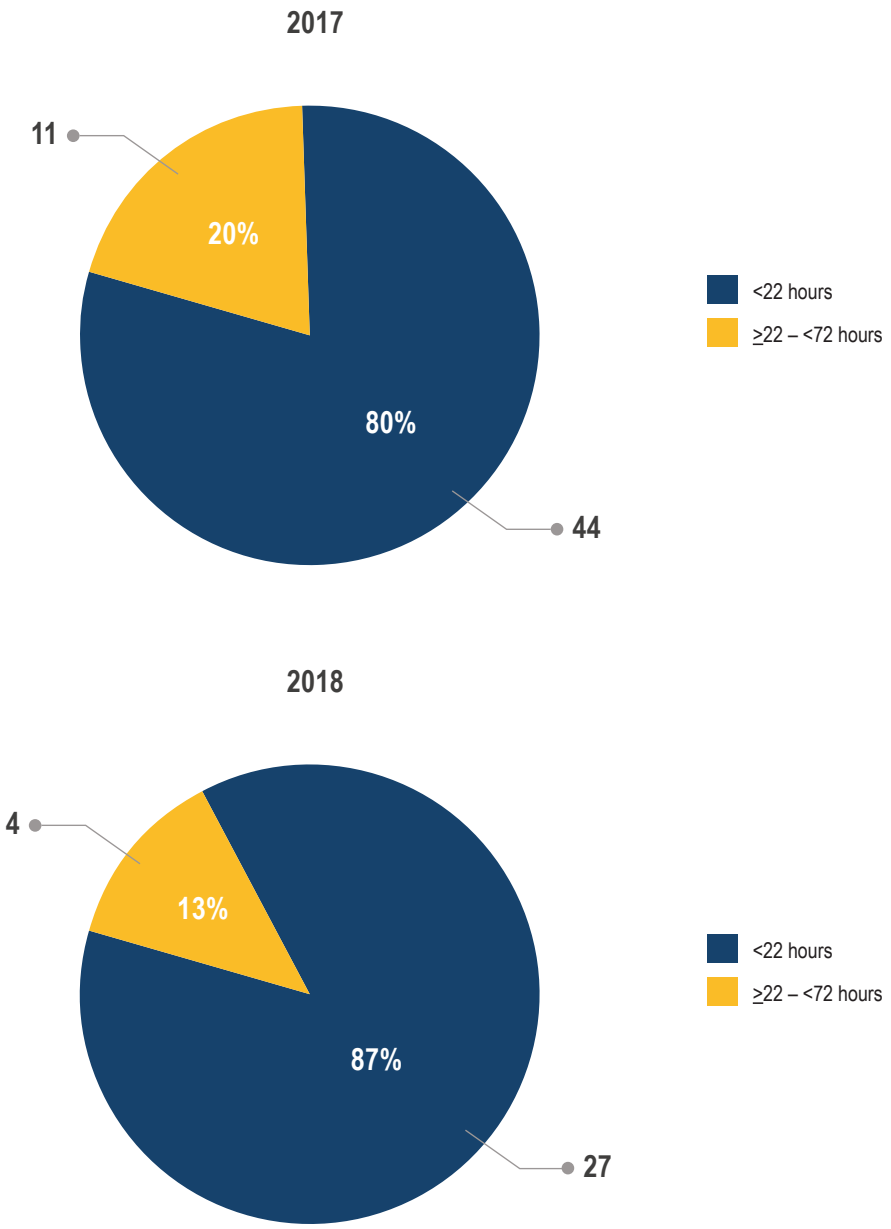
As shown in Figure 19, we found that at PGYCS, short-term separate confinement (under 22 hours) was used 44 times in 2017 and 27 times in both 2018 and 2019.

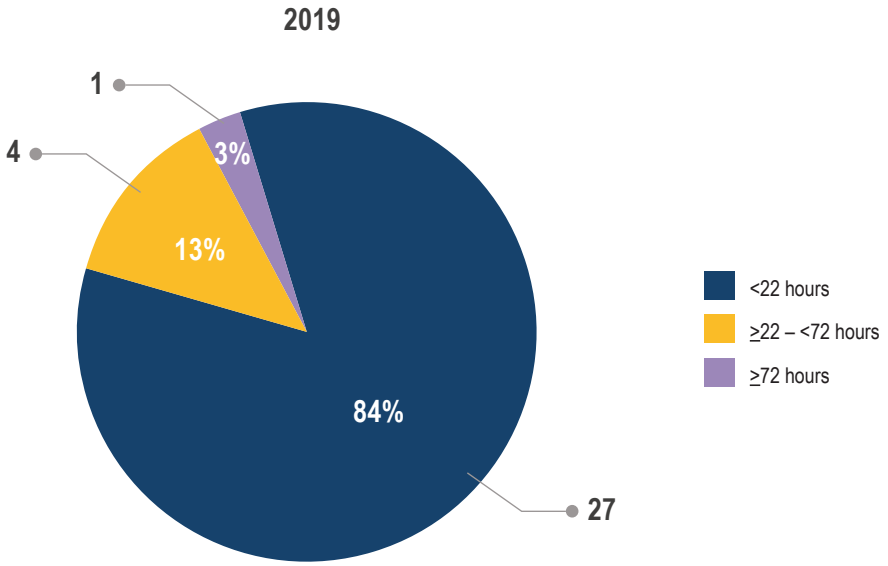
[111] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1(b)(ii) and (iii). Separate confinement for any reason may only be used when all other means of dealing with the youth have been exhausted or are not reasonable in the circumstances: *Youth Custody Regulation,* B.C. Reg. 137/2005, s.15.1(1)(a).

At PGYCS, longer-term separate confinement (over 22 hours) was used 11 times in 2017, 4 times in 2018 and 4 times in 2019. The vast majority (85 percent) of these short-term separate confinements were used to respond to youth that endangered another person or threatened the management, operation or security of the custody centre or were likely to endanger another person or threaten the management, operation or security of the custody centre.[111]

In the same period, there was only one instance of separate confinement that lasted longer than 72 hours at PGYCS. This prolonged instance of separate confinement occurred in 2019 and lasted for 94.97 hours.

**Figure 19: Instances of separate confinement, by duration, PGYCS, 2017–2019**






At BYCS, short-term (less than 22 hours) separate confinement was used 61 times in 2017, 26 times in 2018 and 17 times in 2019 (see Figure 20). Almost half of these short-term separate confinements (43 percent) were used to respond to youth who endangered another person or threatened the management, operation or security of the custody centre or were likely to endanger another person or threaten the management, operation or security of the custody centre. Fifteen percent of these short-term uses of separate confinement were used to respond to youth who were self-injuring or at risk of injuring themselves.[112]

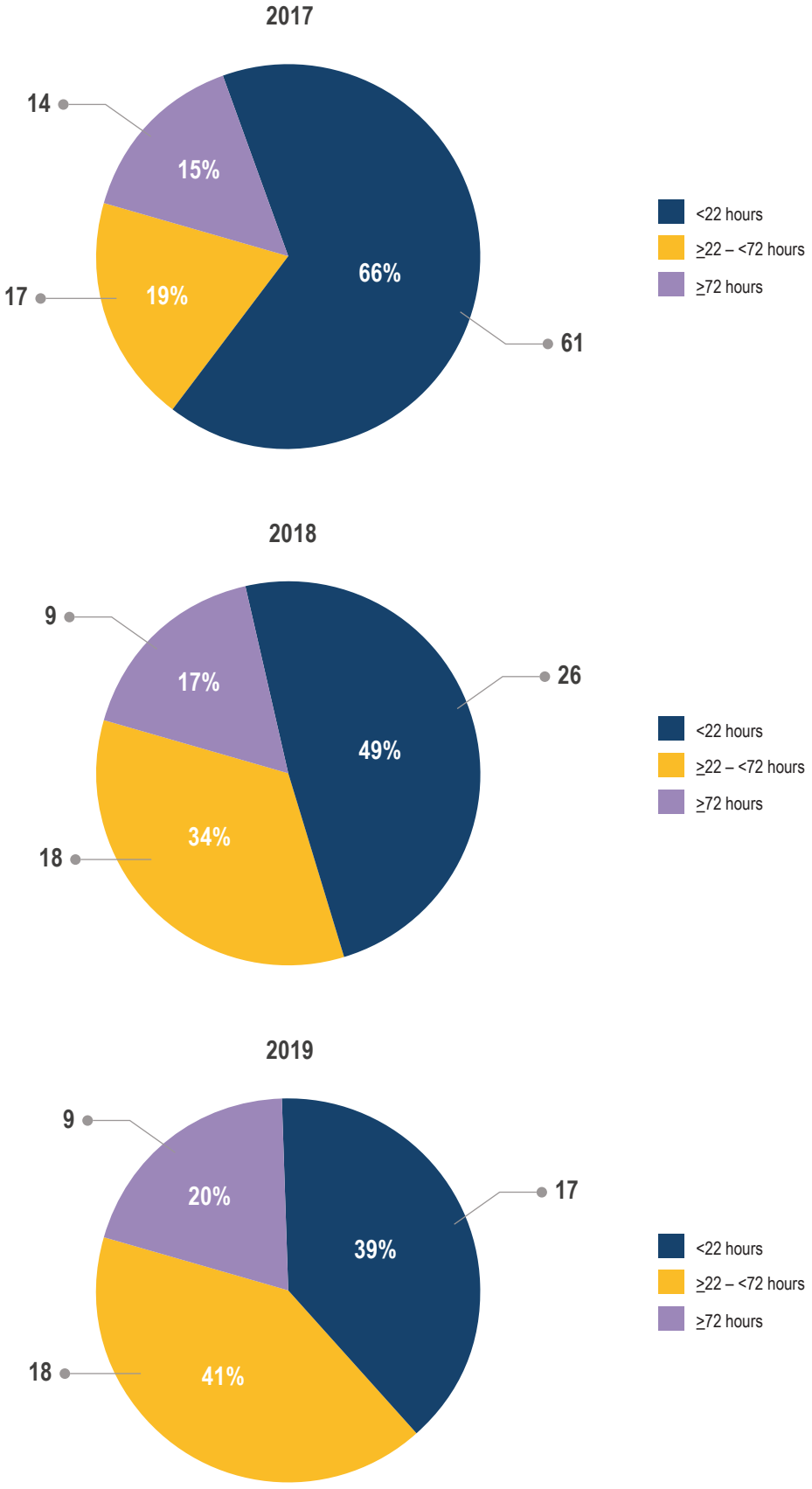
At BYCS, separate confinement over 22 hours was used 31 times in 2017 and 27 times in both 2018 and 2019. Just under one-third – 31 percent – of these instances of separate confinement were used to respond to youth who endangered another person or threatened the management, operation or security of the custody centre or were likely to endanger another person or threaten the management, operation or security of the custody centre. Another 28 percent of these instances of separate confinement were used to respond to youth who staff believed had used an intoxicant and/or were in possession of contraband.[113] Another 35 percent were used in response to youth who were self-injuring or at risk of injuring themselves.

As shown in Figure 20, separate confinement over 22 hours represented an increasing share of the overall use of separate confinement at BYCS. In 2017, separate confinement of more than 22 hours represented 34 percent of all instances of separate confinement. In 2019, separate confinement of more than 22 hours represented 61 percent of all instances of separate confinement.

[112] *Youth Custody Regulation*, B.C. Reg. 137/2005,s 15.1(b)(i) provides that a youth may be separately confined where the person in charge of a youth custody centre has reasonable grounds to believe that a youth is endangering, or is likely to endanger, himself or herself.

[113] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1 (b) (iv) and (v) provides that a youth may be separately confined where the person in charge of a youth custody centre has reasonable grounds to believe that a youth has contraband hidden on or his or her body or has taken an intoxicant into his or her body.

## Figure 20: Instances of separate confinement, by duration, BYCS, 2017–2019



As Figure 20 shows, periods of prolonged separate confinement (over 72 hours) made up 15 percent of all instances of separate confinement at BYCS in 2017. This increased to 20 percent of all instances of separate confinement in 2019. Each of these instances of separate confinement are set out in Figure 21, which shows that between January 1, 2017, and December 31, 2019, a total of 22 individual youth at BYCS were separately confined 32 times for periods ranging from 72 hours to 1,133 hours.[114]

## Prolonged separate confinement

We closely examined each instance at BYCS in which a youth was separately confined for more than 72 consecutive hours (three days). We wanted to understand how and why the director at BYCS and the provincial director of youth justice decided to separately confine youth for these prolonged periods, as well as how the youth themselves experienced confinement.

We focused on the longest periods of separate confinement for three main reasons.

First, the research is clear that the risk of psychological harm from separate confinement increases over time, so we wanted to understand why and how these longest periods of separate confinement occurred and what their impacts were.

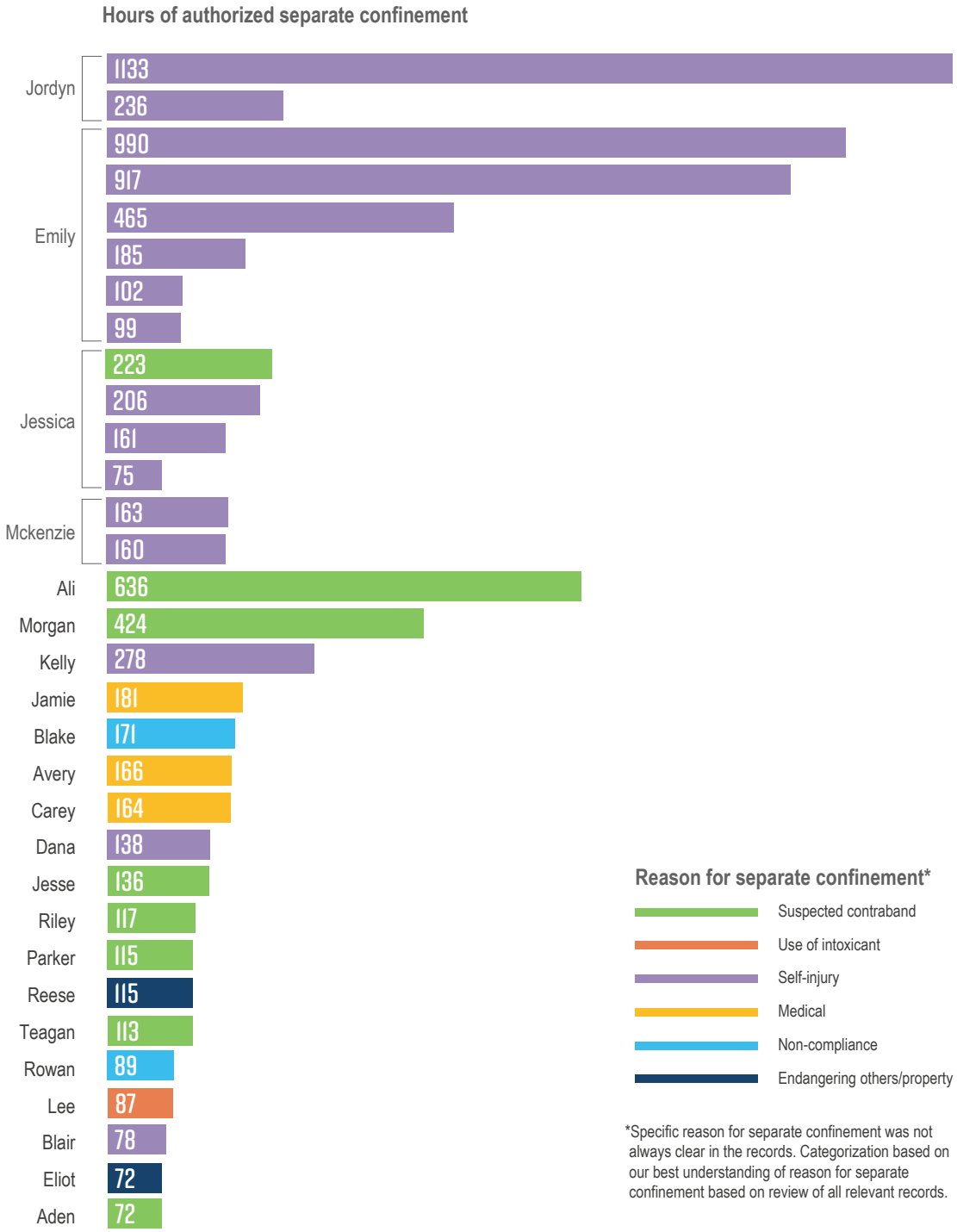
Second, the provincial director becomes involved in decision making at this point: it is the provincial director who must authorize continued separate confinement that continues for more than 48 consecutive hours. At 72 hours, the provincial director must provide authorization and in doing so, is required to conduct a thorough review of the youth's circumstances and the need for continued separate confinement. Focusing on separate confinements that lasted for more than 72 hours allowed us to understand how that level of review functions in terms of providing oversight of separate confinement. We further discuss the role of the provincial director in section 7.2 of this report.

Third, the *Manual of Operations – Youth Custody Programs* anticipates that separate confinement for more than 72 hours will be used in "only the most unusual and extreme circumstances (i.e. imminent safety risk or medical risk which prevents the youth from being returned to the general population),"[115] so examining how often this occurred allowed us to assess whether it was an exceptional practice.

[114] These numbers are based on separate confinement records provided by the ministry and include only periods of authorized separate confinement. As discussed in section 7.1, we identified periods were youth were separately confined but not authorized to be. These unauthorized periods of separate confinement are not included in the numbers shown here, as we were unable to conclusively identify the start and end dates and time from the records provided. As a result, we believe that separate confinement was used for more times than was reflected in the ministry's separate confinement records and shown here.

[115] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.03, 24.

## Figure 21: Authorized separate confinement of 72 hours or more, BYCS, 2017–2019[116]




[116] To protect their identities, we have chosen pseudonyms where necessary for each of the youth in this report. We chose these names from a list of popular baby names in B.C. from 2000-2003, which represents the approximate age range of youth in custody when our investigation began in 2017. We recognize that these names do not reflect the ethnic diversity of B.C.'s population or of youth in custody. They are also not intended to signify a youth's gender except where we have specifically identified the gender of a youth.

Our review of each of the instances of separate confinement of more than 72 consecutive hours resulted in three key conclusions:

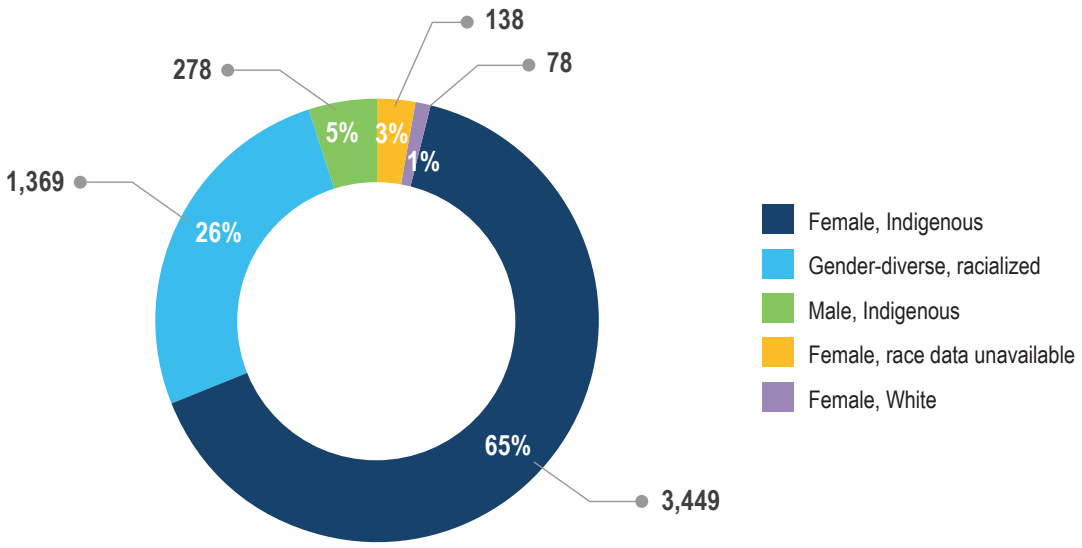
**1. These prolonged periods of separate confinement (over 72 hours) were most commonly used to respond to youth who were self-injuring or suicidal.** As Figure 21 shows, 15 of the 32 instances of separate confinement over 72 hours at BYCS were in response to youth who were self-injuring or identified to be at risk of suicide. We also found that separate confinement in response to self-injury or suicidal behaviour accounted for 64 percent of the total number of hours of separate confinement over 72 hours at BYCS.[117] Prolonged separate confinement is being used to respond to risks of self-injury and suicidal behaviour more than for any other reason.

**2. These prolonged periods of separate confinement in response to self-injury were experienced almost exclusively by female youth and mostly by Indigenous and racialized female youth.** Seven individual youth were separately confined on 15 different occasions in response to their self-injuring or suicidal behaviours. Of these seven youth, five were female, one was gender-diverse and one was male. As shown in Figure 22, female and gender-diverse youth experienced 95 percent of the hours of these prolonged periods of separate confinement. Moreover, 65 percent of the prolonged confinement was experienced by Indigenous female youth. In contrast, white female youth experienced no more than 4 percent of these hours of prolonged separate confinement.

**3. We found that several of these separate confinement periods lasted for a very long time.** The longest consecutive periods of documented separate confinement were 38 days, 41 days and 47 days. The very longest periods of separate confinement – four of the five longest instances – were of two individual youth who were self-injuring and suicidal. As Figure 21 shows, these four prolonged periods of separate confinement ranged from 465 consecutive hours (19 days) to 1,133 consecutive hours (47 days).

[117] Total number of hours of separate confinement over 72 hours is 8,267.95. Of the total, 5,310.92 hours are attributed to self-injury and risk of suicide.

**Figure 22: Total hours of prolonged separate confinement due to self-injuring behaviour, by gender and Indigeneity, BYCS, 2017–2019**




## Prolonged separate confinement as a response to mental illness

We found that the most common use of prolonged separate confinement was as a response to youth who were experiencing a deterioration of their mental health, primarily characterized by self-injuring and suicidal behaviour.

The *Youth Custody Regulation* authorizes separate confinement when a youth "is endangering, or is likely to endanger, himself or herself."[118] The youth custody operations manual includes policy direction to assist staff working with youth who are exhibiting non-suicidal self-injury (NSSI) or who are at risk of suicide, with the objective of providing a safe environment for all youth at a custody centre.

The operations manual defines NSSI as "deliberately injuring oneself without suicidal intent. The most common form of NSSI is self-cutting, but other forms include burning, scratching, hitting, intentionally preventing wounds from healing, and other similar behaviours."[119] While NSSI is understood to be self-injury without suicidal intent, NSSI may be linked with increased suicide risk.[120]

The operations manual emphasizes the importance of identifying and documenting youth at risk of NSSI and suicide as early as possible. Once a youth is identified as at risk for NSSI, the operations manual requires operations staff to involve health professionals to examine the youth and to consult on developing a plan for their support and care.[121]

[118] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1(1)(b)(i).
[119] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.8.02.
[120] Representative for Children and Youth, *A Way to Cope: Exploring Non-suicidal Self-Injury in B.C. Youth,* September 2020, 6, https://rcybc.ca/wp-content/uploads/2020/09/RCY_NSSI_Report.FINAL_.pdf.
[121] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.8.06 and D.9.01–9.11.

The operations manual reminds staff that NSSI and suicide attempts are not infractions and that disciplinary consequences may not be used. It outlines general strategies to keep the youth safe, including increasing staff monitoring of the youth by, for example, checking them every 15 minutes at a minimum and increasing staff communication with the youth.[122] The operations manual also notes that "attention should be paid to providing essential human interaction with staff or other youth."[123]

In addition to these general strategies, the operations manual provides for more extreme interventions in response to NSSI and suicidal behaviour, including the use of a strong shift and blanket, discussed in more detail in section 4.3. Moreover, the operations manual states that staff may confine a youth in an individual room or medical area for the purposes of observing the youth and ensuring their safety. This isolation for the purposes of ensuring a youth's safety is consistent with the grounds for separate confinement set out in the *Youth Custody Regulation*. In other words, it is currently a permitted use of separate confinement.

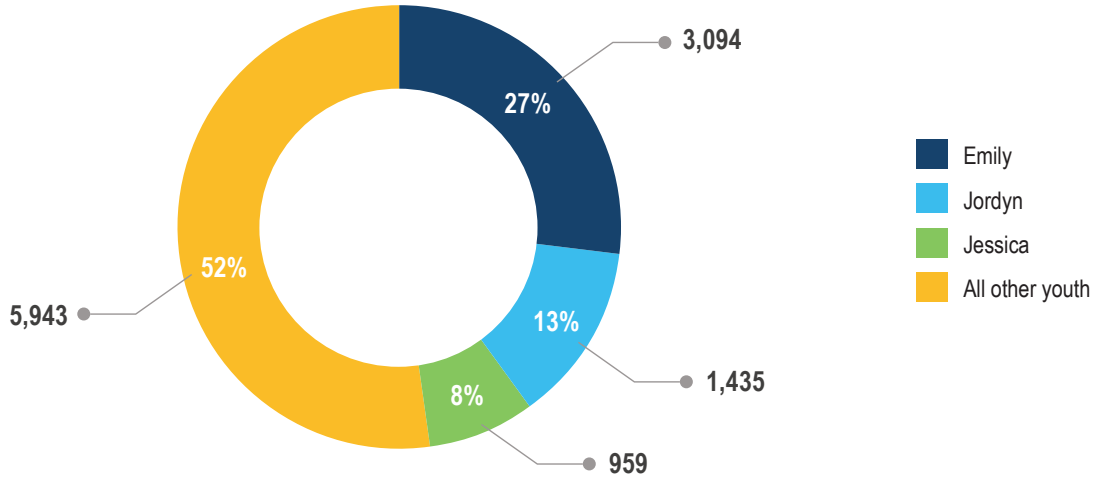
As described above, youth who were self-injuring or suicidal were separately confined for the longest periods of time. These longest periods of separate confinement were experienced by two female youth, Emily and Jessica.[124] A third youth, Jordyn, also experienced lengthy periods of separate confinement for the same reasons.

Figure 23 illustrates the amount of time these three youth were separately confined, relative to other youth in custody. Over the course of our investigation, 79 individual youth were separately confined at BYCS for a total of 11,431 hours. As Figure 23 shows, these three youth were separately confined for a disproportionate amount of time. Emily experienced 27 percent of these total separate confinement hours. The other two youth experienced 13 percent and 8 percent of the total hours, respectively.

In the following paragraphs, we provide some contextual information about these youth so that we can better describe the ways in which they have been made more vulnerable to the harms of separate confinement. Our goal in this report is to develop a better understanding of the "systems and structures that uphold and reproduce circumstances of situated vulnerability."[125] By providing these details we aim to illustrate the urgent need for youth custody centres to adopt a different approach to these youths' needs, one that is supportive and therapeutic rather than harmful. We recognize that it is a limited description of their circumstances and their lives, and it is not our intention to present this information as a complete picture of these youth.

[122] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.8.07 and D.9.01–9.11.
[123] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.8.07 and D.9.01–9.11.
[124] The names for these three youth are pseudonyms. See footnote 116.
[125] A similar approach was described by the Representative for Children and Youth in *Illuminating Service Experience: A Descriptive Analysis of Injury and Death Reports for First Nations Children and Youth in B.C., 2015 to 2017*, December 2020, 47, https://rcybc.ca/wp-content/uploads/2020/12/IlluminatingServiceExperience.pdf.

**Figure 23: Hours of separate confinement of three youth, as a proportion of total separate confinement hours, BYCS, 2017–2019**




When our investigation began in January 2017, all three of these youth were either 15 or 16 years old. Two are identified in the ministry's records as Indigenous, living off reserve and in the care of the ministry through continuing custody orders under the *Child, Family and Community Service Act*.[126] Ministry records for the third youth indicate that they are racialized and gender-diverse.

While the specific circumstances of each youth are different, the two youth in care under continuing custody orders have a documented history of severe childhood trauma, neglect and abuse. The ministry records also describe neurodevelopmental disabilities, mental health concerns and psychiatric diagnoses. The ministry records for the other youth refer to their extensive historical involvement with medical and psychiatric services in the community.

Two of these youth had a history of involvement with the youth justice system before our investigation began. One youth had multiple admissions to custody before our investigation began, which included lengthy periods of separate confinement. For example, in the months prior to our investigation this youth was separately confined on 12 occasions, for a total of 1,255 hours (52 days).[127] The ministry's records confirm that custody centre staff had identified both of these youth to be at high risk for self-injury and suicide.

[126] A continuing custody order must be issued by a court if the parents of the child cannot be located or the parents are unable or unwilling to resume custody of a child. A continuing custody order may be issued by a court if there is no significant likelihood that the circumstances that led to the child's removal will improve within a reasonable time or the parent will be able to meet the child's needs. The effect of a continuing custody order is to make the director of child welfare the sole personal guardian of the child, and the Public Guardian and Trustee the sole property guardian of the child: *Child, Family and Community Service Act*, R.S.B.C. 1996, c. 46, s. 49 and 50.

[127] MCFD, Youth Justice Services, PQI Report, FY 16/17 Q4.

## Frequency and duration of separate confinement of three youth

Each of these three youth was admitted to BYCS multiple times during the course of our investigation.

### *Emily*

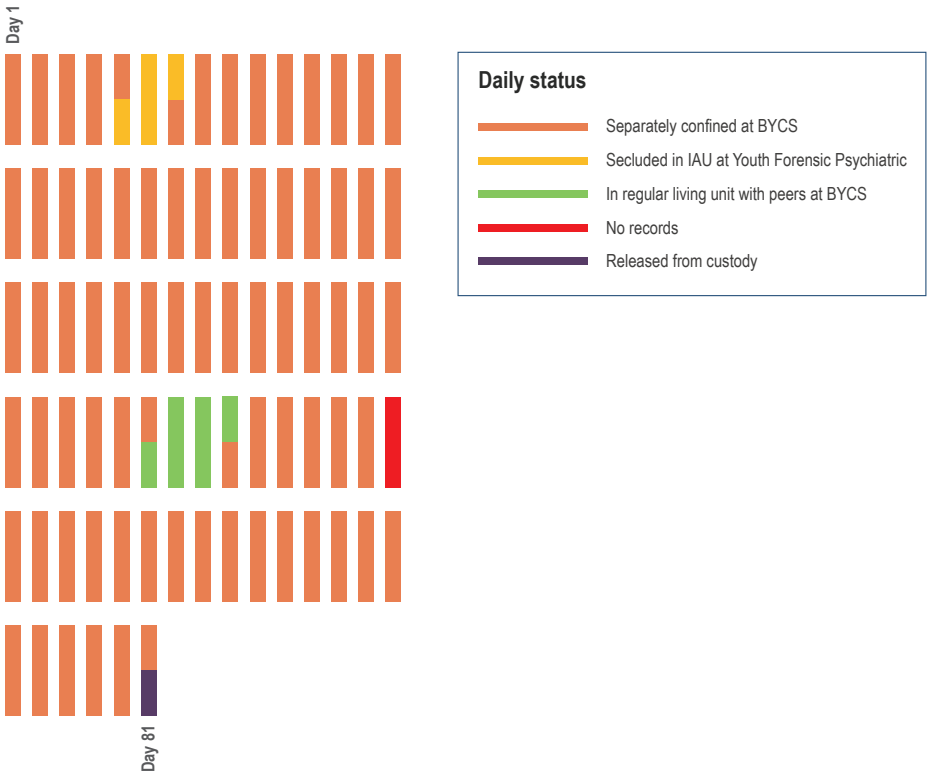
Emily was admitted to custody multiple times between January 1, 2017, and December 31, 2019. The lengths of the admissions varied, but taken together she was in custody for approximately 343 days. Ministry records show that she was separately confined with authorization from the ministry for 129 of those days.

Emily was also frequently and repeatedly isolated from other youth without any of the required authorizations or documentation, sometimes for significant periods of time. For example, on one occasion she was isolated without the required authorization for approximately 30 days (720 hours) and for another 10 days on a later occasion. We discuss these unauthorized periods of separate confinement in greater detail in section 7.1.

Some of the authorized separate confinement periods that Emily experienced were very lengthy. For example, on one occasion she was separately confined for 990 hours (41 days).

On another occasion, Emily was separately confined four times over a three-month period, as set out Figure 24. First, she was separately confined for four days, following which she was certified under the *Mental Health Act* and transferred to the adjacent Youth Forensic Psychiatric Services (YFPS) site, where she was housed in seclusion for two and a half days. She was then transferred back to BYCS, where she was separately confined for 43 days. She was then moved into a regular living unit with other youth but was returned to separate confinement after approximately three days. She remained separately confined for another 27 days until she was again released directly into the community. As shown in Figure 24, over an 81-day period, Emily was separately confined for 78 days at BYCS.

**Figure 24: Emily's isolation at BYCS over 81 days**




### *Jessica*

Jessica was separately confined 13 times over the course of our investigation, for a total of 959 hours or 40 days. Each of these instances was documented by the ministry in accordance with the Regulation and the operations manual. For example, on one occasion she was separately confined for 206 hours (nine days) and then transferred to the adjacent YFPS site, where she was housed in seclusion for a further four days. Several weeks later, she was separately confined again for 160 hours. On a later return to custody, she was separately confined for 223 hours.

We found that Jessica was also frequently and repeatedly isolated from other youth without any of the required authorizations or documentation. For example, she was housed separately from other youth while in custody at BYCS for 72 days over a three-month period, interrupted only by short transfers to hospital or the adjacent YFPS site for assessment or treatment for major suicide attempts.

### *Jordyn*

Jordyn was separately confined on three different occasions in the course of our investigation, primarily in response to self-injuring and suicidal behaviour. The length of these periods of separate confinement varied. For example, during one stay in custody, they were confined for 66 hours. On another occasion, they were separately confined for 1,133 consecutive hours (47 days) until their release from custody. On release, they were certified under the *Mental Health Act* and transferred directly to a hospital. Less than four weeks later, they returned to custody from the community and were immediately separately confined for 236 hours (10 days), until they were transferred to the adjacent YFPS site after the court ordered that a forensic assessment be completed to inform the court's disposition.

### Conclusion: Prolonged separate confinement of three youth

The ministry separately confined these three youth far more than any other youth in custody. In each of these instances, separate confinement was used primarily as a response to behaviours associated with a deterioration of these youths' mental health, including self-injuring and suicidal behaviours.

As we have described, the risk of psychological harm from separate confinement increases over time, and separate confinement exacerbates existing trauma or mental illness. Moreover, time spent separately confined further increases the risk of incarcerated people self-injuring or attempting suicide.[128] Because of the multiple lengthy periods of separate confinement that these youth experienced, and because of their known histories of trauma and mental illness, these three youth were disproportionately exposed to the risk of psychological harms posed by the use of separate confinement. As young people living with mental illness, they are especially vulnerable to the harms caused by separate confinement. Their vulnerability to these harms arises from their unique social positioning, social histories and identities as Indigenous and racialized, and as girls and gender non-conforming youth.[129] Their vulnerability to the harms of separate confinement is a result of many factors, including the intergenerational effects of colonialism and systemic discrimination.[130]

Through our investigation we tried to understand how and why these youth were separately confined at BYCS for prolonged periods of time. We also tried to understand how these youth experienced separate confinement and why it might have such profound negative impacts on their well-being.

## 4.3 Conditions of separate confinement

In the following sections, we describe in more detail how separate confinement was used in response to these three youth who were separately confined most frequently and for the longest periods of time. To the extent possible, and within the limitations of our investigative methods, we describe the conditions experienced by the youth while separately confined.

The details in these sections come from in-person visits to BYCS as well as our review of ministry records related to the three youth. This section is not intended to be an exhaustive accounting of each youth's experience. In some cases, staff logs are not complete or are less detailed; for example, there is less documentation in the file from any periods of stability. Several details are absent from the logs, including visits with family

[128] *British Columbia Civil Liberties Association v. Canada (Attorney General),* 2019 BCCA 228, para. 90.
[129] RCY, *A Way to Cope*, 9. According to this report, in 2018, 47 percent of gender-diverse youth reported NSSI in the previous year (page xxi). This research demonstrates that age and gender are important to consider when examining NSSI in youth. Specifically, this research indicates that girls are at the highest risk of engaging in NSSI during late adolescence.
[130] Truth and Reconciliation Commission, *Honouring the Truth,* 170; RCY, *A Way to Cope*, 9; *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2018 BCSC 62, paras. 470 and 496.

members, the nature of some infractions or misbehaviours, and some observations about youth showering, napping or eating.

While the following does not represent the experience of all youth who are separately confined, it describes, in part, the conditions that characterized the repeated and prolonged periods of separate confinement experienced by three individual youth.[131]

## Physical conditions of confinement space

The experience of separate confinement is defined by many factors, including the physical condition of the space where the confinement occurs. Studies show that confinement can feel punitive (even if not intended to be) because the space people are confined in lacks features that allow individuals to maintain their dignity and at least a minimal degree of privacy, autonomy and engagement, while still ensuring their safety.[132] When youth are confined to a space for most of their time – day and night – the physical conditions are significant factors in defining their experience of separate confinement.

Over the course of our investigation, the vast majority of youth who were separately confined at BYCS were housed in a unit designated for separate confinement. Today, this unit is commonly referred to as the Independent Observation Unit (IOU). Previously, it was referred to as the Separate Confinement Unit. The IOU is located within Venture unit, a secure custody unit at BYCS, that is located at a distance from the regular living units.

The IOU receives very little natural light and, as a result, it is darker than the regular living units. It includes two small individual rooms, each with a door and a small window that looks onto a common area where the staff office is located. The designated outdoor space associated with the IOU is a narrow airing court with no amenities, surrounded by high concrete walls and security wire. On several visits to BYCS, we observed that the IOU was less clean and well maintained than the other living units, as well as less welcoming.

We also found that the separate confinement space in the IOU and Venture unit had various safety hazards; youth were repeatedly able to access materials that they subsequently used for self-injury. For example, on one occasion, a youth was able to loosen metal screws that fastened a metal plate to the floor and use these metal screws to self-injure. The same youth was able to remove a metal vent tray from the ceiling of the unit and use metal pieces to self-injure. This youth used the hard floor and wall as a surface on which to hit their head. They were able to loosen and secure metal screws on light fixtures, mirror mounts and overhead sprinkler fixtures, as well as metal plates inside the door window. They were also able to break off glass shards from windows, using these to self-injure.

These examples are evidence of the deficiencies in the structural design, construction and durability of the units used to separately confine youth. For some youth, the units were a source of materials to cause injury, thus heightening the risk of the

[131] In this section, we have deliberately not identified the youth by name in describing their experiences so as to further protect their identities.

[132] Ministry of Health, *Secure Rooms and Seclusion Standards and Guidelines: A Literature and Evidence Review*, September 2012, 40–44, https://www.health.gov.bc.ca/library/publications/year/2012/secure-rooms-seclusion-guidelines-lit-review.pdf.

youth causing harm to themselves or staff. Moreover, when youth were trying to obtain or were in possession of these materials, staff often responded with force to stop the youth from self-injuring or from further damaging the unit. The units did not adequately support the youths' safety. Instead, they contributed to the risk of injury and harm youth experienced while separately confined.

The IOU has basic hygiene facilities, including toilets and sinks, in the individual rooms and a designated shower area in the common space. However, we observed that for the youth separately confined in the IOU, maintaining basic hygiene was sometimes difficult because they had difficulty accessing showers and there was a lack of privacy. For example, one youth was denied a shower because "their attitude and behaviour do not warrant it." The same youth was also denied a shower just prior to their release into the community. On a different occasion, that youth was escorted by staff to the shower in handcuffs and leg shackles. On another occasion, the records indicate that a youth was mechanically restrained during a shower.

The IOU, including the interior of each of the two individual rooms, is monitored by surveillance cameras 24 hours a day. Based on our review of the records, it appeared that the overhead lights remained on constantly to assist staff in their overnight monitoring of youth housed in the IOU. The ministry explained that each room is equipped with lights that dim at night, allowing staff to conduct visual checks on youth in what it described as "the least intrusive way possible." In one case, the lights were modified after a youth complained that lights made it too hard to sleep.

The doors of the two individual rooms in the IOU include a slot. We observed the slot being used in different ways. For example, it was used to provide youth with their meals in situations where the staff believed that it was unsafe to unlock the door to give the youth their meal. We also observed communication occurring through the slot. The ministry explained that talking to a youth through the slot is not a common practice and occurs "only in the most extreme and unusual circumstances where the risk or harm to the youth and staff is unmanageable in any other way." In our review of the records, we observed multiple instances where staff communicated with youth about basic needs through the slot. In one case, staff played cards with youth through the slot.

In another case, a youth had to communicate with mental health clinicians through the slot. The psychologist recorded that they had to speak with the youth "through the trap door as security [operations staff] felt [the youth] was too high risk to open the door and talk to." The psychologist further noted that because of this restriction, the youth received only superficial mental health support. The ability to access meaningful mental health support was especially critical for this youth; at this point, they had been separately confined for more than 30 consecutive days in response to their self-injuring behaviour.

In this case, the use of the slot was a barrier to youth receiving mental health care and meaningful social contact. A similar issue has arisen in other situations of separate confinement. In 2013, the jury in the Ontario coroner's inquest into the death of Ashley Smith recommended that mental health professionals should not meet with prisoners though a door slot in any circumstances.[133]

[133] Correctional Service Canada, "Coroner's Inquest, Ashley Smith," Recommendation 32.

Similarly, the B.C. Supreme Court concluded there was no justification for communicating with inmates through the door slot because it is "demeaning and inhumane."[134] In federal prisons, staff are required to make "every reasonable effort" to ensure that communication with inmates in the structured intervention unit "is not mediated or interposed by physical barriers such as bars, security glass, door hatches or screens."[135] Given what we have observed about the use of the slot for communicating with youth separately confined in the IOU, in our view a similar requirement must be established in the *Youth Custody Regulation*.

**Finding 1:** It is unreasonable to require youth in separate confinement to communicate with mental health clinicians through the slot in the door of their separate confinement room.

**Recommendation 1:** By April 1, 2022, the Minister of Children and Family Development propose to the Lieutenant Governor in Council that the *Youth Custody Regulation* be amended to require that staff, including mental health practitioners, make all reasonable efforts to ensure that communication with youth in custody is not mediated by physical barriers, including a door slot.

## Restricted movement and limited access to programs, activities and supports

When youth are separately confined, staff are supposed to allow them time outside their room for at least one hour in every 24-hour period.[136] In reviewing the records, we observed that youth who were separately confined for prolonged periods were not routinely locked in their cell for 23 hours a day, but were still experiencing significant restrictions of their voluntary social interactions.

In periods where the youth were considered to be sufficiently stable, we observed that they were allowed to spend more time in the IOU and Venture day room, outside their individual cells. While this gave them access to a larger space, they continued to be separated from other youth in the centre.

In the IOU, youths' primary human contacts were with staff – youth supervisors and senior youth supervisors. We observed that the nature and quality of social human contact depended primarily on the capacity and willingness of individual staff to engage youth who are separately confined. The nature of the interactions between staff and these youth was varied and inconsistent. For example, the records noted instances where staff played cards with youth. We also observed a case where staff were instructed to have "no contact" with the youth apart from essential duties such as performing safety checks and providing food. On reviewing the records, it was clear that some staff tried to engage meaningfully with the youth, while others engaged with them in a more perfunctory manner.

Sometimes, when they were separately confined, youth were able to have contact with family by telephone or in-person visits. Sometimes they were able to write letters. However, contact with family was not a frequent or regular experience of separate confinement for these youth.

Based on our review of the records, the youth were not provided with any cultural supports

[134] *British Columbia Civil Liberties Association v. Canada (Attorney General),* 2018 BCSC 62, paras. 138 and 139. The court cited evidence of an Elder at one centre who was forced to kneel or squat on the floor outside inmates' cells in order to make eye contact with inmates when he spoke with them. The court noted that based on the evidence of other witnesses, most individuals "simply stand erect outside the inmates' cells, speak to the inmates without making eye contact and rely on their voices being heard through the food slot" (para. 139).

[135] *Corrections and Conditional Release Act*, S.C. 1992, c. 20, s. 32(2). Similar prohibitions exist in Yukon and proposed legislation in Ontario.

[136] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.11.

while separately confined. Nor were the youth provided with any religious or spiritual support while separately confined.

The records showed that there was significant variation in how separately confined youth were supported in using their time during the day, when other youth in the centre would be in school or programs. In periods of stability, some youth received school work in the form of worksheets to do on their own. Often, the youth were not able to do this school work, and did not have access to a teacher or other support to assist them.

Very infrequently, these youth were able to attend a short period of in-class instruction. Sometimes this would be with other youth, and sometimes the youth would be on their own in class with just a teacher. The records suggested that the youth saw attending school as a positive experience; however, their access to in-class instruction was inconsistent and limited.

We also saw in the records that youth would sometimes be integrated in small ways into programs elsewhere in the custody centre, such as attending gym, fitness, track and field or the garden with staff or a small number of other youth for a short period of time. However, as with attending school, this integration and programming was not a frequent or consistent experience for these youth.

In the unit itself, youth were often significantly limited in their ability to access materials or activities to occupy their time. For example, when staff identified a separately confined youth as being at a high risk of self-injuring, they would be given no materials at all – no clothes, no books, no fidget toys and no silverware when eating. On other occasions, we observed youth being provided with books, fidget toys, colouring books and crayons, or being allowed to watch a television that was set up in the staff office in such a way that the youth could watch through the window.

## Use of strong shift or blanket

The operations manual provides for the use of a strong shift or blanket in situations where a youth is believed to be at imminent risk of suicide and no other option exists or is reasonable in the circumstances.[137] Strong shifts are commonly referred to as safety or anti-suicide smocks and are made from a tough, quilted material that is difficult to fold or be rolled. The strong shift and blanket are intended to provide the wearer some modesty and warmth, as the wearer is naked underneath. The shift includes neck and armholes, fastened and adjusted by Velcro strips, whereas the blanket is one flat piece of material.

The policy further provides that staff should not place a youth in a strong shift or blanket based on their NSSI behaviour.[138] Instead, the strong shift or blanket should only be used if directed by a mental health professional or nurse practitioner, if it is part of a youth's overall safety plan and if it is authorized by a custody centre director prior to application.[139]

Policy guidelines on the use of a strong shift or strong blanket state that they are to be used for the shortest possible amount of time to ensure safety.[140] The operations manual requires staff to reassess the use of a strong shift or blanket every four hours, in consultation with a mental health professional and the provincial director of youth justice, and consider whether alternatives are possible. It also requires staff to conduct a health assessment every two hours for as long as a strong shift is being used, and to document all aspects of the use, reassessment and removal of the strong shift and blanket.[141]

[137] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.9.08.
[138] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.9.08.
[139] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.9.08.
[140] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.9.08.

In the cases we reviewed, mental health professionals were involved in the decision to place, maintain and remove youth from the strong shift or blanket. Central to their involvement was the development of a structured multi-day protocol to guide the use of a strong shift and blanket. This protocol was developed by a YFPS psychologist and psychiatrist before our investigation began. The protocol was initially developed in response to one youth and subsequently applied to other youth who were separately confined for prolonged periods for self-injuring and suicidal behaviour. Staff relied on the multi-day protocol when other youth were placed in a strong shift/blanket. The protocol sets out the following steps:

> Step 1 (2 days): placement in IOU, use of a strong gown, in a room with video monitoring, access to IOU dayroom only
>
> Step 2 (4 days): remain in IOU, in a room with video monitoring, with one set of regular clothing, a comforter, pillow (without a pillowcase) and access to Venture dayroom "if available"
>
> Step 3 (1 day): remain in IOU, return on standard clothing and bedding, "consideration" of move out of IOU; "significant dangerous behaviour" such as destruction of strong gowns or clothing returns her to step 1[142]

In our investigation we found that youth who were separately confined for prolonged periods of time in response to their NSSI and suicidal behaviours were also repeatedly placed in a strong shift and blanket during these periods of separate confinement

Our two key observations about the use of the strong shift/blanket protocol for youth who are separately confined are discussed below.

### *Length of time in strong shift or blanket*

In reviewing the records, we were mindful of the policy direction that the strong shift and blanket should be used for the shortest possible amount of time and only if the youth is at imminent risk of suicide, not in response to NSSI behaviours.

Given the limitations of our documentary review, we were unable to determine how staff assessed the suicide risk in every case and whether the assessments were appropriate in the circumstances. However, consistent with the strong shift protocol, set out above, we found that youth were sometimes in a strong shift or blanket for days at a time.

Over a 12-month period one youth was placed in a strong shift and blanket on seven different occasions. The time spent in the strong shift varied. On one occasion, the youth was placed in the strong shift and blanket for six days. On a separate occasion, the youth was placed in the strong shift for three days. Over the course of a single month, this youth was placed in the strong shift on three different occasions, lasting three days, five days and six days.

Another youth whose file we reviewed was placed in the strong shift for five days and another six days over a two-month period.

### *Forcible removal of clothing*

The use of the strong shift or blanket necessitates the removal of the youth's clothing. The operations manual emphasizes that the preferred approach is to negotiate a voluntary removal and exchange of clothing. It emphasizes that staff should communicate using supportive language, give youth control and choice to the degree possible in exchanging their clothing for a strong shift or

[141] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.9.08.
[142] This protocol was described in multiple email communications between mental health care staff and operations staff.

blanket, and, if youth are being co-operative, allow them to exchange clothing discreetly.[143]

In our investigation, we observed many instances where youth removed clothing of their own accord. However, in some cases, we found that BYCS staff forcibly removed the youth's clothing before providing them with a strong shift or blanket. The operations manual provides direction in situations where use of force is required to remove clothing. If staff use force to remove a youth's clothing, the policy provides that they should seek the prior approval of the provincial director "if feasible." At a minimum, the provincial director should be notified within 24 hours of any use of force to remove clothing.[144]

We observed several instances where staff sought to remove a youth's clothing, equipped with what they described as "full riot gear" – including a full-length protective shield (a large piece of shatterproof constructed equipment) and handheld video camera.

The use of a strong shift and blanket was also often accompanied by staff removing bedding, including mattress, blankets, pillows and sheets.

One youth's case further illustrates how these significant interventions can be used. After being separately confined and placed in an individual room in the IOU, the youth tied a piece of clothing around their neck. Staff entered the room and handcuffed the youth in order to cut off the ligature. The records show that the youth began hitting their head against the floor when staff physically restrained them. Once staff subdued the youth, staff removed the youth's clothing and provided them with a strong gown and strong sheet. Four hours later, staff observed that the youth had pulled threads from the strong gown, had tied them around their neck, and was hiding under the strong blanket, refusing to remove the blanket for visual safety checks. A team of seven staff (three male, four female) entered their room, cut the string from their neck, removed the strong shift and blanket, leaving the youth naked on the floor of the room. The youth was issued a new strong blanket later that evening after agreeing to take sleep medication. The records show that the youth was denied a mattress (and thus slept on the floor with only a strong blanket) because in the past they had damaged the mattress to obtain material to self-injure.

## Use of force prior to or during separate confinement

In addition to the forcible removal of clothing described above, staff repeatedly used force to control or respond to the behaviour exhibited by these three youth while they were separately confined. Staff used force to gain control of a youth, bring them to the ground and restrain them.

The use of force and the use of physical and mechanical restraint devices is authorized by the *Youth Custody Regulation* in certain circumstances, when "all other means of dealing with the youth have been exhausted or are not reasonable in the circumstances," and includes measures to prevent or discontinue harm to a person or to "overcome resistance or compel compliance necessary for the security of the youth custody centre."[145]

For the three self-injuring youth who were subject to prolonged periods of separate confinement, the use of force appeared to be a regular, and repeated, experience, often beginning with the decision to separately confine them. On one occasion, a youth was on a regular living unit and had covered the

[143] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.9.08.
[144] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.9.08. We did not conduct a comprehensive assessment of whether the provincial director's approval was sought in accordance with the policy and note that the policy was amended in October 2020, removing the requirement that the provincial director be notified. See MCFD, *Manual of Operations – Youth Custody Programs*, October 2020, D.9.08.
[145] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 14 and 15.

window to her room with paper and did not respond to staff knocks. On entering the room, staff observed that the youth was "sitting on her desk looking at the wall." It appears that staff decided at this point to move the youth to the IOU; when the youth did not agree to walk to IOU herself,

> the team went hands on in order to get her into physical restraints and take her down to I.O.U. [Another staff member] and myself grabbed her left arm and tried to pull her hand out from underneath her front side. At this time, [the youth] was attempting to bang her head off the wall and or desk.…[A staff member] secured her arms in handcuffs while [another staff member] shackled her legs. Once we had a good hold on her our team transferred her to the ground.…We attempted to roll her onto her feet to get her up and walking but she began to resist…after some time we got her up and I went hands off. She walked down the stairs…

In a different instance of separate confinement, a youth repeatedly refused to return to her room in the IOU, and the senior youth supervisor directed staff to "use physical restraint to escort her to her room." The records completed by one staff member describe what followed:

> [Staff member] and I approached [the youth]; I grabbed her right arm but did not have control as she was flailing her body around. Other responding staff attempted to gain control of her but her flailing around was making it difficult. She was dragged toward her room due to her combative behavior and along the way grabbed hold of my ankle. I trapped her arm with my knee and then [another staff member] gained control of my arm so I could remove my knee. She was dragged into her room but as staff attempted to exit she quickly got up and rushed the door, attempting to punch [a staff member]. She was restrained in the prone position and placed in mechanical restraints…once the mechanical restraints were on, the team was able to safely exit the room.

In a separate incident, staff responded to a concern that a youth had placed her mattress against the door of her room on the IOU and covered the camera with soap. Staff opened the door and removed the mattress and soap "while the other responding staff restrained [the youth]" on the ground. Soon after, the youth began to rip her shirt into pieces and staff intervened to cut her clothing off and place her in a strong gown. During this process, the youth was again restrained on the ground.

In a separate case involving a different youth, the records described the steps staff took on observing a youth lying on the ground with a ligature tied around her neck:

> I witnessed [the youth] struggling and fighting with the Staff who were trying to remove the ligature from her neck. I immediately located [the youth's] left leg and assisted in restraining it from thrashing about and injuring anyone else or herself. Once the ligature was removed, we continued to restrain [the youth] until handcuffs were applied. Once she stopped struggling, she was placed on her bed and the room was cleared of all objects and staff.

Approximately 20 minutes after this incident, the youth was moved to the Inpatient Assessment Unit, where she was "stripped of her clothing and given a strong gown" and medication was administered.

The records indicated that the use of force was a consistent feature of the separate confinement experienced by these youth. We observed a pattern: a youth would engage in injurious or disruptive behaviour; the staff would verbally instruct the youth to stop and the youth would refuse; and staff would

intervene with physical force and restraints and restrictions on the youth's limited privileges. These incidents created a high-risk environment for both youth and staff, and in many cases, ended with a youth being restrained or placed in a strong shift.

Under the *Ombudsperson Act,* we may find that a decision or action is "oppressive."[146] A decision or action may be oppressive if it is punitive or harsh, or if it inflicts harm. Oppressive acts are assessed primarily by their effects, not the motives of those who do them.

We found that force was used repeatedly in response to the self-injuring and suicidal behaviour of these youth. The repeated use of force in these circumstances diminished the youths' sense of autonomy and privacy. It is likely that the use of force had a retraumatizing effect on youth who have a significant and known history of trauma. For these reasons, the use of force in relation to the separate confinement of these youth – even though permitted by the regulation and policy – was oppressive.

In light of our observations about the repeated use of force against youth who were separately confined, the ministry should conduct a broader review of the use of force against youth in custody. This review should include the collection of data about which youth are subject to use of force interventions, and the extent to which they are connected to the use of separate confinement, and should make recommendations for reducing the use of force in custody.

**Finding 2:** The repeated use of force against youth while separately confined including the forcible removal of clothing was oppressive.

**Recommendation 2:** By October 1, 2021, the Ministry of Children and Family Development conduct an independent review of the use of force in youth custody that includes:

a) the collection and analysis of data to understand which youth are most affected by the use of force and the circumstances in which force is used, and

b) recommendations to reduce the use of force, including the forcible removal of clothing, and development of alternative models of non-violent de-escalation based in trauma-informed practice and cultural safety.

**Recommendation 3:** Within one month of the completion of the use of force review, the Ministry of Children and Family Development provide a copy of the completed review report to our office with a plan for implementing its recommendations.

## 4.4 Impacts of separate confinement on mental health

Separate confinement, often in conjunction with the use of a strong shift and/or strong blanket, was used by BYCS staff and directors to manage self-injuring or suicidal behaviour with the objective of ensuring the immediate safety of the self-injuring or suicidal youth. At the same time, staff sometimes recognized the potential long-term consequences of the isolation. For example, writing about a youth, a mental health professional observed the following:

> It is our belief that [the youth's] residence at the IOU…has helped maintain a degree of stability and decreased her risk for serious self-harm. It has also had the benefits of protecting peers from

[146] *Ombudsperson Act*, R.S.B.C. 1996, c. 340, s. 23.

> [the youth's] labile mood and behavior, and providing staff with a safer environment in which to intervene when/if necessary. It is very likely that, if she returns to a regular unit, she will destabilize at some point and will again be at risk for serious self-harm. If possible, her current protocol should be maintained.
>
> This protocol, however, has come with a degree of isolation, which has presented its own challenges.…It is very possible that [the youth] could engage in progressive acting out behavior in an attempt to demonstrate her perceived need to return to a regular unit.
>
> There is, unfortunately, no option that fully addresses the concerns of all parties.

Based on our review of the records, we found that the social isolation caused by separate confinement contributed to a decline in the youths' mental health and an escalation of self-injuring and suicidal behaviour. For example, staff recorded one youth's complaints that they were "bored," "lonely" and "too isolated." After nine consecutive weeks in the IOU, staff recorded the youth saying that they were "feeling like a caged animal… resentful and wanting to self-harm again." The next time that youth was admitted to custody they were recorded telling staff "I'm not going back there [to IOU] again, I only want to go to a regular unit." Staff documenting the separate confinement of a different youth recorded that after four days in the isolation unit the youth was "beginning to unravel" due to boredom and began to self-injure that night. Staff recorded that another youth had expressed hopelessness, feelings of isolation and depression, and asked about a plan to reintegrate with their peers.

While separately confined, youth self-advocated for access to personal items, programs, mental health support and reintegration with peers. Many of their requests were dismissed or minimized by staff. For example, in one case, a youth repeatedly asked operations staff for her bedding to be returned. Her bedding was not returned and she sought out support from mental health staff. Despite repeated requests by the youth and three follow-up attempts from mental health staff, it took nine days for the youth's bedding to be returned. In another case, a youth asked for a hand-held stress ball to help her cope while separately confined, but this request was denied by operations staff, who said that she had to "demonstrate stability" before she could have access to a stress ball.

In another case, a youth asked repeatedly to be able to meet her psychologist in the psychologist's office instead of the unit where she was being separately confined. Despite support from the psychologist and evidence that the youth's behaviour had settled, her requests were denied. In yet another case, a youth repeatedly asked to meet with her psychiatric social worker and psychologist, when she was feeling at risk of self-injury. The records indicate that these requests were not followed up by operations staff and that as a result the youth was not given access to these mental health supports. When such requests went unanswered, the youth consistently escalated to serious self-injury attempts within a short period of time.

One youth repeatedly reported to the mental health team at the custody centre, as well as medical staff at the Inpatient Assessment Unit and hospital, that being isolated was making her suicidal and she wanted to move to a regular unit. The mental health team advocated for this youth's transfer to a regular unit; however, the assistant director of operations refused to approve this transfer until they upgraded the beds on that unit, which took more than six months. During those six months, the youth was housed in the IOU on each admission to custody, during which time she made three serious suicide attempts.

The impact of separate confinement on one youth's mental health was described by a mental health clinician at BYCS, who wrote, in part:

> Beyond the vague and general statement that [the youth] needs to "stabilize" there does not appear to be a clear and specific plan in place at this time. The dichotomy here is that [the youth] is being kept in the [isolation unit] for their safety (and the safety of staff), so when [the youth] talks about wanting to hurt themselves, and others, people feel [the youth] needs to remain in the [isolation unit]. However, remaining in the [isolation unit] contributes to the further deterioration of [the youth's] mental health by having them essentially stuck in a "fish bowl" with limited programs and interactions. This results in [the youth] feeling hopeless and continuing to engage in suicidal and homicidal ideation. Repeat…it is very important to have a clear plan in place outlining step by step specifically what [the youth] needs to do in order to move forward. Such a plan will be far more beneficial in managing [the youth's] mental health concerns.

On another occasion, staff recorded that a youth "continues to ask 'when will I get out of [the separate confinement unit], and what is the plan for me, how long until I get moved from here.'" In response, staff noted they had "explained that hygiene,…cleaning room/unit, and incident-free behavior must happen for several days for any consideration." Later the same day, staff noted, "It was decided stay on unit [separately confined] as [youth] was presenting as unstable, high pitched yelling, banging, wordless stares, suggestions of self-harm, and torn shirt (recovered)."

As the above statements suggest, a lack of appropriate supports, facilities and tools for staff contributed to the length of time that some youth were separately confined. The records show that despite staff being aware of the significant deleterious impact of separate confinement, youth continued to be housed in the IOU, in some cases "indefinitely" or "until further notice" because there was no other model of care that could meet these youths' complex mental health needs in a safe way. In other words, while staff may have wanted to seek alternatives to separate confinement, one of the reasons they could not was a lack of appropriate support resources and facilities.

We also saw examples of a youth being required to "commit to positive behaviour" such as "no self-harm attempts" and "no suicide attempts" before being considered for a move back to a regular living unit. The records indicate that the youth listened but "was not ready to commit to positive behaviour." This refusal was part of the rationale for keeping them in the IOU. These record entries reflect staff's understanding of the youth's self -injuring and suicidal behaviour as an individual choice that may be remedied by their own commitment to positive behaviour. The records do not indicate a consideration of the youth's history of trauma or the complexity of their mental health needs. Rather, the records frame their self-injuring and suicidal behaviour solely as their individual choice or decision. This approach obscures the youth's need for specialized mental health supports, as well as the ministry's responsibility to provide these supports.

## 4.5 Conclusion: Conditions and impacts of prolonged separate confinement

Youth were typically not locked in a cell for 23 hours a day while separately confined. We observed that some staff made attempts to provide sensory stimulation and human contact. However, these attempts were infrequent and inconsistent. The day-to-day experiences of youth in separate confinement were characterized by a significant restriction and minimization of meaningful social contact,

social isolation from other youth, and little or no contact with family. The youth did not access cultural or spiritual supports. While separately confined, operational and health care staff were the youths' primary source of human interaction but, as noted above, this too was inconsistent.

The unit most often used to separately confine youth was a dismal and unwelcoming space – noticeably darker, starker and less well maintained than regular living units. Staff routinely communicated with youth through the slot in their door, and we found that this was a barrier to youth receiving mental health care. The unit lacked features that would allow youth to maintain a minimal degree of privacy and autonomy while ensuring their safety. For youth who have been physically or sexually abused, this lack of privacy may invoke heightened anxieties and fear. Moreover, the physical components of the unit were not sufficiently durable, and the safety of youth was compromised as a result.

As was evident in the records we reviewed, some youth experienced separate confinement as a cycle of self-harm, involving interventions such as the use of force – including the forcible removal of clothing, the use of strong blankets or strong shifts, and significant restrictions – followed by a brief period of stabilization and then another deterioration due to lack of appropriate support. In these cases, it appears that BYCS staff believed that the youth could not be safely reintegrated with other youth in the custody centre and as a result they remained separately confined for the duration of their time in custody. We observed many instances where these youth were released into the community directly from separate confinement.

In this section of the report, we have made two specific findings and recommendations in relation to two aspects of the conditions under which youth were separately confined. In the following sections, we outline the legal framework under which the separate confinement of youth in custody is permitted and then describe our analysis and recommendations regarding the use of separate confinement for youth in custody.

# 5. LEGAL PRINCIPLES GOVERNING THE TREATMENT OF YOUTH IN CUSTODY

The legal framework under which youth in custody are separately confined is, in one sense, straightforward. As we will describe in this section, the provincial *Youth Custody Regulation* sets out the circumstances under which separate confinement can occur and establishes certain procedural requirements that must be followed.[147] There is, however, a broader legal context that must be considered when examining how separate confinement is used in youth custody and which youth are affected by this practice. In the following sections, we describe this overarching legal framework that flows from the federal *Youth Criminal Justice Act* (YCJA). We then describe the specific rules and policies that govern the use of separate confinement in youth custody centres in British Columbia. Finally, we analyze this legal and policy framework in light of our factual findings, described in section 4.2, about the prolonged separate confinement of certain youth.

## 5.1 Canada's *Youth Criminal Justice Act*

Canadian law recognizes that youth lack a fully developed sense of moral judgment and, as a result, must not be held accountable for criminal acts in the same way as adults are. For this reason, Parliament has enacted criminal justice legislation – the *Youth Criminal Justice Act* – that applies solely to youth.[148]

The preamble to the YCJA sets out the broadly rehabilitative aims of the Act and highlights the shared societal responsibility to "address the developmental challenges and needs of young persons and to guide them into adulthood."[149] Importantly, the preamble acknowledges that Canada is a party to the United Nations Convention on the Rights of the Child and recognizes that youth engaged with the justice system continue to have rights and freedoms, including those set out the *Canadian Charter of Rights and Freedoms.*[150]

The UN Convention on the Rights of the Child, which Canada ratified in 1991, includes internationally accepted principles and minimum standards for government treatment of children in a range of matters, including health, education and youth justice.[151] The express reference to the Convention in the YCJA is significant because, while the Convention is not directly enforceable in domestic courts, it is an established principle

[147] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1.
[148] *Youth Criminal Justice Act*, S.C. 2002, c. 1.
[149] *Youth Criminal Justice Act*, S.C. 2002, c. 1, Preamble.
[150] *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), c. 11.
[151] UN General Assembly, Convention on the Rights of the Child (United Nations, Treaty Series, vol. 1577, November 20, 1989), https://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf.

of statutory interpretation that domestic legislation is ordinarily expected to be consistent with international law and Canada's international obligations.[152]

As a result of the reference to the Convention in the YCJA preamble, Canadian courts have relied on the Convention to interpret the YCJA and to apply the Charter to cases involving youth.[153] This includes separate confinement in youth custody. In a 2018 decision that was not appealed, an Alberta provincial court judge found that the solitary confinement of a youth contravened Articles 37(b) and (d) of the Convention. This conclusion was central to the judge's finding that the two years of unlawful separate confinement experienced by the youth violated his right under section 9 of the Charter to not be subject to arbitrary imprisonment.[154]

### United Nations Convention on the Rights of the Child[155]

The United Nations Convention on the Rights of the Child contains provisions relevant to the treatment of youth detained in the criminal justice system:

*Article 3*

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.
2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.
3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

*Article 37*

States Parties shall ensure that:

(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age;

(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time;

[152] *Suresh v. Canada* (Minister of Citizenship and Immigration), 2002 SCC 1, para. 59.
[153] For example, in *R. v. R.C.*, 2005 SCC 61, para. 41, the Supreme Court of Canada referenced the Convention in determining that young offenders require "enhanced procedural protections" in the criminal justice system. In *R. v. C.D.*, 2005 SCC 78, para. 35, the Supreme Court of Canada used the reference to the Convention in the YCJA preamble to explain why the Act is "aimed at restricting the use of custody for young persons."
[154] In Alberta, unlike B.C., there is no statutory framework governing the separate confinement of youth. In *R v. CCN,* 2018 ABPC 148, para. 72, the judge found that relying on a policy to separately confine the youth was unlawful, stating, "any capacity of corrections officials to confine a young person in solitary confinement should be narrowly interpreted, and does not exist in the absence of clear and specific legislation."
[155] UN Convention on the Rights of the Child.

(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;

(d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

*Article 40*

1. States Parties recognize the right of every child alleged as, accused of, or recognized as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.

In addition to the preamble, the YCJA contains a declaration of principle that establishes four overarching policy goals of the youth criminal justice system in Canada:

- The purpose of the youth justice system is to promote protection of the public by holding young persons accountable for their offending, promoting the rehabilitation of youth offenders and preventing youth reoffending by referring youth to community agencies to address the circumstances of their offending behaviour.
- The youth criminal justice system must be separate from that for adults. It must be based on the principle of diminished blameworthiness and must emphasize rehabilitation and reintegration; fair and proportionate accountability that reflects young persons' dependency and reduced maturity; enhanced procedural protections to ensure fair treatment and protection of youths' rights; and timely intervention and enforcement of the Act.
- Fair and proportionate accountability measures for youth who commit offences should reinforce respect for societal values, encourage repair of harm to victims and the community, be meaningful given the youth's needs and development and involve parents and the broader community where appropriate, and respect and respond to general, cultural, ethnic and linguistic differences and the needs of Aboriginal young persons.
- Any criminal proceedings against young persons should recognize youths' rights and freedoms, respect the dignity and privacy of victims, and involve parents to support their children in addressing offending behaviour.[156]

[156] *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 3.

The Supreme Court of Canada has ruled that a similar statement of principle contained in the *Young Offenders Act*, which preceded the YCJA, "should be given the force normally attributed to substantive provisions."[157] As a result, the declaration of principle has had a significant impact on the interpretation and application of the YCJA.[158]

In addition to the preamble and declaration of principle, the YCJA makes clear that treating youth in custody and under supervision safely, fairly and humanely, and rehabilitating and reintegrating youth involved with the criminal justice system is essential to the protection of society in general.[159] Similarly, a youth who is housed in a place of temporary detention must also be "detained in a manner that is safe, fair and humane."[160] Section 83(2) establishes some principles that are to be applied, in conjunction with the declaration of principle, to achieve the overall purpose of protecting society.[161] Three principles are particularly relevant in defining the obligations of provincial governments operating youth custody facilities:

- Staff caring for youth must use the "least restrictive measures" in custody, consistent with protecting the public, staff and youth.
- Youth in custody retain their rights except to the extent that they are necessarily removed as a result of a sentence.
- Custody decisions must be made in a "forthright, fair and timely manner" with access to an "effective review procedure."[162]

As section 83 acknowledges, youth in custody retain their rights, including those guaranteed under the *Canadian Charter of Rights and Freedoms,* to the extent possible given their custodial sentence. This includes:

- the right to life, liberty and security of the person[163]
- the right to not be arbitrarily detained or imprisoned[164]
- the right to not be subjected to cruel and unusual treatment or punishment[165]

These rights are subject only to the reasonable limits that can be justified in a free and democratic society.[166] All legislation governing youth custody, whether federal or provincial, and all actions of youth custody centre administrators, must be consistent with the Charter. To the extent that laws or the administration of those laws unjustifiably infringe on individual Charter rights, they may be unconstitutional.[167]

While the federal government has established the overall framework and principles governing youth criminal justice, the provinces are responsible for administering the youth custody system. British Columbia's legal and

[157] *R. v. M. (J.J.)* [1993] 2 SCR 421 at 428.
[158] For example, in *R. v. L.T.H.*, 2008 SCC 49, the Supreme Court of Canada considered s. 3(b)(iii), which guarantees a youth "enhanced procedural protections," in determining that a youth's videotaped statement was inadmissible. Similarly, in *R. v. D.B.*, [2008] 2 S.C.R. 3, 2008 SCC 25, para. 95, the Supreme Court of Canada considered the principle of diminished moral culpability of youth as set out in YCJA s. 3(1)(b) in determining that a presumption of an adult sentence for a youth was unconstitutional.
[159] *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 83(1)(a) and (b).
[160] *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 30(1).
[161] *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 83(2).
[162] *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 83(2)(a), (b) and (d).
[163] *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), c. 11, s. 7.
[164] *Canadian Charter of Rights and Freedoms*, c. 11, s. 9.
[165] *Canadian Charter of Rights and Freedoms,* c. 11, s. 12.
[166] *Canadian Charter of Rights and Freedoms*, c. 11, s. 1.
[167] See, in the federal adult corrections context, *Corporation of the Canadian Civil Liberties Association v. Canada (Attorney General)*, 2019 ONCA 243 and *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2019 BCCA 228.

policy framework is set out in greater detail in the next section.

## 5.2 British Columbia's *Youth Justice Act and Youth Custody Regulation*

In B.C., the Ministry of Children and Family Development is responsible for a range of services and programs for children and youth, including child protection, youth supports and family development for children at risk of abuse and neglect; specialized mental health services; and youth custody and community supervision programs.[168]

The ministry provides youth custody and community supervision programs under the authority of the federal YCJA and the provincial *Youth Justice Act* and *Youth Custody Regulation*.[169] The youth custody system is separate from the adult system, which is the responsibility of the provincial Minister of Public Safety and Solicitor General (for adults awaiting trial or sentenced to less than two years)[170] or the Correctional Service of Canada under the federal Minister of Public Safety (for sentences greater than two years).[171] The legal requirement to detain youth in custody separately from adults is contained in both federal and provincial legislation as well as the UN Convention on the Rights of the Child.[172] This requirement for separation reflects the principle that the criminal justice system should treat youth differently from adults because of youths' diminished moral blameworthiness.[173]

B.C.'s *Youth Justice Act* establishes a legal framework for the care of youth who have been given a custodial sentence or who have been remanded to custody while awaiting trial on a criminal offence. The *Youth Justice Act* is intended to work in concert with the general principles set out in the federal YCJA. As such, the *Youth Justice Act* and accompanying *Youth Custody Regulation* set out detailed operational procedures for the administration of youth custody centres.

The YCJA requires that each province and territory has at least two levels of custody for young persons. These two levels of custody are distinguished by the degree of restraint applied to the young persons in them.[174]

In B.C. the two levels are called open and secure.[175] Both youth custody centres,

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[168] Ministry of Children and Family Development, *2018/19 Annual Service Plan Report*, 7, https://www.bcbudget.gov.bc.ca/Annual_Reports/2018_2019/pdf/ministry/cfd.pdf.

[169] The *Youth Justice Act* was enacted in 2003 to bring provincial legislation in line with the newly enacted *Youth Criminal Justice Act*.

[170] Government of British Columbia, "Corrections," https://www2.gov.bc.ca/gov/content/justice/criminal-justice/corrections.

[171] Correctional Service Canada, "Frequently Asked Questions," https://www.csc-scc.gc.ca/media-room/009-0002-eng.shtml.

[172] *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 84; *Youth Justice Act*, S.B.C. 2003 c. 85, s. 13(3). The legislation establishes limited exceptions to this requirement. See also the United Nations Convention on the Rights of the Child, which states that children in custody must be separated from adults unless it is in the child's best interest not to be separated: UN Convention on the Rights of the Child, Art. 37(c). The Government of Canada has entered an official reservation to Article 37(c), meaning that it retains the right to not separate children and adults where it is not feasible or appropriate. See Jean-Francois Noël, "The Convention on the Rights of the Child," Department of Justice, 2015, https://www.justice.gc.ca/eng/rp-pr/fl-lf/divorce/crc-crde/conv2a.html.

[173] *Youth Criminal Justice Act,* S.C. 2002, c. 1, s. 3(1)(b). The UN Convention on the Rights of the Child preamble recognizes that children need "special safeguards and care." See also *R. v. R.C.*, 2005 SCC 61, para. 41; *R. v. D.B.*, 2008 SCC 25.

[174] *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 85(1). In accordance with s. 88 of the YCJA, B.C. follows the process for determining the appropriate level of custody as set out in the predecessor legislation, the *Young Offenders Act*: see Order-in-Council 267, 28 March 2003, amended by Order-in-council 931, 2 October 2003. See also MCFD, *Manual of Operations – Youth Custody Programs*, 2018, M.2.

[175] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, M.2.

Burnaby Youth Custody Services Centre (BYCS) and Prince George Youth Custody Services Centre (PGYCS), have units that are designated as open and secure. Secure custody refers to facilities with physical security measures to detain youth, and is intended to be used for those found guilty of serious offences, or with a persistent pattern of offending, who cannot be reasonably supervised in a community setting or open custody. Open custody is intended for youth who cannot appropriately be placed in a community setting, but can be managed effectively with less stringent controls and more privileges. Some of the key differences between open and secure custody units, as described in the *Manual of Operations – Youth Custody Programs*, are listed in Table 1.

**Table 1: Comparison of open and secure custody units**[176]

| Open custody | Secure custody |
|---|---|
| Greater reliance on dynamic security (staff supervision); housed in unlocked rooms subject to operational requirements | Greater reliance on static security measures (locks, fences) |
| Fewer restrictions on movement in unit and through custody centre | More restrictions on movement through unit and custody centre |
| More access to custody centre programs | Less access to custody centre programs |
| Fewer restrictions on ability to access community | More restrictions on ability to access community |

The initial decision about the appropriate level of custody for a youth is made by a judge.[177] However, the provincial director of youth justice may transfer a youth between open and secure custody (and vice versa) if specific conditions are met and certain requirements are followed.[178] According to the operations manual, youth in remand are generally housed in a secure custody unit.[179]

The YCJA authorizes the provincial director appointed under the provincial *Youth Justice Act* to carry out the responsibilities and functions specified in the YCJA; these responsibilities can also be carried out by persons delegated by the provincial director.[180] The provincial director may delegate their responsibilities to the "person in charge" of a custody centre, who may, in turn, delegate some responsibilities to specified youth custody staff.[181]

The director of a youth custody centre (the "custody centre director") has a legislated responsibility to manage and operate the centre in a way that:

[176] Based on MCFD, *Manual of Operations – Youth Custody Programs*, 2018, M.2.03 and 2.05.
[177] *Young Offenders Act*, R.S.C. 1985, c. Y-1, s. 24.1(2) and (4).
[178] *Young Offenders Act*, R.S.C. 1985, c. Y-1, s. 24.2(9), (10) and (11).
[179] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, K.3.03.
[180] *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 2(1). The term "provincial director" is defined in that Act as "a person, a group or class of persons or a body appointed or designated by or under an Act of the legislature of a province or by the lieutenant governor in council of a province or his or her delegate to perform in that province, either generally or in a specific case, any of the duties or functions of a provincial director under this Act."
[181] *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 2(1); *Youth Justice Act*, S.B.C. 2003, c. 85, s. 42.

- provides and maintains order, discipline and security
- protects the safety of persons in the centre
- promotes rehabilitation and reintegration of youth into the community and supports their emotional and personal development[182]

In managing a custody centre, the custody centre director must establish programs for youth to improve their training and education, reduce the risk they present to the community and assist with their rehabilitation and reintegration into the community.[183]

The ministry's Manual of Operations – Youth Custody Programs assists staff in carrying out their responsibilities under federal and provincial laws.[184] The operations manual provides specific guidance to custody centre staff and the provincial director of youth justice on how to implement the relevant legislative provisions. The operations manual also establishes policies and practices for matters not specifically referred to in the *Youth Justice Act* or *Youth Custody Regulation*.

## 5.3 Authority for separate confinement: British Columbia's *Youth Custody Regulation*

As contemplated by the *Youth Justice Act*, Cabinet has established regulations for the separate confinement of young persons in youth custody centres.[185] Decisions to separately confine youth are governed by the *Youth Custody Regulation* and the *Manual of Operations – Youth Custody Programs*.

The following sections describe the regulatory and policy requirements that apply to decisions to separately confine youth in custody.

### Grounds for separate confinement are set out in the Regulation

Separate confinement is intended to be a tool of last resort, where the person in charge of a youth custody centre has reasonable grounds to believe that a youth:

- is endangering, or is likely to endanger, himself or herself[186]
- is endangering, or is likely to endanger, another person
- is threatening, or is likely to threaten, the management, operation or security of the youth custody centre
- has contraband hidden on or in his or her body
- has taken an intoxicant into his or her body
- is at risk of serious harm, or is likely to be at risk of serious harm, if not separately confined
- must be separately confined for a medical reason[187]

A youth may not be placed in separate confinement for a reason not listed above. The Regulation does not authorize the use of separate confinement for disciplinary reasons.[188] Even where one of the above grounds exists, there are other restrictions on the use of separate confinement.

Most importantly, separate confinement must be used only when all other less restrictive means of responding to a youth have been exhausted, or are not reasonable in the circumstances.[189]

[182] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 2(1).
[183] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 3.
[184] MCFD, *Manual of Operations – Youth Custody Programs*, 2018.
[185] *Youth Justice Act*, S.B.C. 2003, c. 85, s. 44(2)(j).
[186] The gendered language is the wording in the *Youth Custody Regulation*.
[187] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1.
[188] While not specifically prohibited in the Regulation, the operations manual states that separate confinement "is not a consequence" and is not imposed "for disciplinary reasons": MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D. 7.01.
[189] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1(1)(a) and (b).

During the COVID-19 pandemic, youth have been separately confined on admission to custody using the "medical reason" grounds in the regulation. These separate confinements occurred in 2020, which is outside the time frame of our investigation. See Appendix D for a more detailed discussion of the use of separate confinement to prevent the spread of COVID-19 in youth custody centres.

## Separate confinement decisions must be documented

The person making the decision to separately confine a youth must document their decision. They must set out a written consideration of all evidence relied on to justify the decision to separately confine the youth.[190] The person making the decision to separately confine a youth must also confirm that all other less restrictive means have been exhausted or were not reasonable in the circumstances.[191]

## Separate confinement cannot continue for longer than necessary

The Regulation provides that separate confinement may not be approved for longer than is necessary to address the applicable concern.[192] This does not prevent separate confinement from continuing if, in the course of a youth's separate confinement, the initial reason for separate confinement is resolved but another concern – that is also set out in the Regulation – arises.[193] Staff must release a youth from separate confinement at the earliest possible time.[194]

The operations manual states that "discontinuation of separate confinement will be considered if, on the advice of a medical practitioner or health care professional, it produces adverse side effects such as illness or severe emotional or physical stress."[195] While the reference to discontinuance of separate confinement is positive, it is important to note that the language of the policy is only permissive. In other words, if separate confinement results in adverse impacts on the youth, this is merely information to be considered in whether the confinement should continue – and does not require the period of separate confinement to end.

## Separate confinement must be reviewed on an ongoing basis

In service of the requirement that a youth should be separately confined for as little time as possible, the operations manual requires staff to regularly assess a youth's placement in separate confinement.[196]

This includes conducting a review at a minimum of every four hours between 8:00 a.m. and 8:00 p.m. daily. In this review, the reviewer must consider their observations of the youth, a review of the records, consultation with those involved with the youth in a supervisory or health care capacity, and an assessment of the youth's progress in relation to the behaviour support plan and potential for reintegration into regular living unit activities. The person conducting the four-hour review can decide to end a youth's separate confinement and reintegrate them into the regular living unit.

### Separately confined youth must be monitored regularly

When a youth is separately confined, a staff member must conduct a visual check of the youth at least every 15 minutes. This check

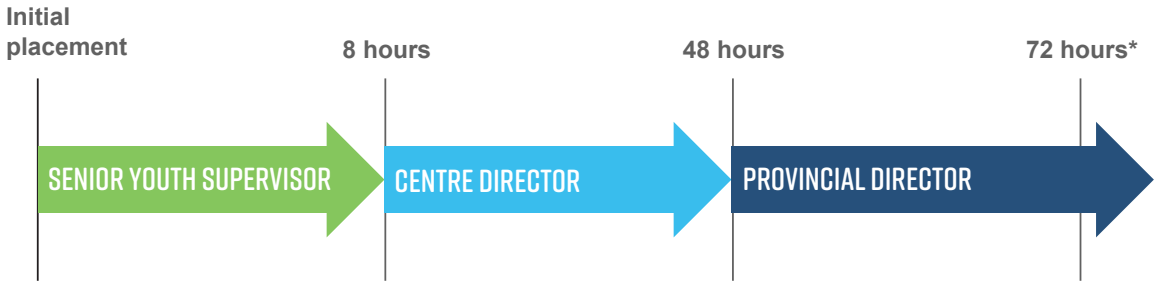
[190] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.04.
[191] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.04.
[192] *Youth Custody* Regulation, B.C. Reg. 137/2005, s. 15.1(4).
[193] *Youth Custody Regulation,* B.C. Reg. 137/2005, s. 15.1(4).
[194] *Youth Custody Regulation,* B.C. Reg. 137/2005, s. 15.1(1)(a) and (4)(a).
[195] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.06.
[196] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.09.

must be recorded in the staff log and must include a description of the youth's activities, demeanor and physical condition.[197] Youth who are "in a state of crisis or increased level of agitation" must be monitored more frequently.[198] This monitoring can be conducted by video, frequent in-person inspections or direct face-to-face supervision by staff.[199]

## Separate confinement decisions must be authorized by specified decision-makers

The Regulation prescribes an escalating decision-making structure for authorizing periods of separate confinement, where longer periods of separate confinement must be authorized by a director of the custody centre or the provincial director of youth justice.[200] These powers are then delegated in certain circumstances: initial decision to separately confine a youth up to 8 hours may be made by a senior youth supervisor in a custody centre. After 8 hours, the decision to continue separate confinement for an additional 40 consecutive hours must be made by a custody centre director.

### Figure 25: Separate confinement decision-making process




**When authorizing separate confinement for more than 72 hours, the provincial director must review:**

- ✓ Rationale for continued confinement
- ✓ Programs and services being provided to support reintegration
- ✓ Feedback from health/mental health and service providers
- ✓ Frequency and nature of contact with other youth
- ✓ Confirmation youth knows about advocacy and review processes

*And every subsequent 72 hour period.

[197] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.07.
[198] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.07.
[199] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.2.07.
[200] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1(2).

### The provincial director must authorize any period of separate confinement beyond 48 hours

The provincial director of youth justice must make any decisions to continue separate confinement for more than 48 hours, and for each additional consecutive period of separate confinement up to 72 hours each.[201] The operations manual further suggests that any decision to separately confine youth for more than 72 hours would occur only in the most "unusual and extreme circumstances," such as an imminent safety risk that prevents the youth from being returned to the general population. [202]

In considering whether to extend separate confinement for 72 hours or more, the provincial director must review information about the youth's individual circumstances, including:

- the rationale for continued separate confinement and why other alternatives are not feasible
- programs and services being provided to support reintegration to regular living unit activities
- feedback from health care, mental health and other service providers
- frequency and nature of contact with other youth
- confirmation that the youth has been advised of external advocacy support and review processes[203]

Taken together, these rules and procedures are intended to provide a measure of transparency and, through increasingly senior decision making, safeguard the rights and well-being of youth who are separately confined while in custody.

However, as we discuss in the following section, we found that the existing legal and policy framework does not protect against the prolonged use of separate confinement and that, because of this, various aspects of the regulatory framework are unjust, oppressive or both.

## 5.4 Analysis: Separate confinement is unjust and oppressive

As we have described, we found that the number of instances of documented separate confinement declined over the three years of our investigation at both BYCS and PGYCS.

At BYCS, most of the decline came from a reduction in the number of short-term instances of separate confinement. There were 61 instances of short-term separate confinement (less than 22 hours) in 2017 and only 17 in 2019. At the same time, the number of instances of separate confinement of more than 22 hours at BYCS was 31 in 2017 and 27 in each of 2018 and 2019. In 2019, 61 percent of all instances of separate confinement at BYCS lasted for more than 22 hours. Further, 20 percent of all instances of separate

[201] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1(2)(c) and (3); MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.03.
[202] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.03.
[203] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.10.

confinement at BYCS lasted for more than 72 hours.

From 2017 to 2019 there was an almost threefold increase in the average duration of separate confinement at BYCS. In other words, the average length of time that youth spend in separate confinement at BYCS has increased. Over the same three-year period, the average duration of each instance of separate confinement at PGYCS remained more or less the same.

Prolonged periods of separate confinement (over 72 hours) were most commonly used to respond to youth who were self-injuring or suicidal. These prolonged periods of separate confinement in response to self-injury were experienced almost exclusively by female youth and mostly by Indigenous and racialized female youth.

We found that youth who were self-injuring or suicidal were separately confined for the longest periods of time. The longest periods of separate confinement were experienced disproportionately by three youth. One youth was separately confined for 47 consecutive days. Another youth was separately confined four times in rapid succession for a total of 78 days. On a subsequent admission, she was separately confined again for 38 days.

These periods of prolonged separate confinement were characterized by a significant minimization of and restriction on youths' voluntary social contacts. Separately confined youth were housed in a stark and dismal space that is insufficiently durable to protect their safety. Separate confinement in response to self-injury and suicidal behaviours was often accompanied by invasive measures, including the use of a strong shift and blanket, as well as the repeated use of force. These measures diminished the youths' sense of autonomy and privacy, and it is very likely that they retraumatized youth who had a significant, known, history of trauma. The records showed the youth struggling in this environment, and we concluded that separate confinement contributed to a deterioration of their mental health over time.

These prolonged instances of separate confinement were authorized in accordance with section 15.1 of the *Youth Custody Regulation*, but that does not make them any less troubling.

## How the Regulation authorizes prolonged and indefinite separate confinement

As described in the previous section, the Regulation gives the custody centre director (or their delegate) the discretion to order separate confinement in order to ensure individual safety and institutional security. The Regulation requires certain conditions to be met in the exercise of this discretion. First, the centre director must reasonably believe that the youth poses a risk to individual safety or institutional security in accordance with the grounds set out in section 15(1)(b). Second, the centre director must be satisfied that all other less restrictive means of dealing with the youth have been exhausted or are not reasonable in the circumstances.

The discretion to continue the separate confinement for more than 8 hours rests with the custody centre director and, for all decisions to continue separate confinement for more than 48 hours, with the provincial director of youth justice. The custody centre director and provincial director apply the same factors in deciding whether to continue separate confinement or reintegrate a youth with other youth.

The exercise of discretion set out in the Regulation is a balancing exercise, where the safety of individuals, including employees and youth in the general population, is balanced against the risk of psychological harm to the separately confined youth. By structuring the exercise of discretion in this way, the Regulation allows for safety and security to be prioritized over the separately confined youth's well-being. Once a separate confinement

decision is made, a youth stays separately confined until the relevant decision maker decides to reintegrate the youth with other youth or the youth is released from custody into the community.

The Regulation requires that separate confinement not be approved for longer than is necessary to address the relevant safety concern.[204] At the same time, however, there is nothing in the Regulation that requires the confinement to end after a specified period. Nor is there a cap on the number of consecutive hours or days a youth can spend in separate confinement. Instead, the length of the confinement is determined by the continued existence of the grounds set out in section 15.1 of the Regulation and the absence of a reasonable alternative to separate confinement, as determined by either the custody centre director or the provincial director.

While the Regulation places some limits on the decision maker's exercise of discretion in placing or maintaining a youth in separate confinement, it fails to safeguard against prolonged use of separate confinement and the consequent psychological harm. Rather, the Regulation allows these prolonged periods to occur. For example, as we found in our investigation, the decision maker can conscientiously apply the limits set out in section 15.1 in exercising their discretion and still conclude that the earliest appropriate time to release a youth from separate confinement is only after days or weeks have passed, or until they are released into the community.

## The Regulation governing separate confinement is unjust

Under the *Ombudsperson Act* we can conclude that a law under which a decision was made, or action was taken, is "unjust."[205]

From our perspective, a law may be unjust if it is inconsistent with the values that are enshrined in the *Canadian Charter of Rights and Freedoms* or other accepted legal norms or standards.

A regulatory scheme that allows for prolonged and indefinite separate confinement cannot be reconciled with the broader legal framework governing youth custody, recent court decisions on segregation of adults, or relevant international standards.

### *Youth justice legislation*

The *Youth Criminal Justice Act* requires a "safe, fair and humane" youth custody system that focuses on rehabilitation and the rights of incarcerated youth. It is difficult to see how these youth could have experienced separate confinement, with the attendant isolation, boredom, loneliness and trauma, as a rehabilitative intervention consistent with the policy goals of the *Youth Criminal Justice Act*.

The UN Convention on the Rights of the Child, which is expressly incorporated into the YCJA, calls on signatory countries to ensure that every child who is deprived of their liberty is treated with humanity and respect for their inherent dignity.[206] Considering the known harms caused by separate confinement, we cannot reconcile these important principles in the Convention and the YCJA with a regulatory scheme that permits separate confinement of youth for documented periods of up to 1,133 consecutive hours (47 consecutive days). At a bare minimum, a safe, fair and humane system must safeguard against such foreseeable and significant psychological harm.

[204] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1(4).
[205] *Ombudsperson Act*, R.S.B.C. 1996 c. 340, s. 23(1)(ii) and (iii).
[206] UN Convention on the Rights of the Child, Art. 37(c).

### *International standards*

The United Nations Standard Minimum Rules for the Treatment of Prisoners (known as the "Mandela Rules") speak directly to the standards of care expected in custodial settings. As the Ontario Court of Appeal stated, the Mandela Rules reflect an "international consensus" on appropriate correctional practices.[207] The B.C. Court of Appeal affirmed that the Mandela Rules inform constitutional interpretation and, in particular, our understanding of the principles of fundamental justice.[208] As such, the Mandela Rules are directly relevant in assessing legislation authorizing segregation and separate confinement.

The Mandela Rules define solitary confinement as the practice of confining prisoners for 22 hours a day or more without meaningful human contact.[209] They prohibit indefinite solitary confinement and solitary confinement that continues for 15 consecutive days or more.[210] Moreover, the Mandela Rules affirm an earlier prohibition of solitary confinement for youth under 18 years old and individuals with mental or physical disabilities, when their conditions would be exacerbated by such measures.[211]

We found that separate confinement in B.C.'s youth custody centres is the confinement of an individual youth in a location that isolates them, physically and socially, from other youth in the centre. While the *Youth Custody Regulation* places some limits on the decision maker's exercise of discretion in placing or maintaining a youth in separate confinement, it fails to safeguard against the prolonged use of separate confinement and the consequent psychological harm. Rather, the Regulation allows these prolonged periods of isolation to occur.

The provisions of the Regulation that allow for the separate confinement of youth under age 18 and youth with mental or physical disabilities for more than 22 hours are therefore inconsistent with the Mandela Rules.

### *Canadian Charter of Rights and Freedoms*

In addition, the Regulation is inconsistent with recent decisions by the B.C. Supreme Court and Court of Appeal that examined the constitutionality of federal legislation that governed "administrative segregation" in adult corrections. Like section 15.1 of the *Youth Custody Regulation,* the federal provisions that the courts examined authorized the use of administrative segregation for as long as the reason for initiating separate confinement existed, and only when there was no reasonable alternative.[212] In addition, the federal provision included the requirement that an inmate be released from segregation at the "earliest appropriate time."[213] The courts concluded that because the federal provisions failed to prohibit prolonged and indefinite segregation, they did not comply with the *Canadian Charter of Rights and Freedoms*. The B.C. Court of Appeal found that

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[207] *Canadian Civil Liberties Association v. Canada (Attorney General)*, 2019 ONCA 243, para. 28.
[208] *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2019 BCCA 228, para. 168.
[209] UN Office on Drugs and Crime, *Standard Minimum Rules for the Treatment of Prisoners*, Rule 45.2.
[210] UN Office on Drugs and Crime, *Standard Minimum Rules for the Treatment of Prisoners*, Rule 43.
[211] UN Office on Drugs and Crime, *Standard Minimum Rules for the Treatment of Prisoners*, Rule 45.2; Rule 67 of the *United Nations Rules for the Protection of Juveniles Deprived of Their Liberty* (UN General Assembly, April 2, 1991, https://www.un.org/ruleoflaw/files/TH007.PDF) prohibits the use of solitary confinement for anyone under the age of 18, stating that all disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned.
[212] *Corrections and Conditional Release Act*, S.C. 1992, c. 20, s. 31(3).
[213] *Corrections and Conditional Release Act,* S.C. 1992, c. 20, s. 31(2).

> a legislative provision that authorizes the prolonged and indefinite use of administrative segregation in circumstances that constitute the solitary confinement of an inmate within the meaning of the Mandela Rules deprives an inmate of life, liberty and security of the person in a way that is grossly disproportionate to the objectives of the law. In addition, the draconian impact of the law on segregated inmates, as reflected in Canada's historical experience with administrative segregation and in the judge's detailed factual findings, is so grossly disproportionate to the objectives of the provision that it offends the fundamental norms of a free and democratic society.[214]

The provisions of the *Youth Custody Regulation* similarly fail to prohibit prolonged and indefinite separate confinement and are incompatible with the principles of fundamental justice articulated in the Charter.

Section 15.1 of the *Youth Custody Regulation* authorizes the prolonged separate confinement of young people in B.C. youth custody centres. The prolonged separate confinement of youth is inconsistent with the governing principles of the *Youth Criminal Justice Act*, including Canada's commitments under the UN Convention on the Rights of the Child. The prolonged separate confinement of youth is inconsistent with the minimum standards of care set out in the Mandela Rules. Finally, the prolonged separate confinement of youth is inconsistent with the values enshrined in the *Canadian Charter of Rights and Freedoms*. As a result, section 15.1 of the *Youth Custody Regulation* is unjust.

**Finding 3:** Section 15.1 of the *Youth Justice Regulation* is unjust because it does not establish a specific time limit on the duration of separate confinement and, as a result, youth have been separately confined for prolonged periods of time.

## Time limits: A necessary safeguard

The injustice created by the current *Youth Custody Regulation* can be addressed, in part, by establishing a specific, mandatory time limit on the separate confinement of a youth in custody. Such a time limit must, in our view, reflect the international consensus on the social isolation of youth in custody.

In this respect, we note that the child and youth advocates of Manitoba and Ontario have each recommended, in recent reports, a prohibition on the isolation of youth in custody in their respective provinces for more than 24 hours.[215] Similarly, the New Brunswick Ombudsman and Child and Youth Advocate, in his report on Ashley Smith's involvement with New Brunswick's youth custody system, recommended eliminating the use of prolonged segregation.[216]

In this report, we have identified 22 hours as an important threshold in addressing the harms of separate confinement. In part, this threshold of 22 hours is informed by the Mandela Rules, which define solitary confinement as the confinement of prisoners for 22 hours per day without meaningful human contact. As noted above, the Mandela Rules affirm an earlier prohibition of solitary confinement for youth under 18 years old and

[214] *British Columbia Civil Liberties Association v. Canada (Attorney General),* 2019 BCCA 228, para. 167.
[215] Office of the Provincial Advocate for Children and Youth, *It's a Matter of Time: Systemic Review of Secure Isolation in Ontario Youth Justice Facilities*, 2015, 61 https://ocaarchives.files.wordpress.com/2019/01/siu_report_2015_en.pdf; Manitoba Advocate for Children and Youth, *Learning from Nelson Mandela*, 54.
[216] New Brunswick, Ombudsman and Child and Youth Advocate, *Ashley Smith Report*, 63.

individuals with mental or physical disabilities, when their conditions would be exacerbated by such measures.[217]

In addition, the threshold of 22 hours is informed by the significant body of research showing that the social isolation of prisoners for any length of time has negative impacts on their mental health and functioning, and that young people are particularly vulnerable to the risk of long-term psychiatric and developmental harm caused by such isolation.

International norms and standards, as well as Canadian law, reflect a move away from the use of isolation in prisons except in limited circumstances. The B.C. Supreme Court said the following, in relation to the application of Mandela Rules to adult corrections:

> Negative health effects can occur after only a few days in segregation, and those harms increase as the duration of the time spent in segregation increases. The 15-day maximum prescribed by the Mandela Rules is a generous standard given the overwhelming evidence that even within that space of time an individual can suffer severe psychological harm.[218]

There have been many calls to eliminate the practice of isolation entirely for youth given the significant harms that can result from even a short period of isolation.

Establishing a legally binding, mandatory, non-discretionary time limit on the use of separate confinement is a key step toward reducing or eliminating the use of separate confinement in the youth custody system in B.C. The practical effect of a hard time limit was articulated by Dr. Margo Rivera, who provided expert evidence at the B.C. Supreme Court trial:

> Time limits on segregation would compel corrections officials to question more carefully the necessity for placing an inmate in segregation, and to turn to the variety of options for alleviating segregation sooner, rather than waiting months unnecessarily. While time limits would create administrative and resource challenges, this is exactly the sort of concrete pressure that would be required to properly control long-term segregation.[219]

Without a legal framework that imposes specific, mandatory time limits on the use of separate confinement, youth will continue to be isolated, sometimes for lengthy periods. For this reason, we have recommended that the *Youth Justice Regulation* be amended to limit the amount of time that a youth can be separately confined to no more than 22 consecutive hours. The Regulation should also be amended to ensure that youth are not repeatedly separately confined by establishing a clear limit on the frequency with which separate confinement can be used in relation to any one youth.

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[217] UN Office on Drugs and Crime, *Standard Minimum Rules for the Treatment of Prisoners*, Rule 45.2; Rule 67 of the *UN Rules for the Protection of Juveniles Deprived of Their Liberty* prohibits the use of solitary confinement for anyone under the age of 18, stating that all disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned.

[218] 2018 BCSC 62, para. 250. The trial judge determined that it was, nonetheless, a defensible standard in the federal adult corrections context.

[219] Expert report of Dr. Margo Rivera, *British Columbia Civil Liberties Association and the John Howard Society of Canada v. Attorney General of Canada*, SCBC Vancouver Registry No. S-150415, 30 December 2015, 11–12, http://dev.bccla.affinitybridge.com/wp-content/uploads/2017/07/Day-15_2015-12-30-Expert-Report-of-Margo-Rivera.pdf. Dr. Rivera is an associate professor and the director of psychotherapy in the Department of Psychiatry, Queen's University, and clinical leader of the Personality Disorders Service at Providence Care, Mental Health Services. She is the author of numerous publications, including *Segregation Is Our Prison within the Prison": Operational Examination of Long-Term Segregation and Segregated Inmates with Mental Health Problems*, Correctional Service of Canada, 2010.

We have also recommended that this regulatory reform be accompanied by a process for collecting and reporting disaggregated demographic data on the use of separate confinement. As B.C.'s Human Rights Commissioner has recently affirmed, data can lead to positive change by making systemic inequalities in our society visible.[220] Moreover, the Commissioner has specifically called on B.C. to begin collecting disaggregated demographic data on the use of segregation and separate confinement.[221] We echo that call in our recommendation to the ministry, and it is our expectation that the ministry will apply the principles outlined by the Human Rights Commissioner in implementing this recommendation.

**Recommendation 4:** By April 1, 2022, the Minister of Children and Family Development propose to the Lieutenant Governor in Council that the *Youth Custody Regulation* be reconsidered by amending the regulation to:

a) prohibit the separate confinement of youth in custody for more than 22 consecutive hours, with no exceptions, and

b) establish a maximum number of times that a youth can be separately confined within a specified period, with no exceptions.

**Recommendation 5:** By July 1, 2021, the Ministry of Children and Family Development:

a) implement a process for collecting and publicly reporting on an annual basis data on the use of separate confinement in youth custody, including the frequency and duration of instances of separate confinement, and

b) develop a framework for public reporting that includes the collection, use and disclosure of disaggregated demographic data in relation to separate confinement and ensures that appropriate processes of Indigenous data governance are followed throughout required data acquisition, access, analysis and reporting.

## 5.5 The disproportionate impact of separate confinement is unjust

In the previous section, we explained our finding that by failing to prohibit periods of prolonged separate confinement, the *Youth Custody Regulation* was unjust within the meaning of the *Ombudsperson Act.*

A law may also be unjust if its impacts are inequitable – that is, if it has a disproportionate impact on some people. Determining whether a law is unjust requires consideration of the specific ways in which certain people or groups, particularly members of disadvantaged groups, may be more vulnerable to its effects.

Under the *Ombudsperson Act,* we can also conclude that a decision or action is "oppressive."[222] A law, decision or practice may be oppressive if it is punitive or harsh, or if it inflicts harm. In assessing whether a practice is oppressive, it is necessary to understand the specific structural factors that may make certain people more likely to be harmed by a practice and, therefore, to experience it as oppressive.

Over the three years of our investigation, we observed that different groups of youth

[220] B.C. Human Rights Commissioner, *Disaggregated Demographic Data Collection*, 8.
[221] B.C. Human Rights Commissioner, *Disaggregated Demographic Data Collection*, 83.
[222] *Ombudsperson Act*, R.S.B.C. 1996, c. 340, s. 23.

were disproportionately subject to separate confinement. We found that Indigenous youth were separately confined more frequently and experienced more hours of separate confinement than non-Indigenous youth. We found that while male youth were separately confined most frequently, female and gender-diverse youth were separately confined for relatively much longer periods of time.

We found that prolonged periods of separate confinement (over 72 hours) were most commonly used to respond to youth who were self-injuring or suicidal. We also found that prolonged periods of separate confinement in response to self-injury were experienced disproportionately by female, Indigenous and racialized youth. These youth were separately confined more often and for significantly longer periods than any other youth in custody. Their experience of often prolonged periods of separate confinement in response to their mental illness disproportionately exposed them to the risk of psychological harm caused by separate confinement.

We understand that the experience of these youth in separate confinement cannot be divorced from their unique social history and identity as female, gender-diverse, Indigenous and racialized. Our examination of the disproportionate effects of separate confinement sought to consider how historical and systemic discrimination, including the intergenerational effects of colonialism, shaped the experience of individual youth in separate confinement.

The disproportionate impact of the practice of isolation in custody has been increasingly identified in independent reviews, judicial decisions and academic work.

An independent review of Ontario's adult correctional system in 2017 found that inmates exhibiting self-harming and suicidal behaviour were routinely segregated, and inmates "with mental health needs end up in segregation more often and for longer periods of time."[223]

Research confirms that social isolation exacerbates distress for incarcerated people with mental illness, and particularly those with histories of abuse and trauma. Most female youth in custody have experienced childhood trauma and are survivors of physical and sexual abuse.[224] Histories of childhood trauma and abuse are linked to a higher likelihood of self-injury in a custody environment.[225]

Moreover, research shows that incarceration can be traumatic in itself, and can also trigger memories of previous abuse.[226] Girls and women who have experienced trauma often feel a heightened sense of danger in the controlled and security-focused custody environment.[227] This is particularly pronounced in situations such as separate confinement where increased surveillance, isolation, use of force, and suicide precautions that force girls to remove their clothes in the presence of others can mirror earlier experiences of abuse, and thus further escalate self-injuring behaviours.[228] These triggers are especially powerful for female survivors of sexual abuse, who tend to have difficulty tolerating,

[223] Howard Sapers et al., *Segregation in Ontario: Independent Review of Ontario Corrections,* March 2017, 65, https://www.mcscs.jus.gov.on.ca/sites/default/files/content/mcscs/docs/IROC%20Segregation%20Report%20ENGLISH%20FINAL_0.pdf.
[224] MCFD, Youth Custody Services, *Strategic Plan 2017/18–2019/20*, 8.
[225] *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2019 BCCA 228.
[226] Stephanie Covington, "Women and Addiction: A Trauma-Informed Approach," *Journal of Psychoactive Drugs* 40 (2008): 382.
[227] Laura Prescott, "Adolescent Girls with Co-Occurring Disorders in the Juvenile Justice System," GAINS Center, December 1997, 12.
[228] Prescott, "Adolescent Girls with Co-Occurring Disorders," 12.

expressing and/or regulating their emotional responses.[229] Separate confinement, then, can increase the likelihood that female youth will self-injure. This, in turn, increases the likelihood that they will be separately confined.

Recent court decisions have confirmed that Indigenous women are more likely to self-injure in a prison environment because of a history of trauma and abuse.[230] In its decision on the constitutionality of segregation in federal corrections, the B.C. Supreme Court found that "administrative segregation is particularly burdensome" for Indigenous women because they suffer higher rates of physical and sexual abuse, and segregation can "exacerbate distress" for abuse survivors.[231]

Our investigation suggests that there is a similar pattern in youth custody, as Indigenous female youth are starkly overrepresented in prolonged use of separate confinement in response to self-injury. This is related to both individual experiences of trauma and the intergenerational trauma caused by colonialism.

**Finding 4:** Prolonged periods of separate confinement in response to self-injury were experienced disproportionately by individual female, Indigenous and racialized youth. The decisions to separately confine these youth for prolonged periods were unjust because Indigenous youth, female youth and youth living with a mental illness are disproportionately exposed to the harms caused by separate confinement.

## Why separate confinement is producing disproportionate effects

We identified three interrelated factors that may contribute to the disproportionate impacts of separate confinement on female youth, Indigenous youth and youth with mental illness:

1. No legal requirement to consider a youth's mental health in separate confinement decisions

2. No legal requirement to consider the social history of Indigenous youth

3. A lack of alternatives to separate confinement

### *No legal requirement to consider a youth's mental health*

There is no legal requirement that staff consider a youth's mental health in deciding to place them in, or release them from, separate confinement. In other words, there is no legal requirement to conduct an individualized assessment of whether a youth's mental health needs are such that they should not be placed in separate confinement.

It has increasingly been recognized that those living with mental illness should not be isolated in the prison context. This is most clearly stated in the Mandela Rules, which prohibit the use of solitary confinement for prisoners with mental or physical disabilities "when their conditions would be exacerbated by such measures."[232] Moreover, the Mandela Rules state that health care personnel should be

[229] Alyssa Benedict, *Using Trauma-Informed Practices to Enhance Safety and Security in Women's Correctional Facilities*, National Resource Center on Justice Involved Women, 2014, 2, https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/NRCJIW-UsingTraumaInformedPractices.pdf.

[230] *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2018 BCSC 62, paras. 471 and 496; *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2019 BCCA 228, para. 210.

[231] *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2018 BCSC 62, paras. 470 and 496. On the basis of these disproportionate impacts, the court found that these inmates' s. 15 rights had been breached and could not be justified under s. 1; however, the Court of Appeal declined to make a declaration that the legislation was invalid on this basis. See *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2019 BCCA 228, para. 272.

[232] UN Office on Drugs and Crime, *Standard Minimum Rules for the Treatment of Prisoners*, Rule 45.2.

authorized to review and recommend changes to the "involuntary separation" of a prisoner to ensure that it does not worsen their mental disability.[233]

The *Manual of Operations – Youth Custody Programs* specifically requires the custody centre director and the provincial director of youth justice to consider the youth's health, including feedback from health care and mental health care staff, in deciding to place or maintain them in separate confinement.[234] The role of mental health staff in youth custody is advisory, meaning their opinion is to be considered by custody centre directors and the provincial director in making decisions about youth in custody, but they do not have a decision-making role.

While separately confined, youth were involved with mental health staff, including daily visits and involvement in planning and case management by mental health professionals, including psychiatrists, psychologists and psychiatric social workers. In most instances, it appeared that health professionals supported the use of separate confinement. In a small number of cases, mental health professionals identified and communicated the risks of separate confinement to operational staff.[235]

Despite this involvement of mental health professionals, youth were still separately confined for prolonged periods of time, during which they experienced chronic risks of self-injury and acute mental health crises, including multiple suicide attempts.

The operations manual requires the director and provincial director only to "consider" a youth's health in deciding whether to place or maintain or remove them from separate confinement. The reference to "consider" is significant, as it implies that the youth's health is only one consideration among others, and not necessarily the most important consideration. By structuring the exercise of discretion in this way, the operations manual allows for other considerations to be prioritized over the youth's health, so long as the youth's health forms part of the decision-making process. Even when the youth's mental health is considered in accordance with requirements set out in the operations manual, it does not protect against the risk of serious psychological harm caused by separate confinement.

### *No legal requirement to consider social history of Indigenous youth*

There is no requirement in the Regulation for custody staff to consider the social history of Indigenous youth and the systemic disadvantages that they face when making decisions about their care in custody, including decisions to place or maintain them in separate confinement. The *Youth Criminal Justice Act* requires that measures taken against young persons should "respond to the needs of aboriginal young persons,"[236] but this statement of principle is not reflected in the provincial legislation, nor has it been operationalized in relation to decisions about whether to separately confine youth.

In its *Gladue* decision, the Supreme Court of Canada affirmed the right of Indigenous people involved with the justice system to have their "unique systemic or background factors" considered in sentencing.[237] These experiences include the history and ongoing effects of colonialism, including racism and systemic discrimination, loss of language,

[233] UN Office on Drugs and Crime, *Standard Minimum Rules for the Treatment of Prisoners*, Rule 46.3.
[234] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.10.
[235] See detailed discussion of this point, on pages 55–57.
[236] *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 3(1)(c)(iv).
[237] *R. v. Gladue*, [1999] 1 SCR 688.

removal from land, residential schools and foster care.[238] An analysis of these factors must inform the judge's consideration of the appropriate sentence for an Indigenous offender.

In adult corrections, staff are required, by law, to apply considerations similar to the *Gladue* factors in correctional decision making for Indigenous people in custody. This includes decisions about placement in a structured intervention unit. Staff must consider systemic factors that contributed to Indigenous peoples' overrepresentation in the justice system, as well as the impact of those factors on the individual offender. Staff must also consider the Indigenous culture and identity of the offender.[239]

The application of a *Gladue* analysis will not, on its own, remedy the disproportionate effects of separate confinement. Rather, a *Gladue* analysis is an attempt to recognize – as the Supreme Court acknowledged – that the justice system as currently constituted does not respond to "the needs, experiences and perspectives of aboriginal people or aboriginal communities"[240] and alternative approaches must be taken. The factors outlined in *Gladue* are the bare minimum that custody centre staff should understand and consider when making decisions about Indigenous youth in custody. Considering social history and systemic racism should inform the development of an alternative model of care for Indigenous youth in custody, and particularly Indigenous female youth who have complex mental health needs. This is discussed in greater detail in section 5.6.

**Finding 5:** The *Youth Justice Act, Youth Custody Regulation* and *Manual of Operations – Youth Custody Programs* fail to address the actual needs and capacities of Indigenous youth and, in this way, perpetuate or exacerbate those youths' disadvantages.

**Recommendation 6:** By April 1, 2022, the Minister of Children and Family Development reconsider the *Youth Justice Act* by introducing legislation to amend the Act to require consideration of the social history of Indigenous youth for all decisions made about them while in custody.

**Recommendation 7:** By July 1, 2022, the Ministry of Children and Family Development develop a policy framework in consultation with the B.C. First Nations Justice Council to support implementation of the legislative changes described in Recommendation 6.

### *No alternatives to separate confinement*

Staff have limited alternatives for responding to the complex mental health needs of some youth in custody, including those who are self-injuring or suicidal, and youth who have experienced trauma.

[238] *R. v. Ipelee*, 2012 SCC 13, paras. 60 and 77.
[239] *Corrections and Conditional Release Act*, S.C. 1992, c. 20, s. 79.1.
[240] *R. v. Gladue,* [1999] 1 SCR 688, para. 73.

We found that separate confinement was viewed and understood by staff as the only appropriate response to keep these youth safe at a time of acute crisis. There were no readily available alternatives or supports for these youth. For example, there was no therapeutic or de-escalation space available; no culturally safe interventions, such as contact with an Elder; and limited therapeutic interventions.

We saw that staff did not address the underlying causes and functions of youths' self-injuring behaviour. Rather, staff intervention was focused solely on ensuring safety in light of the youth's immediate behaviour. Where separate confinement is used as the primary response to self-injuring and suicidal behaviour, it is harmful for the youth who experience it.[241] The failure to ensure access to reasonable and appropriate alternatives perpetuates these harms. We describe these alternatives in greater detail in the following sections.

As a starting point, however, the practice of separately confining certain youth with complex mental health needs must be prohibited. It is clear from a review of the facts found in our investigation, as well as a review of the relevant international principles and recent legislative reform in Canada, that there are some groups of people for whom a time limit on the use of separate confinement is simply not enough.

The United Nations Special Rapporteur on Torture has determined that isolation "of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment."[242] The *Mandela Rules* also state that solitary confinement of prisoners with mental disabilities should be prohibited when their conditions would be exacerbated by the practice.[243]

The Ontario Court of Appeal expressly acknowledged that "those with mental illness should not be placed in administrative segregation."[244]

Two Canadian jurisdictions have passed legislation to prohibit the practice of isolating vulnerable individuals in adult corrections. In 2018, the Ontario legislature passed the *Correctional Services and Reintegration Act*, which included a prohibition on the use of segregation for individuals who are pregnant or have recently given birth; are chronically self-harming or suicidal; have an intellectual disability; need medical observation; or have a mobility impairment.[245] In 2019, the Yukon legislature passed legislation amending the territorial *Corrections Act* to prohibit the use of segregation for the same vulnerable groups.[246] This legislation came into effect in 2020.

These legislative reforms promote substantive equality by creating legally binding limits that shield individuals who are particularly vulnerable to the harms caused by separate confinement in custody. To be effective, legislative reforms must be accompanied by policy that guides a fair and informed process for identifying individuals who are especially vulnerable to the harms caused by separate confinement.

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[241] See College of Family Physicians of Canada, Position Statement on Solitary Confinement; see also Royal College of Paediatrics and Child Health et al., *Joint Position Statement*; UN General Assembly, *Interim Report of the Special Rapporteur of the Human Rights Council*, 66th Session; Haney, "Mental Health Issues," 131.

[242] UN General Assembly, *Interim Report of the Special Rapporteur of the Human Rights Council*, 66th Session, para. 78.

[243] UN Office on Drugs and Crime, *Standard Minimum Rules for the Treatment of Prisoners*, December 17, 2015, Rule 45.

[244] *Canadian Civil Liberties Association v. Canada*, 2019 ONCA 243 at para. 66

[245] *Correctional Services and Reintegration Act*, 2018, S.O. 2018, c. 6, Sched. 2 S.65(3). Passed by the legislature but not yet proclaimed into force.

[246] *Yukon Corrections Act*, S.Y. 2009, c. 3; amended by S.Y. 2013, c. 12; S.Y. 2016, c. 5; S.Y. 2019, c. 10 s. 19.01.

**Finding 6:** Youth were separately confined in response to self-injuring and suicidal behaviour because there were no reasonable alternatives for responding to their needs. Because it perpetuates existing trauma and causes further harm, this use of separate confinement was oppressive.

**Recommendation 8:** By April 1, 2022, the Minister of Children and Family Development propose to the Lieutenant Governor in Council that the *Youth Custody Regulation* be amended to prohibit the use of separate confinement of youth who are especially vulnerable to the harms of separate confinement, including those under the age of 16 years and those with complex mental health needs.

**Recommendation 9:** By April 1, 2022, the ministry develop and implement a policy framework to assess and identify youth who should not be separately confined because they are especially vulnerable to the harms of separate confinement.

## 5.6 The need for an alternative model of care

Using separate confinement in response to self-injuring and suicidal behaviour is harmful to youth in custody and creates an unsafe and stressful working environment for staff. It is inconsistent with the *Youth Criminal Justice Act*'s focus on rehabilitation and the need to address the root causes of youth crime.

Amending the law to impose strict limits on the amount of time that a youth spends in separate confinement, and to prohibit the separate confinement of youth with complex mental health needs, is one way to reduce the prolonged separate confinement of youth. But these legal changes must be accompanied by a fundamental shift in the way that the youth custody system in B.C. responds to youth with complex mental health needs, including youth who are self-injuring or suicidal and youth who have experienced trauma. In other words, the ministry should establish meaningful alternatives to separate confinement so that when youth are in crisis, those alternatives exist and are implemented.

We identified three key ways in which the ministry can create reasonable and meaningful alternatives. First, the ministry should strengthen and fully implement its commitment to trauma-informed practice, particularly in relation to youth with complex needs. Second, the ministry must strengthen culturally safe services for Indigenous youth in custody and ensure that youth can access those services both as a preventive measure and when they are in crisis. Third, the ministry should ensure that youth with complex mental health needs are provided with appropriate treatment in a therapeutic environment where the underlying causes of their behaviour can begin to be addressed. As we will describe, youth with complex mental health needs should be transferred to a facility that is properly equipped to meet those needs in a trauma-informed, therapeutic and culturally safe way. All of these actions are interrelated; together, they represent necessary measures to treat youth in custody safely, fairly and humanely.

### Strengthened trauma-informed practices

In 2017, the Ministry of Children and Family Development released a trauma-informed practice guide for working with children, youth and families. The guide is intended to identify trauma-informed approaches to supporting children, youth and families and to raise awareness and capacity among those delivering services, in order to better serve children, youth and families impacted by trauma and to improve outcomes.[247] As the guide states:

[247] MCFD, *Healing Families, Helping Systems*, 2.

> Trauma-informed approaches to serving children, youth and families recognize how common the experiences of trauma are, and the wide range of effects trauma can have on both short-term and long-term health and well-being. Trauma-informed approaches involve a paradigm shift to support changes in everyday practices and policies to factor in the centrality of trauma for many children, youth, and families, and our growing understanding of how to promote resilience. The overall goal of trauma-informed approaches is to develop programs, services, and environments that do not re-traumatize while also promoting coping skills and resilience.[248]

These guidelines are intended to be applied to youth custody settings.[249] In addition, the ministry's strategic plan for youth custody services states that "incorporating trauma informed practices into all aspects of our organization has been our highest priority over the last few years."[250] Having a "trauma-informed and culturally responsive" organizational culture is one of youth custody services' strategic goals.[251]

Similarly, the *Manual of Operations – Youth Custody Programs* recognizes that "ensuring trauma-informed practices are integrated throughout our organization is key to improving outcomes for youth."[252] The operations manual further states:

> Delivering all custody services from a trauma-informed perspective will reduce the incidents of crisis and violence, and create an environment where youth feel emotionally and physically safe.… Providing services in a trauma-informed manner will promote long term positive outcomes for youth by encouraging respectful interactions and assisting youth to maintain healthy relationships, develop healthy coping strategies and manage their own behaviour and emotions.[253]

Implementing trauma-informed practices can improve the safety and health of youth in custody by offering them the opportunity to "experience safety, trust, choice, collaboration and empowerment."[254] Moreover, implementing trauma-informed practices benefits the staff of custody centres as well as youth, as the ministry has acknowledged.[255] Vicarious trauma is not uncommon among people who care for self-injuring youth.[256] Those at risk of vicarious trauma include staff in custody centres who are repeatedly required to respond to serious incidents of attempted suicide or self-injury by youth under their supervision.[257]

However, by separately confining youth for prolonged periods the ministry is failing to live up to its stated commitment to adopt trauma-informed practices. Separate confinement, and particularly its prolonged and repeated use, is inherently inconsistent with trauma-informed practices because of the high likelihood that it will cause harm and because of the high-conflict, unsafe environment that it creates.

The aspirational statements in the strategic plan and the operations manual were not reflected in the lived reality of the youth

[248] MCFD, *Healing Families, Helping Systems*, 2.
[249] MCFD, *Healing Families, Helping Systems*, 31.
[250] MCFD, Youth Custody Services, *Strategic Plan 2017/18–2019/20*, 3.
[251] MCFD, Youth Custody Services, *Strategic Plan 2017/18–2019/20*, 11.
[252] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, B.1.06.
[253] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.3.01.
[254] Benedict, *Using Trauma-Informed Practices*, 3.
[255] MCFD, Youth Custody Services, *Strategic Plan 2017/18–2019/20*, 4.
[256] RCY, *A Way to Cope*, 19.
[257] Benedict, *Using Trauma-Informed Practices*, 11.

who were separately confined at Burnaby Youth Custody Services Centre. Separate confinement, particularly in the conditions we described in section 4.3, has significant, negative impacts on youths' well-being. Thus, while the centres have implemented trauma-informed principles in some aspects of their operations,[258] we did not see trauma-informed practices reflected in everyday responses to youth with complex mental health needs at BYCS. The ministry's high-level commitments to trauma-informed practices – in strategic planning and in policy – have not translated into meaningful changes for youth who are separately confined.

The guidelines acknowledge that fully implementing trauma-informed practices requires a "paradigm shift" in an organization's culture and service delivery.[259] In our view, youth custody services has not yet made that shift.

To eliminate its reliance on separate confinement as a behaviour management tool, the ministry must take meaningful steps to more fully integrate trauma-informed practices into the youth custody centres' institutional structures, organizational culture and everyday interactions with youth in custody. Properly implemented, a trauma-informed approach should benefit youth and staff by promoting resilience and non-harmful coping behaviours, and reducing the perceived need for separate confinement.

The ministry should also establish tangible measures of accountability for its implementation of trauma-informed practices. In other words, it should bridge the gap between its vision as a "leader in the delivery of…trauma informed practice"[260] and the lived experiences of youth in custody who are separately confined. As we discuss below, practice changes that we see as being most effective include:

- changing the physical space to make it safer and more welcoming
- hiring staff with specific training and expertise in working with youth with complex mental health challenges
- supporting youth in maintaining access to meaningful social contacts, programming, and religious and cultural supports
- improving access to culturally safe mental health services

The changes to the legal framework that we have recommended will provide the framework within which the necessary practice changes must occur. For example, a requirement to understand and consider an Indigenous youth's social history will inform the implementation of programming and other measures in a way that is culturally safe for that youth.

### *A safe physical space*

One essential component of a trauma-informed approach is to modify the physical space to remove elements that may compromise the safety of incarcerated individuals.[261] As we found in our investigation, the separate confinement unit at BYCS is not a safe physical space for youth: some were able to find items within the space to self-injure. Moreover, the security-focused design of the space does not promote calmness or psychological regulation.[262]

Research on the use of seclusion rooms in psychiatric facilities emphasizes the importance of spaces that allow a person to maintain "at least a minimal degree of privacy, autonomy and engagement, while ensuring

[258] MCFD, *Healing Families, Helping Systems*, 31.
[259] MCFD, *Healing Families, Helping Systems*, 2.
[260] Ministry of Children and Family Development, Youth Custody Services, *2018/19 Annual Report*, 3.
[261] Benedict, *Using Trauma-Informed Practices*, 12.
[262] The importance of a trauma-informed physical space is described in Benedict, *Using Trauma-Informed Practices*, 12.

their safety" and suggests a "welcoming and home-like" space as beneficial.[263] Similarly, the physical space of a custody centre can impact the psychological state of youth, and because of this, a home-like and therapeutic environment should be created.[264] This should include culturally appropriate spaces for Indigenous youth to meet with Elders and to connect with their culture.[265] Access to natural light, and welcoming outdoor spaces, are also key to transforming the physical environment.

If this space continues to be used for short-term isolation of youth, it must be modified so that it is safe.

## Culturally safe services for Indigenous youth

Female Indigenous youth were disproportionately separately confined for prolonged periods for self-injuring behaviour. We found that these youth did not access cultural supports while they were separately confined, further isolating them from any cultural connections that could act as protective factors for their social and emotional well-being.[266]

To better serve Indigenous youth, the ministry's strengthened commitment to trauma-informed practices should be complemented by services that seek to provide a culturally safe therapeutic environment. In the health care field, where the term originated, the concept of cultural safety has been defined as "an approach that considers how social and historical contexts, as well as structural and interpersonal power imbalances, shape health and health care experiences," where "practitioners are self-reflective/self-aware with regards to their position of power and the impact of this role in relation to patients" and "'safety' is defined by those who receive the service, not those who provide it."[267]

For Indigenous youth in custody, culturally safe services could be characterized by access to traditional ways of healing, contact with Elders, and other culturally relevant supports.[268] Because of the intergenerational impacts of colonialism, youth in custody may have varying levels of knowledge of their history, culture and community.[269] These services are best viewed not as a "one-off" but instead as part of a "holistic model" that supports Indigenous youths' well-being as well as their rights to be connected with their community and culture.[270]

While the operations manual acknowledges "the unique position of Indigenous youth, the role of the family, the role of extended families, and the distinctive values, traditions and processes of Indigenous communities

[263] Ministry of Health, *Secure Rooms and Seclusion Standards and Guidelines*, 38. The same report describes a consensus among researchers that "seclusion poses a high degree of risk to patients and staff, and most researchers agree that it is of no proven therapeutic value. When physical intervention is unavoidable, it should be delivered according to clear standards of practice, documented, and reported appropriately" (7).

[264] Victorian Equal Opportunity and Human Rights Commission, *Aboriginal Cultural Rights in Youth Justice Centres*, July 2018, 14, https://ccyp.vic.gov.au/assets/resources/Aboriginal-Cultural-Rights/Aboriginal-cultural-rights-in-youth-justice-centres-WEB-180718.pdf.

[265] Victorian Equal Opportunity and Human Rights Commission, *Aboriginal Cultural Rights*, 9.

[266] Research from Australia has found that "strong cultural identity and connection to culture, country [land] and community is a protective factor for the social and emotional wellbeing of Koori young people." See Victorian Equal Opportunity and Human Rights Commission, *Aboriginal Cultural Rights*, 4.

[267] Cheryl Ward et al., "What Is Indigenous Cultural Safety – and Why Should I Care About It?" *Visions Journal* 11, no. 4 (2016): 29, https://www.heretohelp.bc.ca/visions/indigenous-people-vol11/what-indigenous-cultural-safety-and-why-should-i-care-about-it.

[268] Klinic Community Health Centre, *Trauma-Informed: The Trauma Toolkit*, 2nd ed., 51, https://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf.

[269] Victorian Equal Opportunity and Human Rights Commission, *Aboriginal Cultural Rights*, 7.

[270] Victorian Equal Opportunity and Human Rights Commission, *Aboriginal Cultural Rights*, 9.

for resolving harm" and "the obligation to consult with Indigenous communities and invite Indigenous community participation in making services more relevant and responsive to Indigenous youth,"[271] we did not see these policy acknowledgments made meaningful in the day-to-day experiences of Indigenous youth who were separately confined. As we have described in sections 4.3 and 5.5, Indigenous youth did not access cultural support or services during separate confinement and there is no requirement for staff to consider Indigenous youths' social history in decision making in custody.

There are organizations in B.C. that currently provide culturally safe programs in the community for Indigenous youth involved with the criminal justice system. These programs include the opportunity for youth to engage in ceremonies, traditional teachings, and activities on the land and water while being connected with various supports such as counseling, advocacy and case management. The ministry should consult with Indigenous-led organizations on ways for these programs to be adapted to support Indigenous youth in custody.

Implementing culturally safe services with the goal of reducing the use of measures such as separate confinement would be consistent with commitments that the ministry has already made to improve program and service delivery and to promote positive outcomes for Indigenous children and youth.[272]

## Access to mental health care and treatment

We found that separate confinement is used to manage and respond to symptoms of mental illness, such as self-injury and suicidal behaviour. As we have described, this is contrary to the international consensus. We have recommended prohibiting the practice of separately confining youth with complex mental health needs. However, this change will only be successful if it is supported by a commitment to providing youth in custody with necessary mental health care and treatments. The ministry has recognized the importance of a sustained commitment to supporting youth with complex mental health needs, writing the following in its most recent strategic plan:

> The number of youth with mental health concerns presenting to Youth Custody Services has been dramatically rising in recent years. A responsive, integrated and comprehensive continuum of well-resourced services that are appropriate to the developmental needs of young people is essential to ensure that we are providing the most effective interventions.[273]

In support of this goal, the ministry aimed to develop a mental health strategy in youth custody services by June 30, 2018. However, it fell short, writing in its 2018/19 annual report that the only concrete step taken to improve mental health services was to hire a social worker with addictions and mental health experience at Prince George Youth Custody Services Centre.[274]

It became clear in our investigation that Burnaby Youth Custody Services Centre is not equipped to respond to these youths' complex mental health needs without separately confining them. In a small number of cases, we observed youth transferred to psychiatric

[271] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, B.1.08, 4.
[272] Recognition and Reconciliation Protocol on First Nations Children, Youth and Families between the Province of British Columbia as represented by the Ministry of Children and Family Development and the First Nations Leadership Council, March 30, 2009.
[273] MCFD, Youth Custody Services, *Strategic Plan 2017/18–2019/20*, 16.
[274] MCFD, Youth Custody Services, *2018/19 Annual Report*, 9. The report also noted that BYCS had hired a child-care worker; however, that person had moved to another position.

facilities at times of acute crisis. In each of these cases, the youth were certified under the *Mental Health Act* for the duration of their stay at the psychiatric facility, most of which were for short periods of time. In most of these cases, youth were housed in the Inpatient Assessment Unit at the Youth Forensic Psychiatric Services (YFPS) site, located adjacent to BYCS.

While the focus of our investigation was not to assess the effectiveness of these treatment periods, it became apparent after reviewing the records, visiting the site and speaking with YFPS staff that the current Inpatient Assessment Unit facility is not adequately equipped to care for youth with complex needs for any extended period of time. For example, the individual Inpatient Assessment Unit rooms are very small and do not include toilets, sinks or showers. As a result, some youth were physically restrained and escorted by multiple BYCS staff each time they had to use the bathroom. We also observed that the Inpatient Assessment Unit rooms were – like the Independent Observation Unit – vulnerable to damage by youth and on at least one occasion became a source of self-injuring material. There is minimal access to secure outdoor space. Similarly, there is minimal common indoor space to facilitate schooling or any other programming.

Of the small number of these cases we observed, we found that most youth were secluded under physician orders for the majority of the time they were housed at the Inpatient Assessment Unit. In most of these instances, seclusion was identified in the youth's care plan with an associated goal of stabilizing the youth in crisis. However, in some cases the social isolation and lack of stimulation caused by seclusion contributed to a further deterioration of the youth's mental health.

In one unique case, a youth was transferred to the Maples[275] after a very long period of separate confinement at BYCS and seclusion at YFPS. Their time at BYCS and YFPS was marked by increasingly risky and violent self-injuring behaviour. In contrast, after arriving at the Maples they appeared to quickly stabilize, responding positively to the model of care practised by the Maples staff – a model of care that did not include seclusion or further isolation.

It is also important to note that the Ministry of Mental Health and Addictions strategy for improving mental health and addictions care in B.C. places a significant emphasis on better mental health care for children and youth and Indigenous communities.[276] The strategy emphasizes the need to address gaps in equitable access to trauma-informed and culturally safe care for young people and to provide seamless and integrated care.[277] These principles apply equally to youth who, because of their involvement in the youth justice system, end up in custody.

The ministry should build on existing resources to create a secure and therapeutic facility with appropriately trained staff who can provide trauma-informed behavioural interventions, counselling, psychological assessment, Indigenous-specific care and recreational activity that incorporates frequent, sustained opportunities for meaningful social contact. In this respect, we note that through the Maples Adolescent Treatment Centre, the ministry has developed various programs to support youth with complex mental health needs, including providing what it describes as culturally safe

[275] See section 2.6 for a description of the Maples.

[276] Ministry of Mental Health and Addictions, *A Pathway to Hope: A Roadmap for Making Mental Health and Addictions Care Better for People in British Columbia*, 2019, 3, https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/initiatives-plans-strategies/mental-health-and-addictions-strategy/bcmentalhealthroadmap_2019web-5.pdf.

[277] Ministry of Mental Health and Addictions, *A Pathway to Hope*, 7 and 24.

services for Indigenous youth.[278] This last point – ensuring that mental health services are culturally safe – should be a priority.[279]

Such services would also be consistent with the conclusions of the National Inquiry on Missing and Murdered Indigenous Women and Girls, which has called on correctional services across Canada to

> provide intensive and comprehensive mental health, addictions, and trauma services for incarcerated Indigenous women, girls, and 2SLGBTQQIA people, ensuring that the term of care is needs-based and not tied to the duration of incarceration. These plans and services must follow the individuals as they reintegrate into the community.[280]

As such, the services provided while youth are in custody would be integrated with a plan of care that seeks to meet the identified needs of Indigenous youth, both in custody and once they return to the community.

We have therefore recommended that the ministry develop and implement a trauma-informed, culturally safe way of responding to youth with complex mental health needs – including self-injuring and suicidal youth – without separately confining them. We expect that in implementing this recommendation, the ministry will:

- draw on best practices within B.C. and in other jurisdictions in providing appropriate care to youth in custody who are living with serious mental illness
- integrate this work with the Ministry of Mental Health and Addictions strategy on mental health, to ensure a continuum of mental health care for youth who end up in custody
- engage in consultations with Indigenous leadership – and with Indigenous youth – on the best ways to implement culturally safe practices in youth custody
- secure any additional funding necessary to implement appropriate mental health services for youth in custody

In our view, these practice changes must be accompanied by the regulatory changes we recommended (Recommendation 4 and Recommendation 8) that prohibit the use of separate confinement as an intervention for youth with mental illness likely to be exacerbated by separate confinement. It will be essential that these changes do not simply result in separate confinement by another name.[281] Further, the transfer of youth with complex mental health needs to a secure facility that can respond to their needs appropriately – whether the Maples or elsewhere – must be mandated in the *Youth Justice Act*. [282]

Ultimately, it is the strengthening of trauma-informed practice, the implementation of culturally safe services, and better access to appropriate mental health treatment that will, in our view, give real meaning to the

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[278] Ministry of Children and Family Development, *The Maples Adolescent Treatment Centre and Complex Care Unit in Coquitlam, B.C.*, https://www2.gov.bc.ca/assets/gov/health/managing-your-health/mental-health-substance-use/child-teen-mental-health/maples_treatment_centre.pdf.

[279] See Victorian Equal Opportunity and Human Rights Commission, *Aboriginal Cultural Rights*, 9.

[280] National Inquiry into Missing and Murdered Indigenous Women and Girls, *Reclaiming Power and Place*, "Call for Justice," 14.6.

[281] The federal government's recent amendments to the *Corrections and Conditional Release Act*, which replaced administrative segregation with "structured intervention units," have been criticized on this basis; see, for example, Senator Kim Pate, "Solitary by Another Name Is Just as Cruel," November 16, 2018, https://sencanada.ca/en/sencaplus/opinion/solitary-by-another-name-is-just-as-cruel-senator-pate/.

[280] Similarly, the need for a mechanism to transfer self-injuring adult prisoners to appropriate psychiatric facilities was discussed in Prisoners' Legal Services, *Damage/Control: Use of Force and the Cycle of Violence and Trauma in BC's Federal and Provincial Prisons*, June 2019, 51, https://prisonjustice.org/wp-content/uploads/2019/06/use-of-force-report-online-1.pdf.

*Youth Criminal Justice Act* requirement that youth custody be "safe, fair and humane."[283]

**Recommendation 10:** By July 1, 2022, Youth Justice Services develop and implement culturally safe, trauma-informed supportive alternatives to separate confinement for youth that include:

a) staff with training and expertise in mental health, trauma-informed practices and youth development

b) structured activities and access to programming, school and skills training

c) meaningful social contact

d) access to counselling and behaviour therapy and other mental health services, and

e) cultural, religious and spiritual support.

**Recommendation 11:** By July 1, 2024, the Ministry of Children and Family Development complete an independent review by an expert in trauma-informed practices of the changes made in response to Recommendation 10, and implement any resulting recommendations by September 1, 2024.

**Recommendation 12:** By October 1, 2021, the Ministry of Children and Family Development complete an independent review of the Independent Observation Unit that applies trauma-informed principles in recommending physical changes to the unit to ensure that it is safe and allow it to support the delivery of trauma-informed and culturally safe services. The ministry is to implement the resulting recommendations by March 31, 2022.

**Recommendation 13:** By July 1, 2021, the Minister of Children and Family Development propose to the Lieutenant Governor in Council to designate as a place of secure custody for the purpose of the *Youth Criminal Justice Act* and the *Young Offenders Act* one or more secure youth psychiatric facilities that are equipped to provide trauma-informed, culturally safe treatment for youth with complex mental health needs.

**Recommendation 14:** By April 1, 2022, the Minister of Children and Family Development reconsider the *Youth Justice Act* by introducing amendments to the Act to require that youth in custody with complex mental health needs be transferred to a designated youth psychiatric facility.

**Recommendation 15:** At the same time as the amendments in Recommendation 14 come into force, the Ministry of Children and Family Development implement a policy and procedures for ensuring that youth with complex mental health needs are identified on admission and transferred to a designated facility.

[283] *Youth Criminal Justice Act*, S.C. 2003, c. 1, s. 83(1).

# 6. SEPARATE CONFINEMENT OF YOUTH SUSPECTED OF CONCEALING CONTRABAND

The *Youth Custody Regulation* sets out three grounds for separate confinement that are relied on when youth are intoxicated, are experiencing drug withdrawal symptoms and/or are suspected of concealing drugs. Under the Regulation, a youth can be separately confined if the director of a youth custody centre believes "on reasonable grounds" that the youth:

- has taken an intoxicant into [their] body
- has contraband hidden on or in [their] body
- must be separately confined for a medical reason

The *Youth Justice Act* defines "contraband" to include an intoxicant.[284] In our investigation we observed youth separately confined because they were intoxicated, were experiencing drug withdrawal symptoms or were suspected to be concealing contraband. Staff at the custody centre are understandably vigilant about the risk of drugs being smuggled into the centre and distributed. This concern is heightened by the significant increase in illicit-drug-related overdoses and deaths in B.C. in recent years.[285] In conducting our investigation, we noted a specific concern among centre staff about the risk of youth concealing drugs inside their body on admission.

From January 1, 2017, to December 31, 2019, 32 youth at BYCS and PGYCS were separately confined a total of 50 times because they were either experiencing drug withdrawal symptoms or were suspected of concealing contraband. Separate confinement related to drugs represents 22 percent (2,896 hours) of the total time youth spent separately confined during our investigation, second only to separate confinement due to self-injuring or suicidal behaviour (discussed in section 4.2).

Of the 50 instances of separate confinement related to drugs, 16 lasted between 22 and 72 hours, and 9 instances continued for 72 hours or longer. As set out in Figure 21 above, seven youth were confined in relation to drugs for more than 100 hours, with the longest three periods of isolation lasting 223 hours (9 days), 424 hours (17 days) and 636 hours (26 days).

Male youth, and non-Indigenous male youth in particular, were separately confined for these reasons more than any other youth.[286]

In many of the cases we reviewed, staff separately confined youth because they suspected that the youth was concealing drugs inside their body but were unable to confirm this because of limits on searching.

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[284] *Youth Justice Act*, S.B.C. 2003, c. 85, s. 1.

[285] In April 2016, the B.C. Provincial Health Officer declared a public health emergency in response to an increase in illicit-drug-related overdose deaths. Ministry of Health, "Provincial Health Officer Declares Public Health Emergency," news release, April 14, 2016, https://news.gov.bc.ca/releases/2016HLTH0026-000568.

[286] Male youth represented 35 (70%) of the 50 instances of separate confinement on these grounds, with non-Indigenous males accounting for 19 (38%) of these instances.

For example, we reviewed the files related to a male youth who was separately confined on admission to BYCS, and remained in separate confinement for the duration of his time in custody. This amounted to 636 consecutive hours, or just over 26 days, in separate confinement. Relying on several sources of information, staff suspected that on admission he was intoxicated and had illicit street drugs concealed on his person. The youth maintained that he was not in possession of drugs. Unable to determine conclusively, staff decided to separately confine him because of suspicion and risk of concealed drugs.

Over the following 26 days, staff strip searched the youth and conducted random room and unit searches but did not find any drugs or other contraband. The records indicate that the youth provided conflicting information to staff about whether he was in possession of drugs, at one point surrendering a small amount, but at all other times vigorously maintaining that he did not have any.

Without a more objective and conclusive way of determining whether the youth was in possession of drugs, staff managed the risk by separately confining the youth for the duration of his time in custody. He was released into the community directly from separate confinement.

As this example demonstrates, in cases where a search for drugs or other contraband is inconclusive, youth suspected of concealing contraband can remain in separate confinement for significant lengths of time.

The only tool staff currently have to assist in making a determination about suspected contraband is conducting a search. Staff at a custody centre can conduct various searches in accordance with the *Youth Custody Regulation* to attempt to determine whether a youth is in possession of contraband.[287] These include frisk searches, screening searches and strip searches.[288] They involve varying degrees of intrusiveness. A "frisk search" is a search of a clothed person and any personal possessions conducted by hand or by hand-held screening device.[289] A "screening search" means a search by an authorized person of a clothed person that is conducted visually or with the use of a screening device, including a drug detection dog, ion spectrometry device, carbon dioxide detector, walk-through or hand-held metal detector or other screening device that is approved by the person in charge. Currently, the youth custody centres have access to walk-through and hand-held metal detectors as well as a drug detection dog.

The Regulation defines a "strip search" as a visual inspection by an authorized person of a nude person that includes a visual inspection of the youth undressing completely; the youth's open mouth, hands or arms; the soles of the feet and the insides of the ears of the youth; and the youth running their fingers through their hair.[290] We observed that strip searches were conducted regularly in cases where youth were suspected of being in possession of contraband. Strip searches in the prison context have been criticized on the basis that they can cause psychological harm, especially to incarcerated people who have histories of trauma.[291]

[287] An "authorized person" means the custody centre director and staff members designated to perform searches – youth supervisors and senior youth supervisors. See *Youth Justice Act*, S.B.C. 2003, c. 85, s. 1; see also *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 16 and 17.
[288] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 16–18.
[289] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 16.
[290] *Youth Justice Act*, S.B.C. 2003, c. 85, s. 32.1(5) and *Youth Custody Regulation,* B.C. Reg. 137/2005, s. 17(4).
[291] West Coast Prison Justice Society, *Damage/Control: Use of Force and the Cycle of Violence and Trauma in BC's Federal and Provincial Prisons*, June 2019, 10–11, https://prisonjustice.org/wp-content/uploads/2019/06/use-of-force-report-online-1.pdf.

Frisk, screening and strip searches are distinct from internal searches, which are defined in the policy as "invasive searches of body areas." The policy states unequivocally that "youth custody staff do not conduct internal searches." If a situation gives rise to a request for an internal search, staff must consult with the provincial director of youth justice.[292] We did not see any internal searches conducted in the cases we reviewed.

In many of the cases we reviewed, staff separately confined youth because while they suspected that the youth was concealing drugs inside their body, they were unable to objectively determine this. Separate confinement was used to enable staff to closely monitor the youth's well-being and prevent the possible distribution of drugs within the centre if the youth was concealing contraband. We found that some youth were separately confined for prolonged, indefinite periods as a result. Indeed, in the longest instance of separate confinement due to suspicion of contraband, separate confinement only ended when the youth was released from custody into the community.

## 6.1 Analysis: Prolonged separate confinement of youth suspected of concealing contraband

Since April 2016, B.C. has been in a public health state of emergency due to a significant rise in opioid-related overdose deaths.[293] In these circumstances, it is reasonable for staff to be particularly vigilant in relation to the potential use and distribution of drugs within a custody centre. However, prolonged separate confinement of youth is not, in our view, an appropriate means of addressing this concern, given the serious risk of psychological harm of separate confinement.

Moreover, compelling a non-consenting youth to submit to an internal search, or a strip search, in order to end such a "stalemate" situation subjects them to a disproportionate risk of harm when less traumatic and invasive means for controlling for the possibility of concealed contraband exist, such as a body scan. Body scanners are devices that allow for a non-invasive search of a person to determine whether a youth has concealed contraband on their person. Body scanners are currently in use at adult correctional centres in B.C.[294] Staff require specialized training to use body scanners correctly. The appropriate use of body scanners could avoid the separate confinement of youth for reasons of concealing contraband, including for prolonged periods.

As we were finalizing this report, we learned that the ministry had received funding approval to install a body scanner at BYCS. This is a positive step that we hope will lead to a decrease in the use of separate confinement for these reasons. However, it will be essential for BYCS to develop clear policies and procedures and staff training on the use of the body scanner and to track and evaluate whether it reduces the use of separate confinement because of suspected contraband.

**Finding 7:** The prolonged separate confinement of youth suspected of concealing contraband is unreasonable, considering the known harms of prolonged separate confinement and the availability of alternative non-invasive technologies that can assist in determining whether a youth is concealing contraband.

[292] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, E.5.07.
[293] Ministry of Health, "Provincial Health Officer Declares Public Health Emergency."
[294] Ministry of Public Safety and Solicitor General, Corrections Branch, Adult Custody Policy, updated July 2020, 1.19.

**Recommendation 16:** By the date on which the body scanner is operational, the Ministry of Children and Family Development:

a) establish a policy on when and how to use the body scanner, including a requirement for staff to document each use of the body scanner to detect suspected contraband, and develop and implement a standard form for this purpose, and

b) ensure that staff are appropriately trained in the use of the body scanner and interpretation of results.

**Recommendation 17:** One year after the body scanner begins operating, the Ministry of Children and Family Development provide our office with a report that assesses whether the body scanner has reduced the use of separate confinement for suspected contraband at Burnaby Youth Custody Services Centre and, if not, what additional steps will be implemented to reduce the use of separate confinement because of suspected contraband.

# 7. REVIEW AND OVERSIGHT OF INDIVIDUAL SEPARATE CONFINEMENT DECISIONS

When they are separately confined, youth in custody are placed "very far out of the sight of justice." Protecting their rights in such circumstances is challenging but also extraordinarily important.[295] Responsive and fair oversight mechanisms are critical to ensuring that if youth are separately confined, the confinement is "safe, fair and humane"[296] and used as minimally as possible.

Under the current legislative framework, the first level of oversight is provided by the individuals who are responsible for assessing whether separate confinement is necessary in the circumstances. This oversight is carried out by decision makers within the youth custody centres and by the provincial director of youth justice.

A senior youth supervisor is delegated the authority to separately confine a youth for up to 8 consecutive hours.[297] A further period of separate confinement for between 8 and 48 hours can be authorized in writing by a custody centre director. The provincial director of youth justice must authorize, in writing, any separate confinement beyond 48 hours, and each additional consecutive period of up to 72 hours. In addition, a senior youth supervisor must review a youth's placement in separate confinement every 4 hours, at minimum, and determine whether separate confinement should continue. Taken together, these reviews are intended to provide a measure of oversight to ensure that separate confinement is not authorized for longer than necessary to address the circumstances that require the youth's isolation.[298]

We focused our investigation on the initial authorization for separate confinement and the reauthorization decisions by the provincial director. It became clear in our investigation that this process was not effective in ensuring the appropriate use of separate confinement for periods that are no longer than necessary. Instead, as we will describe in this part of the report, decisions to separately confine youth – even for long periods of time – are routine

[295] "The Istanbul Statement on the Use and Effects of Solitary Confinement," December 9, 2007, https://studiesonsolitary.files.wordpress.com/2016/10/istanbul_expert_statement_on_sc.pdf. Statement adopted by a working group of 24 international experts at the International Psychological Trauma Symposium, Istanbul.

[296] *Youth Criminal Justice Act*, S.C. 2003, s. 83(1).

[297] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1(2), and Ministry of Children and Family Development, Office of the Provincial Director of Youth Justice, *Manual of Operations – Youth Custody Programs*, 2018, D.7.03.

[298] *Youth Custody Regulation,* B.C. Reg. 137/2005, s. 15.1(4). The reason for separate confinement can change while a youth is in separate confinement. For example, if a youth is isolated for medical reasons, but then starts self-injuring, that behaviour can be used as a ground to justify continued separate confinement, even if the medical issue resolves.

rather than "unusual and extreme."[299] In the following sections, we describe our findings with respect to the separate confinement authorization process.

## 7.1 Some separate confinement decisions were not authorized

Effective oversight of separate confinement in B.C.'s youth custody centres depends on transparent decision making. The Ministry of Children and Family Development's obligation to document separate confinement decisions is intended to make these decisions transparent and reviewable. When separate confinement is not sufficiently documented, the decision-making process is not subject to meaningful oversight, and the experiences of youth who are separately confined are further hidden from view.

In reviewing the records, we observed that in some circumstances, youth were isolated from other youth without that isolation being recognized or documented as separate confinement. In these cases, staff did not apply the *Youth Custody Regulation* requirement that they document and seek regular reauthorization of the youth's isolation. We saw this unauthorized separate confinement manifested in two different ways. Sometimes, youth were separately confined in accordance with a policy that applies to youth who are "temporarily housed alone." In other examples we reviewed, youth at Burnaby Youth Custody Services Centre were isolated from other youth without any of the required authorizations or documentation – they were simply moved to the Independent Observation Unit until leadership at the centre decided they could return to a regular living unit. The following sections describe these investigative findings in greater detail.

### Youth "temporarily housed alone"

The "temporarily housed alone" policy, created in April 2017, purports to create an exception to the separate confinement requirements as set out in the *Youth Custody Regulation*.[300]

The policy applies to situations in which "exceptional circumstances" dictate that a youth live alone but the grounds for the separate confinement of youth provided in section 15.1 of the *Youth Custody Regulation* have not been met.[301]

The *Manual of Operations – Youth Custody Programs* describes these exceptional circumstances as including, but not limited to, the following:

- a youth is being held in a temporary holding facility (e.g., the interim holding unit in Victoria, or female youth in Prince George)
- all other youth on the living unit are in court, are on reintegration leave, or are temporarily away from the unit for periods of time longer than two hours; or
- the youth is serving a custodial sentence, and the level of custody imposed by the court results in the youth being the only sentenced youth on a particular living unit[302]

In such circumstances, the youth may be housed separately from any other youth in the centre, and staff are not required to submit an incident report or separate confinement paperwork. Instead, staff must review these situations on a case-by-case basis.[303]

The "temporarily housed alone" policy acknowledges that youth may be negatively

[299] The youth custody operations manual suggests that youth should only be confined for more than 72 hours in the most "unusual and extreme" circumstances. MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.03.
[300] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.5.
[301] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.5.01.
[302] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.5.01.
[303] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.5.03.

affected, psychologically and emotionally, when they are separated from other youth.[304] To counter these potential impacts, staff are expected to provide support and supervision to youth as though they were in regular living arrangements with other youth. Staff must also consider alternative housing arrangements, such as transferring youth to another unit or centre, before deciding to house the youth alone.[305]

When no alternative housing arrangements are available or reasonable in the circumstances, the senior youth supervisor must advise a custody centre director as soon as practicable of their intent to use the policy. The custody centre director must then confirm that all other options have been exhausted or are not reasonable in the circumstances. The custody centre director must also ensure that this decision and the reasons for it are clearly documented in the youth's detailed client log (CORNET).[306]

In our investigation we examined how often and how long youth were housed alone under the policy. We also examined how these decisions were documented.

Based on our review of the information provided by the ministry, we found that staff relied on the policy to house youth alone at BYCS, Prince George Youth Custody Services Centre and at the Interim Holding Unit in Victoria. In Victoria, the policy was primarily used when only one youth was at the facility. For example, in 2017, the ministry relied on this policy 22 times when housing youth alone at the Victoria facility. While two of these instances lasted more than 24 hours, most were for less than 14 hours.

The policy was applied at BYCS to house female youth. The ministry explained that these youth were housed alone because they were the sole female youth at the facility. The ministry reported that it relied on this policy six times to house youth alone at BYCS. Of these, the shortest period was 18 hours and the longest was 154 hours.

The policy was also applied at PGYCS to temporarily house female youth who were in custody awaiting a transfer to BYCS or a local court appearance. (The ministry told us that there are seldom two female youth in custody at PGYCS at the same time, and as a default any female youth in the centre are housed alone.) At those times, there were male youth in the facility, and ministry policy does not permit male and female youth to be housed together.[307] In 2017, four female youth were housed alone on 7 different occasions. In 2018, four female youth were housed alone on 11 different occasions. And in 2019, five female youth were housed alone on 9 different occasions. The periods of time for which these female youth were housed alone ranged from several hours to six days. The records therefore show that the policy has primarily been used to house female youth alone, in situations where there was only one female youth at the custody centre.

Our review of the records revealed numerous date and time discrepancies between different records. For example, some of the records did not expressly mention the use of the policy and did not specify the start and end times of each period in which a youth was housed alone. This made it impossible to determine how long youth were housed alone and whether they were able to access school, programs, or mental health and cultural support, or engage with other youth during this time. Moreover, none of the records provided by the ministry included the required confirmation by the custody centre director that all other options had been exhausted or

[304] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.5.02.
[305] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.5.02.
[306] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.5.03.
[307] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, I.9.02.

were not reasonable in the circumstances. Finally, none of these decisions were clearly documented on the youths' CORNET records.

## *Analysis: The "temporarily housed alone" policy*

The directors of the youth custody centres did not ensure that the documentation related to each use of the "temporarily housed alone" policy met the policy requirements.

More troubling, however, is that when youth are held separately from any other youth (male or female) in the facility under the "temporarily housed alone" policy, this amounts to separate confinement as defined in the *Youth Custody Regulation*. But the ministry does not recognize these housing arrangements as separate confinement. Instead, the policy expressly exempts staff from complying with the "separate confinement paperwork."[308] There is no provision for a regular review of the youth's living arrangements by either the custody centre director or the provincial director of youth justice. Such reviews are required when a youth is separately confined under the Regulation.

We raised our concerns about this policy in 2017 and questioned whether it amounted to separate confinement. At that time, the ministry explained its view that "[t]hese infrequent scenarios are not decisions made to separately confine youth from other youth in a centre, such as is contemplated in section 15.1 of the…[Regulation]; rather, the policy [section D.5] is directed at managing those situations in which there are no other youth in the facility."[309]

We recognize that this policy was developed to operationally manage situations in which there are small numbers of youth, or no other youth, in a facility. However, the application of this policy results in individual youth being confined separately from other youth in the centre. This isolation from other youth is the very essence of separate confinement as defined in the *Youth Custody Regulation*.[310] The Regulation sets out the circumstances in which separate confinement is authorized. The Regulation does not include a general power to separately confine youth for operational reasons outside of the grounds set out in section 15.1, nor does it permit the separate confinement of a youth by means of a policy. Indeed, the harms of separate confinement are caused by the nature and extent of the isolation. These harms can be felt regardless of the intention of the decision maker or the operational challenges at hand.

The separate confinement provisions in the Regulation are designed, in part, to constrain the use of separate confinement and to establish some mechanisms of oversight for the use of this intervention. In the context of this regulatory scheme, it is not appropriate for the ministry to create another set of different exceptional circumstances to justify the use of isolation without even minimal safeguards, such as regular reviews.[311] As such, we are unable to reconcile this policy and the corresponding practice with the existing regulatory provisions. The *Youth Custody Regulation* does not permit the isolation of youth from other youth by means of a policy, no matter how well documented it is.[312]

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[308] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.5.03.

[309] Ministry of Children and Family Development, Youth Justice and Forensic Services, response to Ombudsperson, September 2017.

[310] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1.

[311] In a recent case in Yukon, the Supreme Court found that the territory had created a "secure living unit" that was, in fact, separate confinement, through policy. This was unlawful, as the *Corrections Act* required separate confinement to be established in regulation, and the policy did not contain the necessary procedural safeguards. See *Sheepway v. Hendriks*, 2019 YKSC 50 at paras. 117, 122 and 123.

[312] As we noted in section 5.1, an Alberta provincial court decision concluded that a practice of placing youth in solitary confinement on the basis of institutional policy, without a legislative or other legal basis, was unlawful: *R. v. CCN*, 2018 ABPC 148.

We also found that this policy disproportionately affects female youth. Given the low numbers of female youth in custody, it is likely to be a regular occurrence that there is only one female youth in custody at a given time. This circumstance is not new or unusual, and it is incumbent on the ministry to seek alternatives to isolation for these youth. At the same time, we recognize that there are important policy reasons for maintaining the separation between male and female youth in custody, particularly in living units. Without steps to mitigate their isolation, however, the disproportionate impacts of isolation on female youth – solely because they are female – will continue.

Although the records we reviewed did not indicate that this policy was used in relation to gender-diverse youth, we have similar concerns that they may be disproportionately separately confined because of challenges accommodating their gender identity, although we also note that in such cases the policy recognizes that isolation would amount to separate confinement. The operations manual currently states:

> Whenever possible and subject to the youth's preference, transgender/non-binary youth are integrated into the general population and not isolated because of their gender unless there are overriding health and safety concerns present which cannot be resolved. If the youth is separately confined, it is for as short a time period as possible. The youth is given as many social and programming opportunities as possible when separately confined. All of the policies and procedures related to separate confinement are followed.[313]

If the ministry is of the view that the existing regulatory framework is inadequate to reflect its operational realities given the low numbers of youth currently in custody, then it must seek the appropriate regulatory changes to ensure that any "housed alone" placements occur with the same limits and oversight that would exist in the case of any other separate confinement decision. This would include specific time limits on these placements and regular, ongoing reviews of the youth's housing arrangements, including their access to schooling, programs, religious, spiritual and cultural support, mental health services and opportunities for meaningful social contact, as well as consideration of alternatives.

In addition, the ministry should take steps to ensure that the court is informed when detained youth are housed alone in custody for operational reasons. This information is particularly relevant when the court is making pre-trial decisions about individual youth, including bail hearings, reviews of detention orders and pre-sentence proceedings. To support this communication with the court, the ministry should revise its Manual of Operations, Community Youth Justice Services[314] to require that community probation officers provide the court with information about the conditions of a youth's detention to ensure that situations in which a youth is or has been, or is likely to be, housed alone for operational reasons are communicated to the court in relevant pre-trial and pre-sentence proceedings. For Indigenous youth, this information should also be included in Gladue pre-sentence reports prepared for the court.[315]

[313] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, I.11.07.
[314] MCFD, Office of the Provincial Director of Youth Justice. *Manual of Operations—Community Youth Justice Services*, 2019, D.1, D.5 and D.7.
[315] MCFD, *Manual of Operations—Community Youth Justice Services*, 2019, F.4.

**Finding 8:** The "temporarily housed alone" policy permits the separate confinement of youth for a reason that is not set out in the *Youth Custody Regulation* and without the authorization and documentation required for every instance of separate confinement. In cases where there are other youth in the centre, this constitutes an unlawful use of separate confinement.

**Recommendation 18:** By April 1, 2022, the Minister of Children and Family Development propose to the Lieutenant Governor in Council that the *Youth Custody Regulation* be amended to establish a legal framework that applies to youth who are housed alone for operational reasons and that, at a minimum:

a) requires staff to ensure that these youth have meaningful human contact

b) requires staff to immediately implement alternatives to isolation

c) requires staff to document cases where youth are housed alone for operational reasons, and

d) establishes a process for authorizing and reviewing such placements that is equivalent to the review process for youth who are separately confined in other circumstances.

**Recommendation 19:** By October 1, 2021, Youth Justice Services develop and implement a policy identifying and requiring the use of

a) alternatives to isolation for female youth who are separately confined solely because they are the only female youth in custody at that time, and

b) cultural supports, including the development of a program to connect Indigenous female youth with specially trained Indigenous Elders to provide ongoing support, encouragement and care during separate confinement

**Recommendation 20:** By October 1, 2021, Youth Justice Services revise the *Manual of Operations – Community Youth Justice Services*, to acknowledge the significant risk of psychological harm caused by being housed alone in custody and require community probation officers to:

a) identify when specific youth are living alone or are likely to be housed alone for operational reasons, and

b) communicate this to the court in relevant pre-trial proceedings, including bail hearings, reviews of detention orders, consideration of Indigenous social history (Gladue reports and reviews) and pre-sentence proceedings.

## Some periods of separate confinement were unauthorized and undocumented

There can be no formal oversight of separate confinement that occurs without authorization or documentation. In reviewing the records from BYCS, we found that youth who were separately confined for the longest periods of time were also separately confined, on some occasions, without the authorizations or documentation required by section 15.1 of the *Youth Custody Regulation* and the operations manual.

We identified these unauthorized periods of separate confinement by reviewing the CORNET records for individual youth and cross-referencing these records with the separate confinement records provided by the ministry. In each case, we concluded that

the youth was separately confined without authorization, based on two key indicators:

- The youth was housed in the Independent Observation Unit, the unit most often used to separately confine youth.
- The records indicated that the youth's social interactions were restricted and minimized relative to a regular living unit.

Because these periods of isolation were not documented as instances of separate confinement, it was sometimes difficult to determine precisely when youth were and were not isolated. However, the records referenced above were sufficient for us to conclude that two youth were separately confined without authorization, sometimes for significant periods.

We focused our review of these detailed records on a one-year period between June 2017 and June 2018.

During this period, one youth was separately confined without authorization for 282 hours (almost 12 days). In some instances where this youth was isolated, the records suggest a disregard among some staff for the need to follow the rules for separate confinement in relation to the youth. For example, a CORNET entry confirmed that this youth was being housed in the IOU because she had self-injured. The entry stated, "as per ADO [Assistant Director of Operations], the youth is to have no programs other than playing cards or boardgames with staff for the weekend and that she is to be confined to her room and the IOU." One day later, the CORNET entry stated that the same youth "is locked in her cell and asks to be unlocked. [T]hat as per ADO she must remain in the [IOU] until further notice she is told by ADO that she has to behave this weekend to be considered to have her restrictions removed." On the following two days the CORNET records confirmed that the youth continued to be restricted in the IOU. Records indicate that she asked to be able to attend programs with other youth, but staff refused that request.

These records confirmed that this youth was being housed in the IOU and was isolated from other youth. In addition, the records indicate that staff intended to isolate this youth for multiple days without ongoing review. The suggestion that the youth had to "behave" to be eligible for programming or reintegration with peers does not reflect a trauma-informed response to the youth's self-injuring behaviour. Instead, it suggests that her self-injuring behaviours were seen as "bad" and that separate confinement was being used as a disciplinary measure, which is not a ground for separate confinement in the *Youth Custody Regulation*. Because the separate confinement was not authorized, and therefore not subject to periodic review by the provincial director, there was inadequate documentation and no formal reviews or oversight of this potentially inappropriate use of separate confinement.

During the same period, the second youth whose file we reviewed in detail was separately confined without authorization for 3,315 hours, or 138 days (not all consecutive). This represented 44 percent of the total time this youth spent in custody over that time. In addition, over the same period, the youth was separately confined with authorization for a further 775 hours, or 32 days. In total, 54 percent of this youth's time in custody over this one-year period was spent in separate confinement.

In this youth's case, the records indicated that staff were trying to facilitate programming and activities to the extent that the youth was able to handle them. These efforts to maintain some meaningful contact with the youth's peers may have mitigated, to some extent, the isolating effects of separate confinement. However, the separate confinement continued and remained unauthorized.

## *Analysis: Unauthorized separate confinement*

The ministry's authority to separately confine a youth flows from the *Youth Custody Regulation*. Section 15.1 of the Regulation requires the ministry to document the rationale for the separate confinement and seek appropriate authorizations at regular intervals.[316]

When staff do not properly authorize or document separate confinement decisions in accordance with this regulatory framework, there is no record of their decision making. Transparency of decision making is critical in ensuring accountability, and the absence of clearly documented records makes it difficult to understand how and why these decisions were made.

For example, completing the documentation requires staff to articulate a rationale for the separate confinement. If such documentation is not completed, there is a risk that the separate confinement is for a reason not set out in the Regulation. As we described in the previous section, some of the records we reviewed suggested that separate confinement was being used as a disciplinary measure, which is not permitted.

Further, because there is no limit on the maximum amount of time that a youth may spend in separate confinement, the provincial director's reauthorization is intended to review the circumstances of the separate confinement to ensure that it does not last for longer than necessary. However, if separate confinement is not properly authorized at the outset, this review by the provincial director does not occur.

We saw in our investigation that two youths' unauthorized separate confinement continued for days or even weeks without the procedural protections provided by the Regulation because staff did not identify the youths' isolation as separate confinement. This was not a momentary lapse in paperwork. Rather, it was a systemic failure to acknowledge that isolating youth from other youth constitutes separate confinement and triggers the requirements in the regulation. We would expect the directors of youth custody centres to ensure that every instance where a youth is isolated from other youth is recognized, authorized and documented as separate confinement in accordance with the *Youth Custody Regulation*. Anything less exposes youth in custody to the risk of being confined arbitrarily without the *Youth Criminal Justice Act* guarantee of "enhanced procedural protections,"[317] which we would expect to include, at a minimum, regular reviews of their separate confinement placement required by the Regulation.

Under the *Ombudsperson Act,* we can find that a procedure through which a decision is made is arbitrary.[318] A procedure is arbitrary when it does not have regard to the applicable rules or standards.[319] In the cases we reviewed where youth were separately confined without authorization, there was no documentation on which to assess the lawfulness or the appropriateness of that decision, including, for example, whether the regulatory requirements for separate confinement had been met. It was only through a careful parsing of the various records that the fact of these youths' separate confinement became apparent. Because the required authorizations and documentation were absent from these youths' files, we concluded that this use of separate confinement was arbitrary.

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316 *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1(2).
317 *Youth Criminal Justice Act,* S.C. 2002, c. 1, s. 3(1)(b)(iii).
318 *Ombudsperson Act*, R.S.B.C. 1996, c. 340, s. 23(1)(a)(v).
319 Office of the Ombudsperson, *Code of Administrative Justice*, 11, https://bcombudsperson.ca/assets/media/Public-Report-No-42-Code-of-Administrative-Justice.pdf.

**Finding 9:** Between July 1, 2017, and June 30, 2018, staff at Burnaby Youth Custody Services Centre separately confined two youth without the authorization and documentation required by the *Youth Custody Regulation* and *Manual of Operations – Youth Custody Programs*. This constitutes an arbitrary use of separate confinement.

## 7.2 The role of the provincial director

The provincial director of youth justice becomes involved in separate confinement decisions when contacted by a senior youth supervisor or the custody centre director with a request to authorize the continued separate confinement of a youth beyond 48 hours. The provincial director can authorize further periods of separate confinement for up to 72 hours each time. There is no limit on the number of 72-hour periods that can be reauthorized by the provincial director.

The operations manual requires the provincial director to consider the following information, which is generally provided by staff at the custody centre:

- demographic information about the youth
- the rationale for the initial separate confinement
- the rationale for the continued separate confinement (which may be different from the initial reason) and why other alternatives are not reasonable
- the length of the total separate confinement and the location of the youth
- programs and services being provided to support reintegration to regular living unit activities
- feedback from health care, mental health and other service providers about the youth's overall health and well-being
- frequency and nature of contact with other youth
- confirmation that the youth has been advised of external advocacy support and review processes[320]

The provincial director reviews this information and decides to either continue or end the period of separate confinement. According to the operations manual, the provincial director must, each time they are considering whether to reauthorize separate confinement:

> evaluate the need to continue separately confining the youth, by considering the youth's individual circumstances, additional information provided since the initial authorization and subsequent reviews, as well as all other relevant factors and reasons, including the advice of a medical practitioner or health care professional.[321]

The provincial director is required to communicate their decision in writing.[322] If the provincial director does not approve continued separate confinement, the youth must be reintegrated with their peers in a regular living unit. If the provincial director does reauthorize separate confinement, then the custody centre director or their delegate is responsible for communicating the decision, reassessment timeline and behavioural expectations to the youth verbally and in writing.[323]

It is essential that the provincial director conduct their review of a youth's separate confinement in a timely way. Delayed decision making means that youth may be separately confined for longer than necessary, which is inconsistent with the requirements of the *Youth Custody Regulation*.

[320] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.10, 27–28.
[321] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.10.
[322] *Youth Custody Regulation,* B.C. Reg. 137/2005, s. 15.1(2) and (3).
[323] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.10.

The provincial director completed most of their separate confinement reauthorizations within the required timelines. In some isolated cases that occurred early in our investigation, the provincial director missed timelines. In one case, the provincial director was more than a day late in reauthorizing separate confinement. However, we did not find that there was a persistent pattern of delay in the provincial director's decision making. Over the course of our investigation, we saw that the provincial director more consistently complied with the requirement for timely reauthorizations.

At the same time, and more troublingly, the provincial director's involvement did not prevent the prolonged or inappropriate use of separate confinement. In theory, because the provincial director is located outside the custody centres, they should be able to objectively consider the rationale for continued separate confinement and intervene when it is not being used appropriately or effectively. Under the existing legislation, the provincial director is the only person outside the centre who reviews, and has the power to overturn, separate confinement decisions. It is also important to note that even after the provincial director has become involved, staff at the custody centre retain the ability to end separate confinement at any time – and, in fact, they must end separate confinement if the criteria for separate confinement are no longer met.

Between 2017 and 2019 there were 46 instances of separate confinement at both custody centres that lasted for 48 hours or more. In 2 of these instances, the youth were released at 48 hours or shortly thereafter, and no reauthorization request went to the provincial director. In one case, the youth was separately confined under the "temporarily housed alone" policy, which does not require any authorizations from the provincial director.

In 3 instances, the separate confinement lasted for significantly more than 48 hours, but the file did not contain a record of any 48-hour approval documentation. In the remaining 40 instances, the provincial director reauthorized a further period of separate confinement. This means that the provincial director did not end separate confinement in any of the 48-hour reviews that they completed.

Similarly, between 2017 and 2019 there were 33 instances of separate confinement that lasted for 72 hours or more (32 at BYCS and 1 at PGYCS). In only 1 of the 33 instances did the provincial director refuse to reauthorize separate confinement at the 72-hour mark. In one other case, the provincial director's approval was not sought because the youth was separately confined under the "temporarily housed alone" policy.

In the vast majority of cases we reviewed in our investigation, the provincial director authorized separate confinement to continue for further 72-hour periods.

## 7.3 Considering the views of youth in separate confinement decisions

A basic component of procedural fairness is the right of a person to be heard prior to a decision that affects their rights or interests. The deprivation of liberty that characterizes separate confinement means that youth should have the right to be heard in relation to these decisions. This is consistent with the *Youth Criminal Justice Act*'s guarantee of "enhanced procedural protections" for youth.

We examined two ways in which youth are – or are not – afforded an opportunity to be heard when custody centre staff, or the provincial director, are deciding whether a youth will be separately confined.

## Separate confinement authorization and reauthorization

The *Youth Custody Regulation* contemplates a role for youth in decisions about separate confinement. It states that a person "must not approve a period of separate confinement… without considering information, if any, provided by the youth."[324] The use of the qualifier "if any" in the Regulation means that the decision maker may approve separate confinement in the absence of any information from the youth themselves. We found that despite the significant impact of a separate confinement decision on the affected youth, they have few opportunities to be heard.

The operations manual states that when making the initial decision as to whether to separately confine a youth, the senior youth supervisor "shall provide the opportunity for the youth to be heard and respond."[325] Similarly, there is also a policy expectation that following the use of separate confinement, a "debriefing and support" meeting will be offered to the youth, at which point the youth "shall be provided an opportunity to express their views on what transpired."[326]

The separate confinement authorization forms include a designated space for staff to record comments by the youth in response to the decision to separately confine them. In some cases, we observed that staff recorded comments by youth, but in many cases this space was left blank or just included confirmation by staff that they had advised youth of the reason for separate confinement and of their right to a review by centre management. The ministry explained that in many instances, youth are in a heightened state of emotion and do not want to provide comments to staff at that time. The ministry further explained that staff are expected to ask the youth if they have comments, but that in some instances the youth have no comments other than expletives which are not recorded by staff. Descriptions of communication and input from youth can be found in various other records, including some documented reviews by senior youth supervisors and CORNET logs.

The operations manual does not specifically require the custody centre director to seek the youth's views when requesting that the provincial director authorize a further period of separate confinement. There is also no policy requirement for the provincial director to contact the youth in order to hear their views.

In practice, staff at a youth custody centre contact the provincial director, usually by email, to request their approval for the continued use of separate confinement. In their request, staff include a summary of the information that the provincial director must consider in approving the continued use of separate confinement (see section 7.2).

As a result, decisions by the provincial director to authorize the continued use of separate confinement are based on information provided by operational staff. To the extent that the provincial director hears the views of the youth – if these views are included at all – the views are mediated by staff. We did not see any instance where the provincial director sought to hear from the youth directly about their experience in separate confinement.

[324] *Youth Custody Regulation*, B.C. Reg. 137/2005, s. 15.1(4)(b)
[325] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.04
[326] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.13.

**Finding 10:** The *Youth Custody Regulation* is procedurally unfair because it does not ensure that a separate confinement decision maker always hears from youth, or always provides them with an opportunity to be heard, before deciding whether to authorize or reauthorize a separate confinement decision.

## Complaints about separate confinement

The ministry is required by law to establish a process for "receiving and investigating complaints" from youth in custody or their parents or guardians. This includes complaints from youth in custody about separate confinement or the use of force.[327]

The operations manual describes a complaint process specific to separate confinement placements.[328] In accordance with this policy, youth should be advised of their right to complain as soon as they are separately confined. The policy describes what should happen when a youth makes a complaint about separate confinement:

> Any complaint lodged by the youth shall be communicated to a youth custody director without delay. The…director shall consider the merits of the complaint and make a decision, after permitting the youth an opportunity to be heard. A suitable adult advocate may assist the youth to present the complaint. The decision shall be communicated to the youth by the next business day.[329]

If a youth wants to make a complaint about separate confinement or use of force outside of normal business hours, they should be given an opportunity to speak to the on-call custody centre director, who is required to begin a formal resolution process.[330]

Separately, the operations manual describes an "informal" complaint process for resolving "minor" complaints at the staff level, where appropriate. We saw some examples of this "informal" process being used by youth who were separately confined – for example, a youth who wanted to return to eating food with silverware complained to the staff member supervising her. In addition, as described in section 4.4, we observed youth self-advocating for personal items, programs, mental health support and reintegration with peers while they were in separate confinement. Many of their requests were dismissed or minimized by staff. None of these requests were channeled through the formal complaint process.

Youth who are separately confined rarely use the formal complaint process described in the policy. Of the 307 instances of separate confinement that occurred between January 1, 2017, and December 31, 2019, only nine youth used this process to complain about being separately confined. All of the complainants were male youth. None of the female or gender-diverse youth who were separately confined for prolonged periods made formal complaints.

In total, these nine youth made 16 formal complaints. Five of these youth were separately confined for between 3 and 17 hours. One of the other complaining youth was separately confined for 636 hours, during which he made seven complaints.

The complaints we reviewed were similar in nature. The complaining youth wrote that they disagreed with the decision to separately confine them and they wanted to be returned to a regular living unit. In one case, a youth wrote, "all I want is to stop

[327] *Youth Justice Act*, S.B.C. 2003, c. 85, s. 41(1).
[328] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.09.
[329] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.12.
[330] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, B.4.11.

being isolated and treated like some caged animal and have a director talk to me." In another complaint a youth wrote, "leaving me in sep con isolated is giving me mental break downs, not good for my health or not a way to rehabilate *[sic]* kids." In another complaint, a youth wrote,

> I've had good behaviour since I've been back, beside last night but that's because I just had a mental break down and snapped. I feel keeping me isolated is bad for my health and rehabilitation. I have a camera in my room that invades my privacy and it has no desk or radio I feel like I'm being punished or treated unfairly.

We compared how often youth made complaints about separate confinement with how often they made complaints about other matters. Table 2 shows the number of internal complaints made by youth about all matters since 2016/17.

**Table 2: Number of internal complaints at all youth custody centres**

| Fiscal year | Number of complaints |
|---|---|
| 2016/17 | 157 |
| 2017/18 | 210 |
| 2018/19 | 386 |
| 2019/20 (first three quarters) | 52 |

Youth make very few complaints about separate confinement, both in absolute terms and relative to other matters. Moreover, we found that the individual youth who make complaints in custody are not the same youth who are subjected to prolonged periods of separate confinement.

The lack of complaints about separate confinement does not demonstrate that youth agree with the decision to separately confine them. Rather, the records show that on many occasions, youth expressed to staff that they disagreed with their separate confinement or were otherwise frustrated or unhappy with their circumstances. For example, staff recorded the following observations about one youth who was separately confined: "Youth continues to express hostility towards staff and is unwilling to talk and discuss behaviour support plan. She indicates she does not like the strong sheet protocol and believes the 'whole process was not fair.'"

When the youth articulated these concerns, staff could have assisted the youth in making a complaint. However, they did not do so.

Similarly, a staff log entry for a later period of separate confinement involving the same youth indicates that she was upset about the decision to separately confine her: "youth very upset with this decision stated 'see what happens now.'" Still, staff did not assist the youth in accessing the complaints process.

In this regard, it is relevant to note that the operations manual states that "any complaint lodged by the youth shall be communicated to a youth custody director without delay."[331]

One reason why youth may not use the formal complaints process in separate

[331] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.12.

confinement is its inaccessibility. Regular living units may have informational posters about complaints processes that include external contact information. However, when youth are separately confined, such posters are a potential safety hazard because paper can be used to cover windows, inflict injuries or plug toilets. In addition, access to writing implements is strictly controlled throughout the centre. To make a written complaint, youth would have to ask staff for paper and a writing implement. Depending on the staff's assessment of the youth's safety risk, this request may be granted only under significant restrictions. From a purely practical perspective, the complaints process is less accessible to youth in separate confinement.

It is difficult to conclusively determine why youth do not use the complaints process in relation to separate confinement. However, it is clear from our investigation that there is a disconnect between the youth's experience of separate confinement and their access to and ability to initiate a review. In a letter to us, the B.C. First Nations Justice Council provides insight into the failures of the complaints process for Indigenous youth, writing that "Indigenous youth are culturally less likely to challenge their separate confinement. Through the history of colonialism and residential schools, many Indigenous people do not challenge authority and are fearful of retribution."[332]

The fact that the records show youth disagreeing with their separate confinement, but no review or complaint, suggests that staff are not adequately facilitating or supporting the review process for youth. Finally, the absence of complaints from youth about separate confinement raises the concern that the experience of being separately confined in custody is a normalized one for youth in separate confinement, rather than an exception. That youth might see separate confinement as a "normal" experience of custody – and therefore not a worthy subject of a complaint – is particularly a concern for youth isolated for prolonged or repeated periods.

**Finding 11:** Youth who are separately confined do not use the internal complaint process to challenge their separate confinement placement or the conditions of separate confinement. The internal complaint process provides inadequate oversight, given the vulnerability of youth in custody and the risk of harm that can result from the use of separate confinement.

## 7.4 External oversight of individual separate confinement decisions

### Investigation and Standards Office

A 2011 memorandum of understanding (MOU) between the Ministry of Children and Family Development and the Investigation and Standards Office (ISO), part of the Ministry of Attorney General, establishes a process by which the ISO will act as an "independent external review body" for complaints from youth in custody.[333] The ISO performs a similar function in relation to adult provincial corrections, although its function there is established through legislation.[334]

[332] BC First Nations Justice Council, letter to the Ombudsperson, April 9, 2021.

[333] Memorandum of Understanding between Youth Custody Services, Ministry of Children and Family Development and Investigation and Standards Office, Ministry of Attorney General, July 20, 2011, para. 20. This MOU also provides that the ISO will be involved in reviewing critical incidents involving youth in custody and in conducting inspections of youth custody centres.

[334] *Correction Act,* S.B.C. 2004, c. 46; Government of British Columbia, "Investigation and Standards Office," https://www2.gov.bc.ca/gov/content/justice/criminal-justice/iso?keyword=Investigation&keyword=Standards&keyword=Office. The ISO also participates in inspections of B.C. correctional facilities.

The MOU provides two avenues by which the ISO can become involved in youth custody complaints:

- A youth may complain directly to the ISO. In such cases, the ISO will try to facilitate communication with the custody centre director and, where appropriate, direct the youth to the centre's complaints process. If these options are unavailable or inappropriate in the circumstances, the ISO may commence an investigation.
- The ISO may review decisions made through a custody centre's complaint process if a youth is either unsatisfied with the response or did not receive a response within a reasonable period of time, defined as five working days from the time custody centre staff receive the complaint.

The MOU provides that in the case of a "serious complaint" that requires an "escalated response time," the ISO may review the complaint more quickly, but the MOU does not define what a "serious complaint" might be, nor does it establish any procedures for a faster response. The ISO is expected to consult with the custody centre director before proceeding with any complaint investigation. Consistent with the *Youth Justice Act*, the custody centre director is expected to provide the ISO investigator with access to any information required to further their investigation.

On completing a complaint investigation, the ISO will advise the youth in writing about the outcome and provide a copy of this correspondence to the director of the relevant youth custody centre, as well as to the provincial director of youth justice. The ISO does not have the authority to overturn a decision to separately confine a youth, nor does it have the power to make a recommendation to a youth custody centre in relation to a youth's complaint. The ISO can only talk to the custody centre director about a youth's complaint.

Further, youth access the ISO complaint process infrequently, and do not access it for concerns related to separate confinement. During our three-year investigation, the ISO received only six complaints from three youth in custody. The complaints were about staff rudeness, food, transfers and the provision of health-related items. During this period, no youth complained to the ISO about separate confinement or the use of force. We spoke with ISO staff, who confirmed that since 2011 it has received an average of two complaints per year from all youth in custody.

As with the internal complaints process, it is difficult to know precisely why youth do not complain to the ISO when they are separately confined. However, it is important to note that a youth seeking to complain to the ISO about separate confinement would first have to know that this complaint mechanism is available, and how to contact the ISO. As described in section 4.3, access to informational posters or other materials, to paper and to writing implements is significantly restricted, so a youth wanting to make a written complaint to the ISO would also have to request the materials necessary to make that complaint. Youth would have to trust that staff would direct their complaint appropriately. To make a verbal complaint to the ISO, a youth would have to know that they can contact the ISO and would have to ask staff for permission to make a phone call. If a youth manages to contact the ISO, but they have not first gone through the internal complaint process, the ISO may refer them back to that process.

There is no timeline set out in the MOU for addressing a complaint to the ISO. Finally, the ISO's lack of authority to change a separate confinement decision, or even to recommend a different course of action, makes it unlikely that a complaint to the ISO would result in a meaningful outcome for the youth. For these reasons, it is not surprising that the ISO has received so few complaints from youth, and none about separate confinement.

**Finding 12:** Youth who are separately confined in custody do not contact the Investigation and Standards Office (ISO) to make complaints about their separate confinement placement or the conditions of separate confinement. The current ISO complaints process provides inadequate oversight, given the vulnerability of youth in custody and the risk of harm that can result from the use of separate confinement.

### Office of the Ombudsperson

Our office receives and investigates individual complaints about youth custody. Between January 1, 2017, and December 31, 2019, our office received 84 complaints about BYCS and 10 complaints about PGYCS.

### Representative for Children and Youth

The Representative for Children and Youth (RCY) is an independent officer of the legislature appointed under the *Representative for Children and Youth Act*. In accordance with that legislation, part of the representative's role is to "review, investigate and report on" the critical injuries and deaths of children and youth receiving a "reviewable service" at the time of, or in the year prior to, their injury or death.[335] These services include those provided under the federal *Youth Criminal Justice Act*, such as youth custody.[336] A critical injury is one that may "cause serious or long-term impairment of the child's health"[337] and includes emotional harm, suicide attempts and physical harm.[338]

During our investigation, we spoke with RCY staff, who informed us that they do not routinely receive reports from the ministry regarding the use of separate confinement in youth custody.

### Public Guardian and Trustee

The Public Guardian and Trustee (PGT) is responsible for protecting the legal and financial interests of children and youth in the continuing care of the ministry under the *Child, Family and Community Service Act*. As property guardian, the PGT is co-guardian with the Ministry of Children and Family Development and any involved Delegated Aboriginal Agencies providing child and family services.[339]

As part of its duty to protect a child's legal and financial interests, the PGT may advance legal claims arising from injury or loss suffered by these children and youth. To identify potential claims, and determine whether legal redress is appropriate, PGT staff review reports of critical injuries and serious incidents, including reports of assault and self-harm.[340]

During our investigation we spoke with PGT staff, who informed us that they do not routinely receive reports from the ministry regarding the use of separate confinement in youth custody.

## 7.5 Analysis: Oversight of individual separate confinement decisions

As the *Youth Criminal Justice Act* confirms, youth who are in custody retain all their rights

[335] *Representative for Children and Youth Act*, S.B.C. 2006, c. 29, 11 and 12.
[336] *Representative for Children and Youth Regulation*, B.C. Reg. 142/2019, s. 4(a).
[337] *Representative for Children and youth Act,* S.B.C. 2006, c. 29, s. 1.
[338] Representative for Children and Youth, *Annual Report 2019/20 and Service Plan 2020/21 to 2022/23*, 39, https://rcybc.ca/wp-content/uploads/2020/11/RCY_AR_2019-20-FINAL_web.pdf; Ministry of Children and Family Development, Reportable Circumstances Policy, June 2015, revised June 2018, 6.
[339] *Public Guardian And Trustee Act*, RSBC 1996, Chapter 383, s. 7; *Child, Family and Community Service Act*, RSBC 1996, c. 46, s. 50 and 51.
[340] The PGT classifies the reported injury or harm according to categories adapted from the World Health Organization International Classification of Diseases. Public Guardian and Trustee of British Columbia, *Child and Youth Guardianship Services 2019–2020 Report*, 36, https://www.trustee.bc.ca/reports-and publications/Documents/GuardianshipServicesReport_20192020.pdf.

except those that are necessarily removed as a result of their sentence. This includes the right under section 7 of the *Canadian Charter of Rights and Freedoms* "to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."[341]

This means that any further deprivation of liberty within a custody centre, such as separate confinement, can occur only if it is consistent with the principles of fundamental justice, which includes a right to procedural fairness in decision making.[342]

As the Supreme Court of Canada has articulated,

> underlying the duty of procedural fairness…[is] the principle that the individual or individuals affected should have the opportunity to present their case fully and fairly and have decisions affecting their rights, interests or privileges made using a fair, impartial and open process, appropriate to the statutory, institutional and social context of the decision.[343]

The YCJA further establishes that youth involved in the justice system are entitled to "enhanced procedural protections" to ensure that they are "treated fairly and their rights…are protected."[344] This includes the requirement set out in section 83(2)(d) of the YCJA, that "custody and supervision decisions be made in a forthright, fair and timely manner, and that young persons have access to an effective review procedure."[345]

The UN Convention on the Rights of the Child provides for similar procedural fairness protections. Article 37 of the Convention states that every child deprived of their liberty "shall have the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action."[346]

A recent decision of the Alberta provincial court applied this provision of the Convention to a decision to segregate a youth in custody, on the basis that segregation constitutes a further loss of liberty for incarcerated youth.[347]

The Mandela Rules also call for specific procedural protections when solitary confinement is used. They provide that it should only be used "in exceptional cases as a last resort," should end as soon as possible, should be subject to independent review and should only be used with proper authorization.[348]

The key element of procedural fairness at issue when youth are separately confined is the right to an impartial decision maker. The B.C. Court of Appeal's 2019 decision on the use of administrative segregation in adult correctional facilities provides some guidance on how an incarcerated person's rights to procedural fairness under section 7 of the Charter can be applied to this context. In its decision, the court ruled that people who are placed in administrative segregation are owed a high degree of procedural fairness. The court stated, in part:

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341 *Canadian Charter of Rights and Freedoms*, c. 11, s. 7.
342 The Supreme Court of Canada confirmed in *Cardinal v. Director of Kent Institution* that the duty of procedural fairness applies (in the adult corrections context) to review of administrative segregation placements. See *Cardinal v. Director of Kent Institution* [1985] 2 SCR 643, para. 14.
343 *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 SCR 817, para. 28.
344 *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 3(1)(b).
345 *Youth Criminal Justice Act*, S.C. 2002, c. 1, s. 83(2)(d).
346 United Nations, *Convention on the Rights of the Child,* adopted by the General Assembly on November 20, 1989, Art. 37, https://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf.
347 *R. v. CCN,* 2018 ABPC 148, paras. 52–55. See also *Hill v. British Columbia,* [1997] 10 WWR 691 (BCCA).
348 UN Office on Drugs and Crime, *Standard Minimum Rules for the Treatment of Prisoners*, Rule 45.1.

> The decision to keep an inmate in administrative segregation is an important one that carries with it the risk that the person so confined will suffer significant emotional harm which, in some cases, will be permanent. The risk of self-harm and suicide also increases with exposure to solitary confinement. The interests at stake are high. The procedural protections required must reflect the extent to which the decision affects an inmate's life, liberty and emotional security.…This factor also weighs heavily in favour of robust procedural fairness protections.[349]

The court considered the complexity of segregation decisions and the need for decision makers to have a "profound appreciation of institutional dynamics, individual behavioural patterns, inmate alliances, security intelligence information and the existence and efficacy of alternatives to administrative segregation."[350] At the same time, the court recognized that to protect the constitutional rights of incarcerated people to life, liberty and security of the person, as set out in section 7 of the Charter, a "fair process attuned to the context" is required.[351] Balancing these factors, the judge found that procedural fairness in relation to decisions to place people in solitary confinement required an external review of those decisions by independent reviewers, beginning at the legislated five-day review.

An external, independent review of separate confinement decisions would have several benefits. As described by the B.C. Court of Appeal, it would ensure careful consideration of whether the facts justified the use of separate confinement, given the legal criteria; it would lead to more careful consideration of alternatives; it would increase accountability and allow the incarcerated person an opportunity to be heard; it would ensure compliance with legal and policy requirements; and it would avoid deferential decision making.[352]

The B.C. Court of Appeal's decision confirms that a meaningful, independent, external review is the cornerstone of a procedurally fair and constitutional separate confinement regime. Given the heightened procedural protections that must be afforded youth, the requirements set out in the B.C. Court of Appeal decision provide guidance on the minimum standard necessary for the meaningful oversight of separate confinement decisions in youth custody.

Our investigation found that the existing internal and external oversight processes are not sufficient to protect against the inappropriate or prolonged use of separate confinement.

Youth who are separately confined rarely access the internal complaint process, and do not contact the Investigation and Standards Office about their separate confinement. The ISO does not otherwise exercise any role in relation to individual separate confinement decisions, and even if it did, it lacks the power to change a separate confinement placement. Because it is required to consult with the

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[349] *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2019 BCCA 228, para. 185. See also *Hamm v. Attorney General of Canada (Edmonton Institution)*, 2016 ABQB 440, para. 68, stating that given the severity of a decision to place an inmate in administrative segregation, "the appropriate level of procedural fairness required is, therefore, one which mirrors the safeguards contained in the criminal trial process as attenuated by the lower level of overall jeopardy."

[350] *British Columbia Civil Liberties Association v. Canada (Attorney General),* 2019 BCCA 228, para. 189.

[351] *British Columbia Civil Liberties Association v. Canada (Attorney General),* 2019 BCCA 228, para. 190.

[352] This list of benefits was outlined by the B.C. Supreme Court in *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2018 BCSC 62, and cited with approval by the B.C. Court of Appeal in *British Columbia Civil Liberties Association v. Canada (Attorney General),* 2019 BCSC 228, which concluded that an external process was required.

custody centre director on any complaints it receives, the ultimate outcome of any ISO review is in the hands of the custody centre director who first authorized the separate confinement – either directly or through delegated staff members or the provincial director. Neither the Representative for Children and Youth nor the Public Guardian and Trustee regularly receive reports from the ministry about the use of separate confinement.

Our investigation also found that in some cases, youth are separately confined without any of the required documentation being completed. In these unauthorized instances of separate confinement, even the minimum legislated procedural safeguards are not being observed.

Further, the process by which the provincial director of youth justice is required to reauthorize separate confinement is not a meaningful safeguard in terms of preventing the prolonged separate confinement of youth. This is most clearly demonstrated by the 32 instances of separate confinement for more than 72 hours at BYCS between 2017 and 2019 that the provincial director authorized (and in many cases, reauthorized multiple times). Moreover, when – as described above – the provincial director almost always approves the centre's request to extend separate confinement, it raises concerns that the provincial director is too deferential to operational concerns as articulated by staff at the centres.

However, even if the provincial director were to exercise their powers in a different way, the position of provincial director is not structurally independent from other youth custody decision makers. This is because the provincial director also has broader operational responsibility for the administration of youth custody centres in B.C.

Moreover, after 48 hours, it is the provincial director alone who has authority to continue the separate confinement of a youth. This means that the same person is considering and weighing the evidence in the same way at each decision point. This raises questions about whether that decision maker can operate with a fully open mind, because they have already reached a certain conclusion on the same question previously. The B.C. Court of Appeal considered a similar decision-making process in the context of administrative segregation decisions in federal adult corrections. In that case, the Attorney General acknowledged that "the legislation is procedurally unfair because it requires institutional heads to review their own segregation decisions."[353]

Finally, the fact that the decision maker rarely hears directly from the youth who is being separately confined raises further questions about whether the review process is procedurally fair.

This oversight is far from the robust procedural fairness that the B.C. Court of Appeal found was required in the federal adult corrections context.

The existing law insufficiently protects young people's rights and their mental and physical well-being while in custody. It allows for prolonged, indefinite separate confinement of youth with no limits, no automatic, independent oversight and no obligation to hear from youth. The existing safeguards and, in particular, the escalating levels of authorization for continued separate confinement do not prevent the harms of separate confinement from occurring.

The existing safeguards did not prevent 22 youth at BYCS from being separately confined on 32 occasions for prolonged periods of time. Most concerningly, they did not prevent 3 youth living with mental illness from being repeatedly separately confined for prolonged periods over the three years that were the focus of our investigation. The prolonged

[353] *British Columbia Civil Liberties Association v. Canada (Attorney General),* 2019 BCCA 228, para. 173.

separate confinement of these youth reflects a failure of effective oversight.

The closed nature of youth custody, and the known risks associated with the use of separate confinement, heighten the consequences of ineffective oversight mechanisms.

For these reasons, we have recommended that government establish an independent review body that is notified of all separate confinement decisions and has the authority to review and overturn them in a timely way. We would expect this notification to occur immediately when a youth is separately confined and, in any event, no more than one hour after the separate confinement begins, and documentation to be provided with the notification so as to permit a prompt review. This review should not be limited in its scope – in other words, it should be a full consideration of the applicable facts and law – and should provide an opportunity for the affected youth to be heard.

Given that we have also recommended, in Recommendation 4, that any instance of separate confinement be limited to no more than 22 hours, it is our expectation that independent reviews will be conducted in a timely way. At a minimum, this independent body should be empowered to ensure that no youth is separately confined for more than 22 hours and that youth living with mental illness (or other circumstances that preclude their separate confinement) are not separately confined or otherwise isolated. In addition, we recommend that the independent review body be notified of every instance of separate confinement, within the first hour of confinement, so that it can ensure that youth are not repeatedly separately confined beyond the limits set out in the amended regulations.

We have also recommended that the ministry develop a process for seeking the youth's consent to immediately notify their parent or guardian of any placement in separate confinement. In making this recommendation, we acknowledge that the current policy requires all use of separate confinement to be included in monthly service plan review reports that are provided to the youth's parent or guardian.[354] However, in our view these notifications after the fact are insufficient. Youth in custody are better placed to assert their rights in relation to separate confinement when they can access external support and advocacy. As the policy acknowledges, youth have the right to complain about separate confinement decisions and have an advocate assist them in presenting their complaint.[355] But it is not enough to merely advise youth of their rights and expect that they will seek the necessary assistance. Instead, separate confinement decisions must be communicated immediately to someone outside the centre who may be able to assist the youth. Such notification may also make it more likely that the independent review body will hear from the youth.

Our investigation suggests that there may be some cases in which the use of separate confinement itself may constitute a critical injury as defined by the Representative for Children and Youth. While we do not purport to draw any conclusions in that regard, we believe that it is essential that the RCY, as an oversight body be provided with a report on each use of separate confinement in youth custody so that it can assess whether or not it has an investigative role. For this reason, we have recommended that the ministry provide the RCY with a report each time a youth is separately confined in youth custody so that the RCY can consider these reports pursuant to its responsibility to review critical injuries of children and youth receiving youth justice services.

Our investigation also suggested that there may be some youth in the continuing care of the ministry who may have suffered

[354] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.13.
[355] MCFD, *Manual of Operations – Youth Custody Programs*, 2018, D.7.12.

critical injuries or harm during periods of separate confinement while in youth custody and that their individual cases should be reviewed by the Public Guardian and Trustee retrospectively. Moreover, the risk of harm posed by separate confinement warrants a report being provided to the PGT each time a youth for whom the PGT is property guardian is separately confined while in custody. We have therefore recommended that the ministry provide the PGT with reports about the separate confinement of youth who are in the continuing care of the ministry so that the PGT may review and consider those reports in accordance with their mandate.

**Finding 13:** The processes for authorizing and reauthorizing separate confinement decisions in the *Youth Custody Regulation* and *Manual of Operations – Youth Custody Programs* are not procedurally fair because:

- the provincial director is not sufficiently independent from the custody centres
- the provincial director is required to review their own decision in deciding whether to continue separate confinement beyond 48 hours, and
- the decision maker rarely hears from the youth before making a decision

**Finding 14:** The existing processes for reviewing separate confinement decisions are not sufficient to safeguard against the overuse or inappropriate use of separate confinement.

**Recommendation 21:** By April 1, 2022, the Minister of Children and Family Development recommend to the Lieutenant Governor in Council that the *Youth Custody Regulation* be amended to establish an independent review body for all separate confinement decisions that:

a) is separate from the Ministry of Children and Family Development

b) receives notification of every decision to separately confine a youth, and

c) reviews compliance with the laws, policies and procedures that govern the use of separate confinement and specifically,

i. has the power to order that a youth be released from separate confinement

ii. ensures that no youth is separately confined for longer than 22 consecutive hours

iii. ensures that no youth is separately confined for more than the maximum number of times in a specified period.

**Recommendation 22:** By July 1, 2021, the Ministry of Children and Family Development develop a policy to:

a) seek the prior consent of youth in custody to immediately notify a parent or guardian of their placement in separate confinement, and

b) if the youth is in care under the *Child, Family and Community Service Act,* immediately notify their social worker of the placement.

**Recommendation 23:** By July 1, 2021, the Ministry of Children and Family Development, in consultation with the Representative for Children and Youth (RCY), develop a policy and process for reporting to the RCY about each instance of the use of separate confinement in youth custody.

**Recommendation 24:** By July 1, 2021, the Ministry of Children and Family Development provide the Public Guardian and Trustee (PGT) with information about the separate confinement for longer than 22 hours, since 2017, of any youth for whom the PGT is still property guardian, for the purpose of allowing the PGT to assess whether any of these youth have a legal claim in relation to their separate confinement.

**Recommendation 25:** By July 1, 2021, the Ministry of Children and Family Development, in consultation with the Public Guardian and Trustee (PGT), develop a policy and process for reporting to the PGT about each instance of the use of separate confinement in youth custody where the PGT is property guardian of that youth.

# 8. SYSTEMIC OVERSIGHT OF SEPARATE CONFINEMENT: INSPECTIONS

By their nature, custody centres are closed environments and little is known publicly about their operations. Regular, independent inspections are one way in which custody centres can be held accountable for their operations and the public can be assured that a closed facility is operating properly.

The federal *Youth Criminal Justice Act* recognizes that addressing the developmental challenges and needs of young people is a shared social responsibility.[356] Having a criminal justice system that "fosters responsibility and ensures accountability through meaningful consequences and effective rehabilitation"[357] is particularly important in the operation of youth custody centres. There is a societal interest in ensuring that youth custody centres are run in accordance with the law and in a way that protects the health and safety of youth in custody.

Inspections can, in theory, provide systemic oversight of these questions. The *Youth Justice Act* requires the ministry to establish a process for inspections of youth custody centres "on a periodic basis that the minister considers appropriate in the circumstances."[358] While the Act gives the minister significant leeway to determine the timing of inspections, we would expect that "periodic" inspections of youth custody centres will occur with some predetermined frequency.

An inspector appointed under the Act has significant powers to carry out their role. These powers include the ability to access the centre, to conduct investigations, to compel individuals to provide records and to subpoena individuals and obtain evidence under oath.[359]

## 8.1 Investigation and Standards Office inspections

The 2011 Memorandum of Understanding between the Ministry of Children and Family Development and the Investigation and Standards Office establishes that the ISO will exercise the inspection function set out in the *Youth Justice Act.*[360]

The MOU provides that a team composed of ISO inspectors and youth custody staff will conduct inspections of youth custody facilities. According to the MOU, an expert team would focus on inspections in "critical, high risk" areas, including separate confinement and the use of force and restraints. As set out in the MOU, inspections are intended to be a quality assurance exercise that identifies both positive practices and areas for improvement. Inspections are expected to involve a "peer

[356] *Youth Criminal Justice Act*, S.C. 2002, c. 1, Preamble.
[357] *Youth Criminal Justice Act*, S.C. 2002, c. 1, Preamble.
[358] *Youth Justice Act*, S.B.C. 2003, c. 85, s. 37(1).
[359] *Youth Justice Act*, S.B.C. 2003, c. 85, s. 37(3).
[360] Government of British Columbia, "Investigation and Standards Office."

review model" that includes youth custody services employees with specific expertise in the relevant area.

The wording of the MOU indicates that inspections are to be carried out from a risk management perspective rather than using a youth-centred or rights-based inspections model. The MOU states that the "ISO will review YCS's identified risks and risk prevention and management strategies… and [identify] any gaps between expected and actual performance which may expose YCS to unanticipated risk."[361]

Since the MOU was signed in 2011, the ISO has not conducted any inspections. We are not aware of any other inspections of youth custody facilities being conducted during this period.

## 8.2 Accreditation

Both of the youth custody centres in B.C. are accredited by the Council on Accreditation (COA). The COA is a private accreditation body, offering four-year accreditation programs. The Specialized Intervention and Youth Justice Branch of the ministry has been COA-accredited since 2013, with current accreditation valid through the end of October 2021. Youth custody services at BYCS and PGYCS are accredited as part of the accreditation of the branch, as is Youth Forensic Psychiatric Services.

Youth custody centres are not legally required to be accredited. Accreditation is a voluntary process undertaken by the ministry.

The ministry also requires many of its contracted service providers to be accredited. In that context, the ministry describes accreditation as a key strategy to help ensure accountability by "promoting and supporting quality assurance, continuous quality improvement and performance measurement practices."[362] According to the ministry, accredited programs and services "demonstrate that they have an appropriate level of proficiency and are able to continually improve the quality of services being delivered."[363]

Similarly, youth custody services also emphasizes the accreditation process as a tool for continuous improvement. The initial accreditation process takes several months and includes a comprehensive review of policies and practices as well as a site visit that results in a peer review report. Once the accreditation is granted, it is valid for four years. Retaining accreditation requires that the organization demonstrate in an annual report how it continues to maintain the implementation of the accreditation standards.[364]

In connection with the accreditation processes, youth custody services produces quarterly provincial quality improvement (PQI) reports. These reports are prepared by the ministry's Provincial Quality Improvement Committee for the Youth Custody Management Committee in support of youth custody services' strategic goals.[365] The Youth Custody Management Committee submits PQI reports to the COA in support of meeting COA administration, management and service standards.

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[361] Memorandum of Understanding between Youth Custody Services, Ministry of Children and Family Development, and Investigation and Standards Office, Ministry of Attorney General, July 20, 2011, para. 6.

[362] Ministry of Children and Family Development, "Accreditation of Child and Family Service Organizations," https://www2.gov.bc.ca/gov/content/family-social-supports/data-monitoring-quality-assurance/information-for-service-providers/accreditation.

[363] MCFD, "Accreditation."

[364] Council on Accreditation, "Maintenance of Accreditation (MOA) Report Guidelines: Private, Canadian," https://coa.my.salesforce.com/sfc/p/#300000000aAU/a/500000000B4R/laY.c8DkFSqZaHweu6V1pw2wD2TnHjgtF8OaJxG3yPI.

[365] Ministry of Children and Family Development, Youth Custody Services, *Performance and Quality Improvement Plan*, August 2018; MCFD, Youth Custody Services, *Strategic Plan 2017/18–2019/20*, 11–17.

PQI reports are intended to serve as a foundation for continuous improvement by regularly identifying, reviewing and helping to address emerging issues and priorities, as well as by making and reviewing recommendations.[366]

The reports include quantitative and qualitative data regarding a range of quality measures relating to average daily count and profile of youth in custody, youth injuries, complaints, incident reports, code issued, separate confinement and use of restraint reviews.[367]

Although these sections are standard in PQI reports, the information in each section varies from one PQI report to the next. While we appreciate that there is a need for flexibility in terms of the scope of information covered by PQI reports, the variation in information contained in PQI reports makes it difficult to track benchmarked service, quality, performance and youth demographic indicators over time.

PQI reports include data on the use of separate confinement, including the aggregate number of separate confinement placements per youth custody centre and quarterly totals and either aggregate or disaggregate data for the percentage of separate confinement placements of youth according to Indigeneity, sex and sometimes gender.

PQI reports also include a file review section that contains four quality measures:

- quality of files, presence, clarity and continuity of documentation
- youth's service needs addressed and linked to assessments
- presence of release planning, when applicable
- youth is supported by the Crisis Prevention Model (TCI) and Trauma-Informed Behaviour Support Model (TIBS)

However, we observed that these sections of the PQI reports were frequently left blank.[368] The absence of any content in these sections is particularly concerning as it raises important questions about whether and how the ministry is auditing compliance with these quality standards, especially the use of trauma-informed behaviour supports.

One of the reasons why the COA recommends accreditation is to demonstrate compliance with regulation, law or judicial orders. It states that "in many places, accreditation can be used as a tool to fulfill regulatory requirements and reduce duplication of oversight."[369] According to the COA, regulators use COA accreditation as an oversight or regulatory tool.[370]

## 8.3 Analysis: Systemic oversight

Regular, independent inspections of custody centres are crucial to maintaining system-level oversight of the operation of these facilities. Rather than focusing on individual decisions, inspections can identify trends and patterns in the use of interventions like separate confinement and recommend improvements. Inspections can also look systemically at how well youths' rights are being protected in separate confinement decisions. As described earlier, there is a significant societal interest in ensuring that custody centres are

[366] MCFD, Youth Custody Services, *Performance and Quality Improvement Plan*, 6.
[367] MCFD, Youth Custody Services, PQI Report, FY 16/17 Q4–FY 19/20 Q3.
[368] MCFD, Youth Custody Services, PQI Report, FY 16/17 Q4–FY 17/18 Q3, FY 18/19 Q1–FY 19/20 Q3.
[369] Council on Accreditation, "Why Become Accredited?" https://coanet.org/why-accreditation/.
[370] Council on Accreditation, "Regulator Recognition," https://coanet.org/regulator-recognition/.

carrying out their mandate effectively and in accordance with the law. Inspections are an important part of that oversight. An inspector has important powers under the *Youth Justice Act* to subpoena witnesses and examine them under oath, and to compel the production of documents.

The Mandela Rules, which include internationally accepted standards on the conduct of inspections of correctional facilities, speak to the value of independent inspections.[371] They set out three basic principles for inspections of correctional facilities:

- The responsible authority must develop a system of inspections focused on ensuring compliance with applicable laws and the protection of the rights of prisoners that has an internal (administrative) component and an external, independent component.
- Inspectors have the authority to determine where and when to conduct their inspections, to meet with prisoners confidentially, and to make recommendations for improvement.
- All inspections are followed by a written report to the prison administration, and consideration should be given to making the reports public. The prison administration should indicate whether they will implement any recommendations flowing from the external inspections.[372]

The *Youth Justice Act* requires inspections of youth custody centres. The 2011 MOU between the ISO and the ministry was an important first step in implementing inspections.[373] However, the process it describes falls short in two key ways.

First, and most significantly, the ministry has failed to ensure that any inspections occurred in the intervening nine years. In this, the ministry has failed to live up to its legislative obligations. The requirement in section 37 of the *Youth Justice Act* is not a mere guideline; rather, it is part of the set of legal responsibilities that government has toward youth in custody. Youth in custody and the public are entitled to expect that the ministry will live up to those obligations.[374]

Second, while the ISO is part of the Ministry of Attorney General and intended to be independent from the Ministry of Children and Family Development, the MOU provided that the inspection framework would be "designed and developed by" youth custody and that youth custody employees would be involved in conducting inspections.[375] As such, even if the inspection process contemplated in the MOU did occur, it would not be independent and, therefore, would be inconsistent with the principles articulated in the Mandela Rules.

As described in section 8.2, the ministry has sought, and maintained, external accreditation of its youth custody centres. However, this process is not a substitute for the legislated

[371] The Mandela Rules are being used to inform the development of a new inspections model for adult corrections in B.C.: see Office of the Ombudsperson, "Investigative Update: BC's Correctional Facilities Adopt New Inspections Framework Following Ombudsperson's Recommendations – But Not Yet Complying with International Standards," news release, September 6, 2018, https://bcombudsperson.ca/news_release/investigative-update-b-c-s-correctional-facilities-adopt-new-inspections-framework-following-ombudspersons-recommendations-but-not-yet-complying-with-international-standar/.

[372] UN Office on Drugs and Crime, Standard Minimum Rules for the Treatment of Prisoners, Rules 83–85.

[373] MOU, Youth Custody Services and Investigation and Standards Office.

[374] For a similar discussion in the adult corrections context, see Office of the Ombudsperson, *Under Inspection: The Hiatus in BC Correctional Centre Inspections*, June 2016, https://bcombudsperson.ca/assets/media/Special-Report-No-38-Under-Inspection-The-Hiatus-in-B.C.-Correctional-Centre-Inspections.pdf. The inspection provisions in the adult *Correction Act* and in the *Youth Justice Act* are functionally identical, and so the principles discussed in that report in relation to the legal requirement to conduct inspections are equally applicable in the youth custody context.

[375] MOU, Youth Custody Services and Investigation and Standards Office, para. 5.

obligation to conduct inspections, and cannot be used to meet this obligation, for the following reasons.

The law is clear that inspection – not accreditation – is required. The standards by which the youth custody centres' accreditation is evaluated are established by a private company that is not directly publicly accountable. Moreover, the essential components of inspections as described in the Mandela Rules – independent inspectors with legislated powers, in-person inspections that include meetings with incarcerated people, and written reports with recommendations – are not part of the accreditation process. After the initial accreditation site visit, there is no requirement for further site visits during the next four years. Similarly, the reports that the ministry submits in support of its accreditation are lacking in key areas that we would expect to be part of an inspection – in particular, the compliance reviews of individual youth files.

Oversight mechanisms can exist in tandem and can be mutually supportive, rather than duplicative. We are not suggesting that accreditation is meaningless. The processes that accreditation requires are an important part of how the ministry evaluates the operations of its youth custody centres; the accreditation reports can be considered as part of the inspection process. However, it is not up to the ministry to decide whether or not to follow its legal obligation to conduct inspections, or to choose a different oversight process than that provided for in the legislation. Youth in custody are better protected when there are various mechanisms of oversight in place.

For these reasons, we have recommended that the ministry commit to conducting independent inspections of B.C. youth custody centres, in accordance with its legal obligations, and that those inspections incorporate the principles set out in the Mandela Rules.

**Finding 15:** The Ministry of Children and Family Development has failed to comply with its obligation under section 37(1) of the *Youth Justice Act* to provide for the inspection of each youth custody centre.

**Finding 16:** The inspection process contemplated in the Memorandum of Understanding does not meet the minimum standards set out in the Mandela Rules.

**Recommendation 26:** By October 1, 2021, and in accordance with section 37(1) of the *Youth Justice Act,* the Ministry of Children and Family Development develop and implement a process for inspections of youth custody centres that expressly incorporates the standards set out in Rules 83–85 of the Mandela Rules by:

- establishing a process for conducting regular internal inspections of each youth custody centre
- establishing a team of independent inspectors that includes experts in youth development and trauma-informed practice to conduct regular inspections of each youth custody centre
- ensuring that inspections focus primarily on legislative compliance and matters related to the health, safety and human rights of youth in custody, including separate confinement and the use of force, and
- including a mechanism for reporting in writing on the outcome of inspections and for following up on the implementation of any resulting recommendations

# APPENDICES

## Appendix A: Findings and Recommendations

### Findings

| Conditions of Separate Confinement | |
|---|---|
| 1 | It is unreasonable to require youth in separate confinement to communicate with mental health clinicians through the slot in the door of their separate confinement room. |
| 2 | The repeated use of force against youth while separately confined including the forcible removal of clothing was oppressive. |

| Duration of Separate Confinement | |
|---|---|
| 3 | Section 15.1 of the *Youth Justice Regulation* is unjust because it does not establish a specific time limit on the duration of separate confinement and, as a result, youth have been separately confined for prolonged periods of time. |

| Disproportionate impacts of prolonged separate confinement | |
|---|---|
| 4 | Prolonged periods of separate confinement in response to self-injury were experienced disproportionately by individual female, Indigenous and racialized youth. The decisions to separately confine these youth for prolonged periods were unjust because Indigenous youth, female youth and youth living with a mental illness are disproportionately exposed to the harms caused by separate confinement. |
| 5 | The *Youth Justice Act, Youth Custody Regulation* and *Manual of Operations – Youth Custody Programs* fail to address the actual needs and capacities of Indigenous youth and, in this way, perpetuate or exacerbate those youths' disadvantages. |
| 6 | Youth were separately confined in response to self-injuring and suicidal behaviour because there were no reasonable alternatives for responding to their needs. Because it perpetuates existing trauma and causes further harm, this use of separate confinement was oppressive. |

| Prolonged separate confinement of youth suspected of concealing contraband | |
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| 7 | The prolonged separate confinement of youth suspected of concealing contraband is unreasonable, considering the known harms of prolonged separate confinement and the availability of alternative non-invasive technologies that can assist in determining whether a youth is concealing contraband. |

| Review and oversight of individual separate confinement decisions | |
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| *Youth "temporarily housed alone"* | |
| **8** | The "temporarily housed alone" policy permits the separate confinement of youth for a reason that is not set out in the *Youth Custody Regulation* and without the authorization and documentation required for every instance of separate confinement. In cases where there are other youth in the centre, this constitutes an unlawful use of separate confinement. |
| *Unauthorized and undocumented separate confinement* | |
| **9** | Between July 1, 2017, and June 30, 2018, staff at Burnaby Youth Custody Services Centre separately confined two youth without the authorization and documentation required by the *Youth Custody Regulation* and *Manual of Operations – Youth Custody Programs*. This constitutes an arbitrary use of separate confinement. |
| *Considering the views of youth in separate confinement decisions* | |
| **10** | The *Youth Custody Regulation* is procedurally unfair because it does not ensure that a separate confinement decision maker always hears from youth, or always provides them with an opportunity to be heard, before deciding whether to authorize or reauthorize a separate confinement decision. |

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| *Complaints about separate confinement* | |
| **11** | Youth who are separately confined do not use the internal complaint process to challenge their separate confinement placement or the conditions of separate confinement. The internal complaints process provides inadequate oversight, given the vulnerability of youth in custody and the risk of harm that can result from the use of separate confinement. |
| *External oversight of individual separate confinement decisions* | |
| **12** | Youth who are separately confined in custody do not contact the Investigation and Standards Office (ISO) to make complaints about their separate confinement placement or the conditions of separate confinement. The current ISO complaints process provides inadequate oversight, given the vulnerability of youth in custody and the risk of harm that can result from the use of separate confinement. |
| **13** | The processes for authorizing and reauthorizing separate confinement decisions in the *Youth Custody Regulation* and *Manual of Operations – Youth Custody Programs* are not procedurally fair because:<br>▪ the provincial director is not sufficiently independent from the custody centres<br>▪ the provincial director is required to review their own decision in deciding whether to continue separate confinement beyond 48 hours, and<br>▪ the decision maker rarely hears from the youth before making a decision |
| **14** | The existing processes for reviewing separate confinement decisions are not sufficient to safeguard against the overuse or inappropriate use of separate confinement. |

| Systemic oversight of separate confinement: Inspections | |
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| 15 | The Ministry of Children and Family Development has failed to comply with its obligation under section 37(1) of the *Youth Justice Act* to provide for the inspection of each youth custody centre. |
| 16 | The inspection process contemplated in the Memorandum of Understanding does not meet the minimum standards set out in the Mandela Rules. |

## Recommendations

| Conditions of Separate Confinement | |
|---|---|
| 1 | By April 1, 2022, the Minister of Children and Family Development propose to the Lieutenant Governor in Council that the *Youth Custody Regulation* be amended to require that staff, including mental health practitioners, make all reasonable efforts to ensure that communication with youth in custody is not mediated by physical barriers, including a door slot. |
| 2 | By October 1, 2021, the Ministry of Children and Family Development conduct an independent review of the use of force in youth custody that includes:<br>a) the collection and analysis of data to understand which youth are most affected by the use of force and the circumstances in which force is used, and<br>b) recommendations to reduce the use of force, including the forcible removal of clothing, and development of alternative models of non-violent de-escalation based in trauma-informed practice and cultural safety. |
| 3 | Within one month of the completion of the use of force review, the Ministry of Children and Family Development provide a copy of the completed review report to our office with a plan for implementing its recommendations. |

| Duration of Separate Confinement | |
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| 4 | By April 1, 2022, the Minister of Children and Family Development propose to the Lieutenant Governor in Council that the *Youth Custody Regulation* be reconsidered by amending the regulation to:<br>a) prohibit the separate confinement of youth in custody for more than 22 consecutive hours, with no exceptions, and<br>b) establish a maximum number of times that a youth can be separately confined within a specified period, with no exceptions. |
| 5 | By July 1, 2021, the Ministry of Children and Family Development:<br>a) implement a process for collecting and publicly reporting on an annual basis data on the use of separate confinement in youth custody, including the frequency and duration of instances of separate confinement, and<br>b) develop a framework for public reporting that includes the collection, use and disclosure of disaggregated demographic data in relation to separate confinement and ensures that appropriate processes of Indigenous data governance are followed throughout required data acquisition, access, analysis and reporting. |

| Disproportionate impacts of prolonged separate confinement | |
|---|---|
| 6 | By April 1, 2022, the Minister of Children and Family Development reconsider the *Youth Justice Act* by introducing legislation to amend the Act to require consideration of the social history of Indigenous youth for all decisions made about them while in custody. |
| 7 | By July 1, 2022, the Ministry of Children and Family Development develop a policy framework in consultation with the B.C. First Nations Justice Council to support implementation of the legislative changes described in Recommendation 6. |
| 8 | By April 1, 2022, the Minister of Children and Family Development propose to the Lieutenant Governor in Council that the *Youth Custody Regulation* be amended to prohibit the use of separate confinement of youth who are especially vulnerable to the harms of separate confinement, including those under the age of 16 years and those with complex mental health needs. |
| 9 | By April 1, 2022, the ministry develop and implement a policy framework to assess and identify youth who should not be separately confined because they are especially vulnerable to the harms of separate confinement. |
| 10 | By July 1, 2022, Youth Justice Services develop and implement culturally safe, trauma-informed supportive alternatives to separate confinement for youth that include:<br>a) staff with training and expertise in mental health, trauma-informed practices and youth development<br>b) structured activities and access to programming, school and skills training<br>c) meaningful social contact<br>d) access to counselling and behaviour therapy and other mental health services, and<br>e) cultural, religious and spiritual support. |
| 11 | By July 1, 2024, the Ministry of Children and Family Development complete an independent review by an expert in trauma-informed practices of the changes made in response to Recommendation 10, and implement any resulting recommendations by September 1, 2024. |

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| **12** | By October 1, 2021, the Ministry of Children and Family Development complete an independent review of the Independent Observation Unit that applies trauma-informed principles in recommending physical changes to the unit to ensure that it is safe and allow it to support the delivery of trauma-informed and culturally safe services. The ministry is to implement the resulting recommendations by March 31, 2022. |
| **13** | By July 1, 2021, the Minister of Children and Family Development propose to the Lieutenant Governor in Council to designate as a place of secure custody for the purpose of the *Youth Criminal Justice Act* and the *Young Offenders Act* one or more secure youth psychiatric facilities that are equipped to provide trauma-informed, culturally safe treatment for youth with complex mental health needs. |
| **14** | By April 1, 2022, the Minister of Children and Family Development reconsider the *Youth Justice Act* by introducing amendments to the Act to require that youth in custody with complex mental health needs be transferred to a designated youth psychiatric facility. |
| **15** | At the same time as the amendments in Recommendation 14 come into force, the Ministry of Children and Family Development implement a policy and procedures for ensuring that youth with complex mental health needs are identified on admission and transferred to a designated facility. |

| Prolonged separate confinement of youth suspected of concealing contraband | |
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| 16 | By the date on which the body scanner is operational, the Ministry of Children and Family Development:<br>a) establish a policy on when and how to use the body scanner, including a requirement for staff to document each use of the body scanner to detect suspected contraband, and develop and implement a standard form for this purpose, and<br>b) ensure that staff are appropriately trained in the use of the body scanner and interpretation of results. |
| 17 | One year after the body scanner begins operating, the Ministry of Children and Family Development provide our office with a report that assesses whether the body scanner has reduced the use of separate confinement for suspected contraband at Burnaby Youth Custody Services Centre and, if not, what additional steps will be implemented to reduce the use of separate confinement because of suspected contraband. |

| Review and oversight of individual separate confinement decisions | |
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| **18** | By April 1, 2022, the Minister of Children and Family Development propose to the Lieutenant Governor in Council that the *Youth Custody Regulation* be amended to establish a legal framework that applies to youth who are housed alone for operational reasons and that, at a minimum:<br>a) requires staff to ensure that these youth have meaningful human contact<br>b) requires staff to immediately implement alternatives to isolation<br>c) requires staff to document cases where youth are housed alone for operational reasons, and<br>d) establishes a process for authorizing and reviewing such placements that is equivalent to the review process for youth who are separately confined in other circumstances. |
| **19** | By October 1, 2021, Youth Justice Services develop and implement a policy identifying and requiring the use of<br>a) alternatives to isolation for female youth who are separately confined solely because they are the only female youth in custody at that time, and<br>b) cultural supports, including the development of a program to connect Indigenous female youth with specially trained Indigenous Elders to provide ongoing support, encouragement and care during separate confinement |
| **20** | By October 1, 2021, Youth Justice Services revise the *Manual of Operations – Community Youth Justice Services*, to acknowledge the significant risk of psychological harm caused by being housed alone in custody and require community probation officers to:<br>a) identify when specific youth are living alone or are likely to be housed alone for operational reasons, and<br>b) communicate this to the court in relevant pre-trial proceedings, including bail hearings, reviews of detention orders, consideration of Indigenous social history (Gladue reports and reviews) and pre-sentence proceedings. |

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| **21** | By April 1, 2022, the Minister of Children and Family Development recommend to the Lieutenant Governor in Council that the *Youth Custody Regulation* be amended to establish an independent review body for all separate confinement decisions that:<br>a) is separate from the Ministry of Children and Family Development<br>b) receives notification of every decision to separately confine a youth, and<br>c) reviews compliance with the laws, policies and procedures that govern the use of separate confinement and specifically,<br>i. has the power to order that a youth be released from separate confinement<br>ii. ensures that no youth is separately confined for longer than 22 consecutive hours<br>iii. ensures that no youth is separately confined for more than the maximum number of times in a specified period. |
| **22** | By July 1, 2021, the Ministry of Children and Family Development develop a policy to:<br>a) seek the prior consent of youth in custody to immediately notify a parent or guardian of their placement in separate confinement, and<br>b) if the youth is in care under the *Child, Family and Community Service Act*, immediately notify their social worker of the placement. |
| **23** | By July 1, 2021, the Ministry of Children and Family Development, in consultation with the Representative for Children and Youth (RCY), develop a policy and process for reporting to the RCY about each instance of the use of separate confinement in youth custody. |
| **24** | By July 1, 2021, the Ministry of Children and Family Development provide the Public Guardian and Trustee (PGT) with information about the separate confinement for longer than 22 hours, since 2017, of any youth for whom the PGT is still property guardian, for the purpose of allowing the PGT to assess whether any of these youth have a legal claim in relation to their separate confinement. |

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| **25** | By July 1, 2021, the Ministry of Children and Family Development, in consultation with the Public Guardian and Trustee (PGT), develop a policy and process for reporting to the PGT about each instance of the use of separate confinement in youth custody where the PGT is property guardian of that youth. |

## Systemic oversight of separate confinement: Inspections

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| **26** | Recommendation 26: By October 1, 2021, and in accordance with section 37(1) of the *Youth Justice Act*, the Ministry of Children and Family Development develop and implement a process for inspections of youth custody centres that expressly incorporates the standards set out in Rules 83–85 of the Mandela Rules by:<br>■ establishing a process for conducting regular internal inspections of each youth custody centre<br>■ establishing a team of independent inspectors that includes experts in youth development and trauma-informed practice to conduct regular inspections of each youth custody centre<br>■ ensuring that inspections focus primarily on legislative compliance and matters related to the health, safety and human rights of youth in custody, including separate confinement and the use of force, and<br>■ including a mechanism for reporting in writing on the outcome of inspections and for following up on the implementation of any resulting recommendations. |

# Appendix B: Response from the Ministry of Children and Family Development

BRITISH COLUMBIA

**VIA E-MAIL**

May 19, 2021 File SYS17-1008; 259764

Jay Chalke
Ombudsperson
E-mail: ABockus-Vanin@bcombudsperson.ca

Dear Jay Chalke:

I am writing in reply to your letter of April 28, 2021, regarding your request for a formal response to the recommendations in your report on Separate Confinement in BC Youth Custody. I would like to start by thanking you and your staff for the report highlighting the significant impacts of separately confining youth, alternatives to the use of the practice, ways of building a culturally supportive and trauma-informed system, better protections for youth, and measures for strengthening oversight and quality assurance with respect to the practice. The Ministry of Children and Family Development (MCFD) has carefully reviewed the insights, findings and recommendations of your report, and I am pleased to provide this response summarizing our work to date and our commitment to continue to significantly improve services to youth in custody in British Columbia.

Although separate confinement is used as a last resort to protect the safety of the youth or others in custody, it can be traumatizing and has significant risks for the vulnerable youth we serve. As your report points out, the ministry has reduced the use of separate confinement by 85 percent in the past four years as well as introduced several other changes to improve youth custody services. However, we clearly have more work to do to create a trauma-informed model within youth custody centres and build in better protections for youth, quality assurance and oversight processes. As we have discussed, my staff and I are committed to this.

Your report found instances where youth were placed in separate confinement for extended periods of time and instances where youth had their clothes forcibly removed. I found these practices deeply disturbing and painful to read. They have no place in a trauma informed model and I have been assured that staff have recently issued a policy directive to make it clear such practices can never happen.

I want to assure you that I and MCFD are in agreement with the spirit and intent of the report's findings, that we will endeavour to implement every recommendation in your report and, if there are any that we cannot implement through the means you have described, we will achieve the goal and intent of that recommendation. Below you will find our detailed response to each recommendation including work to date and next steps.

…/2

Ministry of Children and Family Development
Office of the Minister
Mailing Address: Parliament Buildings Victoria BC V8V 1X4
Location: Parliament Buildings Victoria

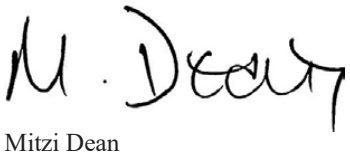
Since your office commenced its investigation in 2017, there have been many changes in youth custody services, including the following actions:

- separate confinement is no longer used as a punitive measure (discipline has been removed from the *Youth Custody Regulation* as a rationale for separate confinement);
- changes to Youth Custody Services Policy (for example, we strengthened language for review and authorization requirements, included language that reflects trauma-informed care, and enhanced documentation requirements);
- implementation of the Trauma-Informed Behaviour Support model. This model considers the individual needs of each youth when developing plans to support the youth, both while in custody and upon return to the community. Training for Youth Custody Services staff on the model has been implemented and includes Therapeutic Crisis Intervention, physical and mechanical restraint, and policy and procedures for enhanced support of the youth in separate confinement. There is an emphasis on using the least intrusive and restrictive method of interacting with youth;
- emphasis on therapeutic programming, services and support: to provide consistency in service, Youth Forensic Psychiatric Services are the sole provider of mental health supports for youth in custody. Other therapeutic programming and support includes the enhancement of substance use services to improve continuity of care; art and music therapy; and animal assisted intervention;
- improvement in the quality assurance associated with documentation. This includes the implementation of planned and random reviews of separate confinement paperwork by directors and the Provincial Director and follow up with staff where appropriate; and,
- significant and rapid reduction of the instances of separate confinement. Excluding COVID-19 admissions to separate confinement, the instances of separate confinement have declined from 94 in FY 2017/18 to 14 in FY 2020/21, a decrease of 85 percent.

Building on the work to date, the ministry is developing a Youth Justice Service Framework to improve youth custody services in British Columbia. This Framework provides the opportunity to modernize youth justice services by identifying priorities, focusing on best practices, enhancing existing services, and allocating youth justice resources to better support youth and their families. Developing a service Framework will ensure youth justice services are aligned with the 2019 *Youth Criminal Justice Act* amendments and will provide opportunities to victims, communities, and human services professionals to be involved in shaping youth justice services in British Columbia. Consistent with our commitment to Indigenous reconciliation, development of the Framework will include consultation with First Nations, Métis, and Inuit peoples.

In conclusion, the ministry has made significant changes to its approach to youth custody, youth justice, and separate confinement since the Ombudsperson initiated its review in 2017 and we have more work to do. The recommendations of your report will be incorporated into the Youth Justice Framework with a commitment to address them as it is implemented. I look forward to reporting our progress on implementing the recommendations as we, in collaboration with our Indigenous partners, build towards a more responsive, culturally supportive and trauma-informed system.

Sincerely,



Mitzi Dean
Minister of Children and Family Development

Appendix- Response to Recommendations

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| ***Recommendation 1*** | *By April 1, 2022, the Minister of Children and Family Development propose to the Lieutenant Governor in Council that the Youth Custody Regulation be amended to require that staff, including mental health practitioners, make all reasonable efforts to ensure that communication with youth in custody is not mediated by physical barriers, including a door slot.* |
| **Response** | This recommendation involves amendments to regulations and, therefore, requires significant consultation with Indigenous communities, Indigenous Governing Bodies, and other partners. We agree to start the consultation process and incorporate feedback into our service framework.<br><br>In the meantime, we will amend policy to require that all efforts be made to remove barriers to support communication with youth in a safe and trauma informed manner.<br><br>Timeline needed to complete: Policy amended and implemented by September 1, 2021. Consultation on amending regulations by December 2022. |

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| ***Recommendation 2*** | *By October 1, 2021, the Ministry of Children and Family Development conduct an independent review of the use of force in youth custody that includes:*<br>*a) The collection and analysis of data to understand which youth are most affected by the use of force and the circumstances in which force is used, and*<br>*b) Recommendations to reduce the use of force including the forcible removal of clothing, including the development of alternate models of non-violent de-escalation based in trauma-informed practice and cultural safety.* |
| **Response** | The ministry accepts this recommendation and will commit to implement it by June 30, 2022.<br><br>The practice of forceful removal of clothing was officially ended on May 18, 2021 when a directive was issued to all staff requiring that a trauma informed approach be utilized in circumstances when youth must be given safer clothing due to an imminent risk of suicide. |

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| ***Recommendation 3*** | *Within one month of the completion of the use of force review, the ministry provide a copy of the completed review report to our office with a plan for implementing its recommendations.* |
| **Response** | The ministry accepts this recommendation and will commit to implement it by September 30, 2022. |

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| ***Recommendation 4*** | *By April 1, 2022, the Minister of Children and Family Development propose to the Lieutenant Governor in Council that the Youth Custody Regulation be reconsidered by amending the regulation to:* |

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| | *a) Prohibit the separate confinement of youth in custody for more than 22 consecutive hours, with no exceptions, and*<br>*b) Establish a maximum number of times that a youth can be separately confined within a specified time frame, with no exceptions.* |
| **Response** | This recommendation involves amendments to regulations and, therefore, requires significant consultation with Indigenous communities, Indigenous Governing Bodies, and other partners. We agree to start the consultation process and incorporate feedback into our service framework.<br><br>The ministry will complete the consultation and incorporate feedback into our service framework by December 2023.<br><br>In the meantime, we commit to amending policy limiting the duration within an individual separate confinement room to a maximum of 22 hours. We have already reduced the instances of separate confinement by 85% and, for safety reasons, we cannot commit to a cap on the number of times that a youth can be separately confined.<br><br>This policy will be implemented by September 1, 2021. |

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| ***Recommendation 5*** | *By July 1, 2021, the Ministry of Children and Family Development will*<br>*a) Implement a process for collecting and publicly reporting on an annual basis data on the use of separate confinement in youth custody, including the frequency and duration of instances of separate confinement.*<br>*b) Develop a framework for public reporting that includes the collection, use and disclosure of disaggregated demographic data in relation to separate confinement and ensures that appropriate processes of Indigenous data governance are followed throughout required data acquisition, access, analysis and reporting.* |
| **Response** | The ministry accepts this recommendation and will commit to complete it by June 30, 2022.<br><br>To date the ministry has established a process for collecting and reporting on the use of separate confinement. This is done through our risk management reports. These reports have not been made public in years past due to operational safety and security concerns. The ministry will review and implement options for distribution of information publicly that would not pose a safety risk to youth custody centres. |

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| ***Recommendation 6*** | *By April 1, 2022, the Minister of Children and Family Development reconsider the Youth Justice Act by introducing legislation to amend the Act to require consideration of the social history of Indigenous youth for all decisions made about them while in custody.* |
| **Response** | This recommendation involves amendments to legislation and, therefore, requires significant consultation with Indigenous communities, Indigenous Governing Bodies, and other partners. We agree to start the consultation process and incorporate feedback into our service framework. |

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| | Ministry policy requires that a social history of Indigenous youth in custody be gathered and inform all decisions made about that youth.<br><br>The ministry will also develop a trauma informed protocol for youth on separate confinement that will exist as a standalone policy within the youth custody manual to ensure separate confinement is only used with vulnerable youth as a last resort and is not continued long term without clear justification.<br><br>The ministry will complete the consultation and incorporate feedback into our service framework by December 2023. |

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| ***Recommendation 7*** | *By July 1, 2022, the Ministry of Children and Family Development develop a policy framework in consultation with the B.C. First Nations Justice Council to support implementation of the legislative changes described in Recommendation 6 above.* |
| **Response** | MCFD is committed to working with the BC First Nations Justice Council to address the strategies outlined in the Indigenous Justice Strategy. This recommendation requires significant consultation with Indigenous Communities, and other Indigenous Governing Bodies.<br><br>The ministry has held discussions with BC First Nations Justice Council Members to support the implementation of the Indigenous Justice Strategy within Youth Justice to modernize youth justice to support long term cultural safety and to address the over representation of Indigenous Youth in Custody.<br><br>Work has begun on a Youth Justice Service Framework involving consultation with the Indigenous communities (First Nation, Métis, and Inuit) and Indigenous governing bodies as required by DRIPA.<br><br>The feedback from these consultations will be incorporated into the service framework by December 2023. |

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| ***Recommendation 8*** | *By April 1,2022, the Minister of Children and Family Development propose to the Lieutenant Governor in Council that the Youth Custody Regulation be amended to prohibit the use of separate confinement of youth who are especially vulnerable to the harms of separate confinement, including those under the age of 16 years and those with complex mental health needs.* |
| ***Response*** | This recommendation involves amendments to regulations and, therefore, requires significant consultation with Indigenous communities, Indigenous Governing Bodies, and other partners. We agree to start the consultation process and incorporate feedback into our service framework.<br><br>The ministry will complete the consultation and incorporate feedback into our service framework by December 2023.<br><br>In the meantime we will develop a trauma informed protocol for youth on |

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| | separate confinement that will exist as a standalone policy within the youth custody manual to ensure separate confinement is only used with vulnerable youth as a last resort and is not continued long term without clear justification.<br><br>Policy will be amended by June 2023. |

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| ***Recommendation 9*** | *By April 1, 2022, the ministry develop and implement a policy framework to assess and identify youth who should not be separately confined because they are especially vulnerable to the harms of separate confinement* |
| **Response** | The ministry accepts this recommendation and will commit to complete it by June 30, 2023.<br><br>To date policy has been developed year over year to support the needs of all youth in the care of youth custody services. This policy is revisited yearly (or more frequently as required). |

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| ***Recommendation 10*** | *By July 1, 2022, Youth Justice Services develop and implement culturally safe, trauma-informed supportive alternatives to separate confinement for youth that includes*<br>*a) Staff with training and expertise in mental health, trauma informed practices, and youth development*<br>*b) Structured activities and access to programming, school and skills training*<br>*c) Meaningful social contact*<br>*d) Access to counselling and behaviour therapy and other mental health services*<br>*e) Cultural, religious and spiritual support* |
| **Response** | The ministry accepts this recommendation and will commit to complete it by June 30, 2022.<br><br>To date there has been an implementation of a trauma informed behaviour support model. This model considers the individual needs of each youth, including those in separate confinement, when developing plans to support the youth both while in custody and upon return to the community. |

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| ***Recommendation 11*** | *By July 1, 2024, the Ministry of Children and Family Development complete an independent review by an expert in trauma-informed practices of the changes made in response to recommendation 10, above, and implement any resulting recommendations by September 1, 2024.* |
| **Response** | The ministry accepts this recommendation and will commit to complete it by July 1, 2024.<br><br>Since the introduction of Trauma Informed Practices we have seen a reduction in separate confinement, use of force and violent incidents which we attribute to these practices. To date independent reviews are conducted through our |

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| | accreditation process every 5 years. The accreditation body is comprised of experts in child and youth care and have backgrounds in trauma-informed services. |

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| ***Recommendation 12*** | *By October 1, 2021, the Ministry of Children and Family Development complete an independent review of the IOU that applies trauma-informed principles to recommend physical changes to the unit to ensure it is safe and allows it to support delivery of the trauma-informed and culturally safe services.*<br><br>*The ministry implements the resulting recommendations by March 31, 2022.* |
| **Response** | The ministry accepts this recommendation and will commit to complete it by June 30, 2022.<br><br>To date facility changes require significant collaboration with other branches of the government. |

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| ***Recommendation 13*** | *By July 1, 2021, the Minister of Children and Family Development propose to the Lieutenant Governor in Council to designate as a place of secure custody for the purpose of the Youth Criminal Justice Act and the Young Offenders Act one or more secure youth psychiatric facilities that are equipped to provide trauma informed, culturally safe treatment to youth with complex mental health needs.* |
| **Response** | This recommendation involves amendments to regulations and, therefore, requires significant consultation with Indigenous communities, Indigenous Governing Bodies, and other partners. We agree to start the consultation process and incorporate feedback into our service framework.<br><br>The feedback from these consultations will be incorporated into the service framework by December 2023. |

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| ***Recommendation 14*** | *By April 1, 2022, the Minister of Children and Family Development reconsider the Youth Justice Act by introducing amendments to the Act to require that youth in custody with complex mental health needs to be transferred to a designated youth psychiatric facility* |
| **Response** | This recommendation involves amendments to legislation and, therefore, requires significant consultation with Indigenous communities, Indigenous Governing Bodies, and other partners. We agree to start the consultation process and incorporate feedback into our service framework.<br><br>The feedback from these consultations will be incorporated into the service framework by December 2023. |

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| ***Recommendation 15*** | *At the same time as the amendments in Recommendation 14 come into force, the Ministry of Children and Family Development implement a policy and procedures for ensuring that youth with complex mental health needs are identified on admission and transferred into a designated facility* |

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| **Response** | This recommendation is linked to recommendation 14 which requires amendments to legislation and, therefore, requires significant consultation with Indigenous communities, Indigenous Governing Bodies and other partners. We agree to start the consultation process and incorporate feedback into our service framework. Policy and procedures developed will be consistent with that feedback.<br><br>The ministry currently has a memorandum of understanding between youth custody services, youth forensics psychiatric services and other youth justice partners to support those with emerging mental health needs detained in custody. We will look for additional opportunities to bridge services from the Inpatient Assessment Unit into youth custody by June 30, 2022 to provide mental health care enhancements. |

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| ***Recommendation 16*** | *By the date on which the body scanner is operational, the Ministry of Children and Family Development*<br>*a) Establish a policy on when and how to use the body scanner, including a requirement for staff to document each use of the body scanner to detect suspected contraband, and develop and implement a standard form for this purpose*<br>*b) Ensure that staff are appropriately trained in the use of the body scanner and interpretation of results.* |
| **Response** | The ministry accepts this recommendation and will commit to complete it by October 31, 2021.<br><br>To date we have sought out and obtained approvals for the installation of a full-body ION scanner. |

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| ***Recommendation 17*** | *One year after the body scanner begins operating, the Ministry of Children and Family Development provide our office with a report that assesses whether the body scanner has reduced the use of separate confinement for suspected contraband at BYCS and if not, what additional steps will be implemented to reduce the use of separate confinement due to suspected contraband.* |
| **Response** | The ministry accepts this recommendation. |

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| ***Recommendation 18*** | *By April 1, 2022, the Ministry of Children and Family Development propose to the Lieutenant Governor in Council that the Youth Custody Regulation be amended to establish a legal framework that applies to youth who are houses alone for operational reasons that, at a minimum:*<br>*a) Requires staff to ensure that these youth have meaningful human contact*<br>*b) Requires staff to immediately implement alternatives to isolation* |

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| | c) *Requires staff to document cases where youth are housed alone for operational reasons*<br>d) *Establishes a process for authorizing and reviewing such placements that is equivalent to the review process for youth who are separately confined in other circumstances* |
| **Response** | This recommendation involves amendments to regulations and, therefore, requires significant consultation with Indigenous communities, Indigenous Governing Bodies, and other partners. We agree to start the consultation process and incorporate feedback into our service framework.<br><br>The ministry will complete the consultation and incorporate feedback into our service framework by December 2023.<br><br>In the meantime, policies for youth who are "living alone" will be reviewed and amendments will be considered to strengthen social interactions and promote meaningful contact.<br><br>We will also commit to a call with the Chief Judge to make judiciary aware that young people may be living alone as well as the low number of youth in custody or have YJ staff share at court where appropriate.<br><br>Policies will be reviewed and amended by September 1, 2021. |

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| ***Recommendation 19*** | *By October 1, 2021 Youth Justice Services develop and implement a policy identifying and requiring the use of*<br>a) *alternatives to isolation for female youth who are separately confined solely because they are the only female youth in custody at that time, and*<br>b) *cultural supports, including the development of a program to connect Indigenous female youth with specially trained Indigenous Elders to provide ongoing support, encouragement, and care during separate confinement.* |
| **Response** | The ministry accepts this recommendation and will commit to complete it by June 30, 2022.<br><br>We currently support cultural connections within custody by having elders work with our youth and will continue to look at options to support youth who are, due to declining counts, the only youth in the building. |

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| ***Recommendation 20*** | *By October 1, 2021, Youth Justice Services revise existing policy to acknowledge the significant risk of psychological harm caused by being housed alone in custody and require Community Probation Officers to:*<br>a) *Identify when specific youth are living alone or are likely to be housed alone for operational reasons; and*<br>b) *Communicate this to the court in relevant pre-trial proceedings, including bail hearings, reviews of detention orders, consideration of Indigenous social history (Gladue reports and reviews) and pre-sentence proceedings.* |

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| **Response** | The ministry accepts this recommendation and will commit to complete it by October 1, 2021. |

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| ***Recommendation 21*** | *By April 1, 2022 the Minister of Children and Family Development recommend to the Lieutenant Governor in Council that the Youth Custody Regulation be amended to establish an independent review body for all separate confinement decisions that:*<br>*a) Is separate from the Ministry of Children and Family Development*<br>*b) Receives notification of every decision to separately confine a youth*<br>*c) Reviews compliance with the laws, policies and procedures that govern the use of separate confinement and specifically.*<br>*i. Has the power to order that a youth be released from separate confinement*<br>*ii. Ensures that no youth is separately confined for longer than 22 consecutive hours*<br>*iii. Ensures that no youth is separately confined for more than the maximum number of times in a specified time period* |
| **Response** | This recommendation involves amendments to regulations and, therefore, requires significant consultation with Indigenous communities, Indigenous Governing Bodies, and existing oversight bodies. This recommendation also has resource implications that require government direction. We agree to start the consultation process and incorporate feedback into our service framework.<br><br>The feedback from these consultations will be incorporated into the service framework by December 2023. |

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| ***Recommendation 22*** | *By July 1, 2021, the Ministry of Children and Family Development develop a policy to:*<br>*a) Seek the prior consent of youth in custody to immediately notify a parent or guardian of their placement in separate confinement, and*<br>*b) If the youth is in case under the Child, Family and Community Service Act, immediately notify their social worker of the placement.* |
| **Response** | The ministry accepts this recommendation and will commit to complete it by September 1, 2021. |

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| ***Recommendation 23*** | *By July 1, 2021, the Ministry of Children and Family Development in consultation with the Representative for Children and Youth, develop a policy and process for reporting to the Representative about each instance of the use of separate confinement in youth custody.* |
| **Response** | The ministry accepts this recommendation and will commit to complete it by June 30, 2022. |

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| ***Recommendation 24*** | *By July 1, 2021, the Ministry of Children and Family Development provide the Public Guardian and Trustee with information about the separate confinement for longer than 22 hours, since 2017, of any youth for whom the PGT is still property guardian for the purpose of allowing the PGT to assess whether any of these youth have a legal claim in relation to their separate confinement.* |
| **Response** | The ministry accepts this recommendation and will commit to complete it by June 30, 2022. |
| ***Recommendation 25*** | *By July 1, 2021, the Ministry of Children and Family Development, in consultation with the Public Guardian and Trustee, develop a policy and process for reporting to the PGT about each instance of the use of separate confinement in youth custody where the PGT is property guardian of that youth.* |
| **Response** | The ministry accepts this recommendation and will commit to complete it by June 30, 2022. |

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| ***Recommendation 26*** | *By October 1, 2021, and in accordance with section 37(1) of the Youth Justice Act, the ministry develop and implement a process for inspections of youth custody centres that expressly incorporates the standards set out in Rules 83-85 of the Mandela Rules:*<br>• *Establishes a process for conducting regular internal inspections of each youth custody centre*<br>• *Establishes a process for a team of independent inspectors that includes experts in youth development and trauma-informed practice to conduct regular inspections of each youth custody centre*<br>• *Focuses primarily on legislative compliance and matters related to the health, safety and human rights of youth in custody, including separate confinement and the use of force*<br>• *Includes a mechanism for reporting in writing on the outcome of inspections and for following up on the implementation of any resulting recommendations.* |
| **Response** | The ministry accepts this recommendation and will commit to complete it by June 30, 2022.<br><br>This work is currently underway. An inspection framework will be introduced to support operational requirements and to ensure added levels of quality assurance are in place to support trauma informed practices in terms of operations within a youth custody facility outlined by an accompanying policy and training roll out. |

## Appendix C: Investigative methods

Our investigation drew on multiple sources of information, including primary records and disaggregated data provided by the Ministry of Children and Family Development.

We obtained and reviewed ministry records associated with every instance of separate confinement at the two youth custody centres over a three-year period from January 1, 2017, to December 31, 2019.

We conducted a qualitative analysis of each record set to identify the duration and condition of separate confinement periods and assess compliance with regulatory and policy requirements. These records were entered manually into a database to analyze trends. We also identified available demographic characteristics of individual youth, including age, gender and race, and cross-referenced these with disaggregated data summaries provided by the ministry.

We conducted an in-depth case review for three individual youth over a one-year period, which included reviewing a more expansive set of records.

The different types of records we received in the course of our investigation are described in Table C-1.

We also reviewed law and policy that relates to the use of separate confinement, including international rights conventions as well as domestic jurisprudence, and federal and provincial legislation, regulation and policy. Finally, we scanned relevant literature with a focus on trauma-informed practice as well as the effects of separate confinement on individuals, and specifically young people, in custody.

### Table C-1: Types of records related to separate confinement

| Name of record | Purpose |
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| **Separate Confinement Authorization form** | Intended to record the reason for the decision to separately confine, including an explanation of the initial incident and risk assessment supporting the decision to separately confine the youth. Also intended to be used to verify that all other less restrictive means have been used, or were not reasonable in the circumstances. |
| **Youth Custody Incident form** | Intended to document the incident that triggered the decision to separately confine, and generally includes a narrative description of the incident by staff involved. |
| **CORNET (client log)** | CORNET is the electronic provincial corrections case management system. Used to keep track of each youth's activity while in custody or in the community, it consists largely of entries by staff describing their involvement with the youth. |

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| **Visual Checks** | A running manual log, intended to be completed in real time by staff for all youth separately confined. The log should document each visual check conducted at 15-minute intervals or, for youth identified as "high risk," each visual check conducted at 5-minute intervals. |
| **Clinical notes** | Handwritten notes, completed by health care professionals (youth custody services, health services) who attend to youth in separate confinement. |
| **Complaint form** | Intended to be filled out and submitted by youth who want to make a complaint about youth custody services, including in relation to separate confinement. |
| **Provincial quality improvement (PQI) quarterly reports** | Quarterly reports prepared by the ministry to serve as a foundation for continuous improvement in line with youth custody services' strategic goals and to submit to the private accreditation body that accredits the youth custody centres in B.C., the Council on Accreditation, in support of meeting that body's administration, management and service standards.[376] |

[376] MCFD, Youth Custody Services, *Performance and Quality Improvement Plan*; MCFD, Youth Custody Services, *Strategic Plan 2017/18–2019/20*, 11–17.

## Appendix D: Separate confinement during the COVID-19 pandemic

Limiting transmission of COVID-19 has posed significant challenges for B.C. youth custody centres. In March 2020, the ministry issued an interim policy, setting out specific operational practices aimed at preventing transmission of the virus in the youth custody centres.[377] The policy establishes a detailed screening and assessment process for all youth admitted to Burnaby Youth Custody Services Centre and Prince George Youth Custody Services Centre.

The policy provides that on admission, all asymptomatic youth be housed separately in an "assessment unit" until the earlier of receiving a negative COVID-19 test, being medically cleared by public health or a medical doctor, or completing a 10-day isolation period.[378] In the event that two or more asymptomatic youth are admitted on the same day, the policy provides that they will be housed on the same unit and not considered separately confined.[379] The ministry advises that it is uncommon for more than one youth to be admitted to custody on any given day, and as a result most youth admitted to custody during the pandemic have been separately confined under this policy.

The policy provides further for symptomatic youth or youth who have tested positive for COVID-19. Specifically, the policy provides that the youth will be separately confined in a single room in the medical observation unit until the morning of the 11th day following onset of symptoms or a positive test.[380] The policy states that "time out of room shall be kept to a minimum in order to manage exposure incidents."[381]

The policy acknowledges the stress and hardship associated with isolation and states that "staff should endeavor to create a supportive environment for youth who are self-isolating to minimize stress and hardship associated with self-isolation as the social and psychological impact can be substantial."[382] Over the course of the pandemic, youth have been separately confined in accordance with this policy. The ministry has advised that the duration of these separate confinement periods has decreased as testing availability has increased.

[377] MCFD, *Manual of Operations – Youth Custody Programs*, December 2020, G.9.01–9.18.
[378] MCFD, *Manual of Operations – Youth Custody Programs*, December 2020, G.9.05 and 9.06.
[379] MCFD, *Manual of Operations – Youth Custody Programs*, December 2020, G.9.06.
[380] MCFD, *Manual of Operations – Youth Custody Programs*, December 2020, G.9.07 and 9.08.
[381] MCFD, *Manual of Operations – Youth Custody Programs*, December 2020, G.9.08.
[382] MCFD, *Manual of Operations – Youth Custody Programs*, December 2020, G.9.09.

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