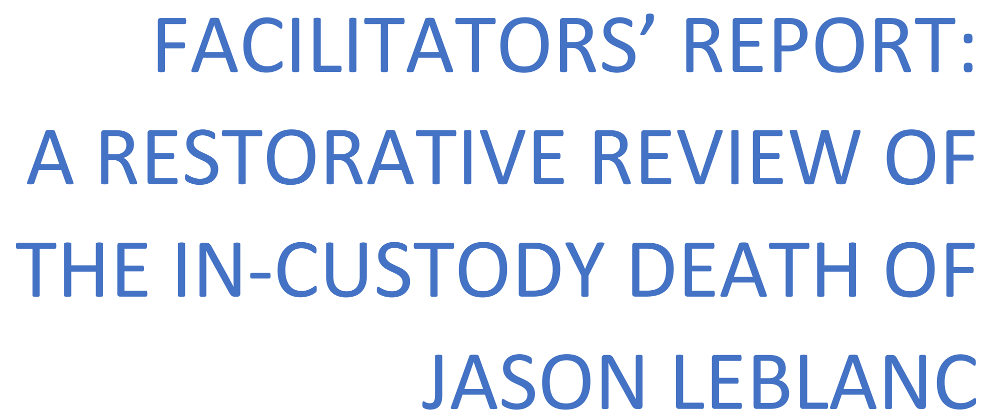
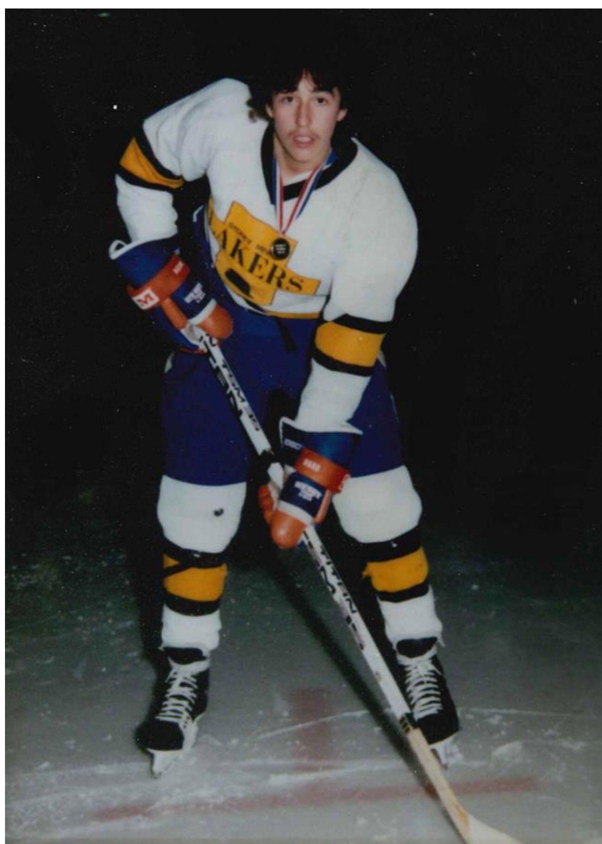


FACILITATORS' REPORT: A RESTORATIVE REVIEW OF THE IN-CUSTODY DEATH OF JASON LEBLANC

February 2018

Prepared by: Jennifer Llewellyn, Jake MacIsaac & Heather McNeil



In loving memory of Jason (Libby) LeBlanc who passed away January 31, 2016

No one knows how much we miss you
No one knows the bitter pain we have suffered since we lost you,
Life has never been the same
In our hearts your memory lingers, sweetly tender, fond and true
There is not a day, dear son, that we do not think of you!

Love and always remembered
Mom, Dad, sister Tanya, niece Courtney and nephew Ashton

Quoted from LeBlanc family post to www.inmemoriam.ca

"Never forget that justice is what love looks like in public."

— Cornel West

Facilitators' Report: A Restorative Review of the In-Custody Death of Jason LeBlanc

Introduction

This report has been prepared by the process facilitation team made up of: Jennifer Llewellyn, Jake MacIsaac, Heather McNeil. The central parties to the process have reviewed the report for accuracy. The parties committed at the outset of the process to share the facts of what happened in this case and the justice process they undertook together to learn from what happened and to ensure that these lessons contribute to improving the lives of individuals and families in Nova Scotia. As such, this report does not make findings of fact or recommendations. It describes the situation, the parties involved, the restorative process in which they engaged, and the insights and outcomes that resulted.

Background

Jason "Libby" LeBlanc was the son of Ernie and Eileen LeBlanc of Sydney Mines, Cape Breton. At the time of his death, on the morning of January 31, 2016, Jason was 42 years old and was housed at the Cape Breton Correctional Facility (CBCF) on a parole violation. He was admitted to the institution less than 14 hours earlier. Correctional officers found Jason unresponsive during an overnight check. Despite their attempts to resuscitate him, he was pronounced dead by Emergency Health Services personnel at 2:45am. It was later determined that Jason died from a drug overdose, having consumed contraband that was not found on his person during the admission process.

Cape Breton Regional Police, the Department of Justice Correctional Services Division, the Nova Scotia Medical Examiner, and the Nova Scotia Health Authority (NSHA) each conducted investigations into what happened within their respective scopes of practice. Police determined upon review of the evidence they collected that it was not a criminal matter.

Ernie and Eileen's lives were left shattered by the sudden loss of their son. Grief grew into frustration as the questions they had about Jason's death were different than the questions being asked by the larger systems in their review of the incident. The systems looked for evidence of individual error or wrongdoing and for violations or failures of policies, best practices, and procedures as a basis for understanding what went wrong. With the assistance of their counsel, Mike Dull, the LeBlanc family applied for more information using the *Freedom of Information and Protection of Privacy Act*. Due to privacy concerns and other factors, only portions of the relevant reports could be shared with the LeBlancs leaving them with more questions than answers in some instances. These investigation reports, while thoroughly prepared, gave little comfort to the LeBlanc family as they were not centrally concerned with understanding the story of Jason's life.

Growing up, Jason's winters were spent playing hockey and his summers filled with baseball. The LeBlanc's home proudly displays his many trophies and medals to show for it. These sports brought together many of the neighbourhood families and Jason was known among them to be a good athlete.

Later in his life, Jason openly acknowledged his struggle with addiction to opioids. A talented tradesperson unable to find work in Cape Breton, he regularly ventured out west to work for short stints, often returning home with lots of money and free time. This was not particularly helpful given his dependency, although it afforded Jason the opportunity to purchase his childhood dream car. The LeBlanc family was not blind to Jason's addiction. Like many Cape Breton families with similar situations, they sought help for Jason through the health care system and community resources with few results. Jason's addiction was a contributing factor in his repeated conflicts with the law. Having received an 18-month custodial sentence in 2015, he was granted day parole on January 14, 2016, only to be arrested again 16 days later for a parole violation for missing curfew. He failed to make it back to Howard House during a major snow storm and was therefore in breach of his parole. The staff at Howard House notified police of the breach. Police arrested Jason the next day upon his return to Howard House.

Following Jason's death, Sean Kelly, Director of Correctional Services, met with Ernie to discuss the findings of the Correctional Services investigation. It was immediately obvious to both men that the LeBlanc family had questions beyond "what happened". They wanted to more fully interrogate "what matters most about what happened" and to understand how to reduce the likelihood of other families having to experience a loss under similar circumstances. Ernie also wanted the system people to know what Jason's loss meant to him and his family. He wanted the lessons from Jason's untimely death to make a difference.

Sean worked alongside of Mike Dull and Ernie to find a way to resolve the matter in a way that would achieve these objectives. It was decided that a restorative approach should be undertaken and Correctional Services turned to a local expert Professor Jennifer Llewellyn to help envision a process, and ultimately engaged a three-person team of restorative facilitators, Jennifer Llewellyn, Jake MacIsaac, Heather McNeil, to oversee and facilitate the process.

This report shares this process and its outcomes. The story of this restorative process is not simply one of the parties in this case coming together to understand and respond. It begins as the story of a family, community supports, and government systems trying to create space to be able to respond to the situation in a restorative way. This required the parties to work together to establish the conditions in which such a process could take place. As the parties worked together on this justice process they were careful to include all those with a stake in the outcome of this situation and also those within the relevant systems who could learn from this process to consider how it might be used in the future. The facilitation team was not called in to simply run the process and report back. They worked closely with the parties – the family and leaders from Justice, Corrections (including those within the correctional facility and the Union and the Nova Scotia Health Authority) to plan and carry out the restorative process. This report shares the work they undertook together throughout the following phases of the process:

1. Design Phase & Stakeholder and Issue Identification

2. Investigation of Issues & Preparation of Participants

3. Sharing Circles

4. Follow-up: Identified Learnings & Outcomes

1. Design Phase & Stakeholder and Issue Identification

Often when something has gone wrong people look to the justice system for answers and a response. In their frustration to get the answers they needed from the existing system processes the LeBlancs looked to access the legal system to get justice. Ernie LeBlanc's efforts to find legal help were frustrating. He ran up against the reality that taking a case like Jason's through the civil justice system would be complicated and costly. Compensation was far from certain in such a case and if it was forthcoming the amount was not likely to be huge given the way in which the loss would be valued. He made many calls before finding someone willing to assist him in this matter. That help came because one of the lawyers he contacted, Mike Dull, had been involved in a restorative process before and had a sense that it might be helpful in this case. Mike was aware that there was a willingness on the part of Correctional Services to explore another way forward in this case. He agreed to take the case in order to support the LeBlancs in their bid for justice through a restorative process.

It quickly became obvious, though, that there would have to be careful thought given to how to proceed in a way that would meet all of the parties needs and create the legal space for a restorative process to proceed without undue risk to the family or those within the systems involved. The first step in the process was to establish a process planning team with the support and guidance of the restorative facilitators. The team came together to identify the issues that needed to be addressed in order for the restorative process to proceed. These issues Included:

- The issue of legal liability for individuals and the systems involved
- The role of a restorative process in the context of staff discipline processes underway
- Legal and policy barriers to sharing information and allowing full participation across the systems of justice and health
- The role of legal counsel in the process

The working group included representatives from the department of justice, corrections and the Health Authority, together with the LeBlancs' legal counsel. They were guided in their work to address these issues and design a restorative process that would meet the needs of the parties by the restorative facilitation team members.

The first issue regarding the potential for legal action and the risk of liability it posed was perhaps the trickiest one to address in order to enable the process to move ahead. In part the issue was difficult because it required rethinking common system and legal responses to such a case. The working group took seriously the need to approach the matter thoughtfully and carefully but with a common commitment to find a good way forward.

They actively sought to take a restorative approach to the way in which they worked together to envision and support this process. They worked hard to understand the risks involved and took care to address them in a way that would be transparent and fair. In the end, rather than act as a barrier to this alternative approach, the legal system served as a key element in creating the right conditions for the process. The prospects of a civil action allowed the parties to come to an agreement to address the issues and concerns through a commitment to participate fully in the restorative process. The parties did not commit to particular outcomes from the process because that would undermine the point of bringing the parties together to understand and determine what, if anything, needed to happen. The restorative process did not require the government to accept "blame" for what had happened to Jason. In fact, the point of the restorative process in this case was to help all those involved understand what had happened not to ascribe blame. The goal was to determine what needs to be done to prevent a similar thing from happening again. The system participants entered into the process acknowledging their responsibilities for the safety and wellbeing of those in their care and custody and that the systems and procedures clearly did not succeed in this case in preventing Jason's death. The correction and health process leaders involved were clear that the systems have a responsibility to learn from this situation and examine what, if anything, might be done differently in the future. They were hopeful that this restorative process would provide an opportunity to support important reflection and learning for the systems involved.

The other issue was to ensure that the staff involved in the situation could participate without fear of disciplinary action. This required a careful response. The process could not undermine the important function of discipline to ensure that employees are accountable for their actions, learn from them, and reform their behaviours in ways expected. It was recognized however, that it is sometimes difficult to encourage open and honest engagement of staff if they are fearful of negative consequences. The working group worked together with the management and union representatives to ensure that the process would meet the goals of discipline and be supportive of staff participation. For many of the staff concerned Jason's death had been a very difficult experience. It was clear that careful attention to preparation would be needed if staff were going to be willing and able to participate in the restorative process.

The remaining issue that posed a challenge for a restorative process was privacy obligations under the Personal Health Information Act which set limitations on sharing of information across systems and with the public. This was particularly challenging for the Health Authority's participation in the process. It had also been an issue in terms of the system responses to Jason's death since privacy issues prevented a joint or integrated investigation of the events surrounding Jason's death. It remains an issue that will require further consideration in terms of its implications for future processes. The parties in this case were able to agree that the Health Authority staff member involved in this situation could participate and share only general information regarding the issues within the parameters of the legislative obligations. The solution was sufficient for the parties to agree to move ahead with the process.

Finally, the working group recognized that working through these issues would take some time and were concerned about the impact on the family of further delays. They recognized how difficult the process of

seeking answers had already been on this grieving family. They also recognized that in asking for this process the family was part of helping the systems to consider alternative and creative justice solutions. In order to ensure no further harm to the family and to support their readiness to participate in the process, the government provided support for counselling and some funding support to offset the cost of the family's legal representation in the planning phase and throughout the process. The process also benefited from the significant pro-bono support Mike Dull provided in order to support this opportunity to advance consideration of this alternative justice process.

The working group also assisted with identifying and agreeing upon the issues to be addressed and the initial round of individuals who should be contacted or interviewed to assess their ability and willingness to participate in the process.

This working group continued to meet to provide oversight and support for the process as it progressed. Members of the working group also committed to participate in the process to support the engagement of their respective systems and ensure follow through.

2. Preparing Participants

Preparing participants for a restorative approach is often not a quick process. It requires careful consideration of the issues and the roles, relationships and experiences of each of the participants and what they might need to understand before participating in a circle with other parties. In January 2017, the process began with the facilitators undertaking a careful review of all of the detailed reports in order to gain an understanding of the facts as they were known and who was involved. Gaining this information was, at times, difficult owing to limits imposed by confidentiality and because of the emotional and sensitive nature of the incident. The facilitators were supported by members of the working group to acquire the information required in order to meet with the individuals involved.

A restorative approach is not simply about bringing people together in a circle. It requires careful preparation of those involved to ensure they are able and ready to participate. It is also important to build trust with the parties so that they understand and are prepared for the process in which they are going to participate. This work must move along at a pace dictated by the needs of the parties, and some individuals require more time than others. Through numerous meetings and phone calls, facilitators worked to support participants by building relationships with them and helping them to understand the principles and process. The facilitators also met with the parties to understand the situation from their perspectives and experiences and to help them reflect on these experiences and their impacts prior to meeting with other parties. Participants were prepared to share and hear not only what happened, but what is most important about what happened, how they were affected, and to contemplate ways to move forward. This was done by meeting individually or in groups using self-reflection, building supports and thinking through how to respond to difficult questions. Some parties required multiple meetings before they were ready to participate together with others in the process.

Throughout, the facilitators met with all those directly involved including Ernie and Eileen LeBlanc, correctional officers and the nurse on duty when Jason died. Those indirectly involved included system players from Correctional Services, Department of Justice and the Nova Scotia Health Authority, Howard House, the Federal Parole Board, the Medical Examiner's Office, a clinical therapist, lawyers, union representatives and other support people.

3. Sharing Circles

The facilitators thought carefully about how participants would engage in the process and how they would be prepared and supported to take part in honest and meaningful dialogue. This required a carefully designed process that would support each participant while encouraging self-reflection and accountability. Participants had to be assured of the opportunity to speak to, and hear from, each other about what happened and about the personal and professional impacts that this incident had on them. From these conversations, lessons were identified to help both the impacted parties as well as the larger systems involved learn from Jason's death and make commitments and plans for how to do better in the future. Ernie and Eileen said repeatedly throughout the process that they wanted to, as best they could, ensure that other families would not have to go through an experience like theirs.

The process facilitators had several considerations when conducting the meetings. What meetings needed to take place? What issues needed to be dealt with and in what order and by whom? Did there need to be more than one meeting? Where should the meetings take place? Who should be invited? How should they each be prepared? What information did each of the parties need to understand and reflect on before meeting with others? What questions would be asked to help the conversation move in a forward focused way? Who should sit next to who in the circle? Who needed to be there to listen and learn from what happened?

It was decided that before participants could look forward and attempt to problem solve, time needed to be dedicated to understanding what happened the night of Jason's death from the perspective of the different people involved and to hear about the impacts from that night on those most directly involved, including: the family, the correctional officers, the institution's management, and the NSHA staff. The process started with this gathering of those most directly involved and affected. This first circle meeting focused on Jason's death and its impact on them. The parties sat together in a circle, with the facilitators, taking turns responding to the invitation from the facilitators to share their experience of what happened that night and since while an outer ring of quiet participants listened. That outer ring included legal counsel and management for Nova Scotia Health Authority, legal counsel for the Department of Justice, a representative from NSGEU, and a registered psychologist. More than observers, these participants committed themselves to listening and learning from the experiences and insights of those most directly involved so that they could support the next stage of the process. They would come back together following the first circle to consider the lessons learned from the situation and the experiences of those involved and develop a plan for a way forward that would address the issues raised.

4. Follow-up: Identified Learnings & Outcomes

In order to respect the process and participants, the intimate details from the circle conversations are private but the participants, through this report, have given facilitators permission to share some of the lessons learned and some of the commitments they have made to ensure that this tragedy makes a difference for the future. The participants had several insights during the process about the context, causes and circumstances related to Jason's death and offered suggestions throughout the process about how to make things better. Three issues were central to these discussions and formed the basis for the work to consider what steps might be taken to address and respond to what was learned.

- **Correctional Facility Offender Admission Process**: Prior to Jason's death, during the admissions process into the Cape Breton Correctional Facility, there was inconsistent practice with regard to obtaining the Health Information Transfer form upon admission. When Jason was admitted, no Health Information Transfer form was provided to Correctional Services.

  Further, it is believed that Jason brought drugs into the facility on the night he died. These drugs were not found during the search process during Jason's admission to the facility. Participants discussed how difficult it is to stay ahead of the practice of bringing in contraband (of various types) into the facility. This issue presents significant safety concerns for offenders and staff and fuels a "drug economy" inside correctional facilities. Participants acknowledged it structures and incentivizes problematic relationships, interactions and behaviours within facilities. Participants identified that increased oversight and an audit process of search procedures together with ongoing training and other supports would be helpful to increase staff compliance and accountability. The supports that would be helpful included, but were not limited to, technological assistance for search processes.

- **Opioid Abuse by Offenders**: Participants identified opioid use and addiction as a persistent safety risk to offenders. They identified a range of practices and tactics employed by offenders to satisfy their addictions. The criminal justice system in general, and Correctional Services in particular, experiences significant overrepresentation of drug addicted persons under their supervision. Participants in the process suggested that staff and offenders need more education about recognizing the signs of an opioid overdose early-on and needed to be better equipped to respond to such medical emergencies in a timely manner.

- **Collaborative Response/Investigations**: Participants identified the difficulty of the lack of integrated investigation and response processes for this and similar incidents. Some expressed that this had a direct impact in terms of the stress and fatigue of having been through several system processes aimed at investigating this situation. Due to the existing interpretation of privacy legislation, certain health related information was not shared between system partners or with grieving parents. Participants

identified the need for better collaboration and integration in investigation and response processes. They discussed the potential of a restorative approach to provide a more integrated means of gathering facts as well as reviewing how grieving families might be better included within the response and gain access to some information about their loved ones. It was also suggested that NSHA staff as well as Cape Breton Correctional Facility (and other facilities in the province) could explore ways to conduct training together. This shared learning experience, along with regular check-in communication with each other, will assist in developing a stronger relationship between and among system partners so they are better able to respond collaboratively when things go wrong.

Following the sharing circle to explore this case and the circumstances and issues involved, participants from the justice and health systems met together to reflect on what they learned and to consider what their next steps might be in responding to the issues raised. At the same time, the LeBlanc family was supported following the process to consider how they might ensure that their experience continues to make a difference for others in their community.

Representatives from the main parties involved met together again to review the lessons gained through the process and to hear about the actions that will be taken and the commitment to address the issues in the future. There was agreement in the room that the actions and commitments form a plan that the parties feel will work to address the broader issues revealed within the process. The parties also had an opportunity to share with each other their experience participating together throughout this process. There was strong agreement that it had been a meaningful and significant experience for those involved on both personal and professional levels.

The following chart reflects the plan that resulted from this restorative process. There are some things that have already been done and others that will be accomplished in the short term. Other issues will require addition time and coordination to address but commitments were made by the parties to do so and to periodically update the parties regarding progress. Finally, there are some issues that will require further consideration but the participants have agreed to raise the issues and continue working on them together. The parties agree to this plan and felt hopeful that it will contribute to ensuring that something positive will come from the LeBlanc family's tragic loss of their son Jason.

The following chart reflects the plan categorized by those items already completed, in progress, or under consideration. It is important to note that some of the actions were undertaken while the restorative process was underway because the parties wished to address the issues as soon as possible. Also, the process affirmed the importance of certain existing practices within NSHA related to addressing addiction issues including strengthening of the medication distribution protocols to address concerns with diversion of prescribed narcotics and the availability of methadone and suboxone to offenders. The parties were careful to ensure that each of these items reflected the lessons that were learned outside and within the restorative process.

Completed	**In-progress/On-going**	**Looking Ahead – Under Consideration**
Correctional Services (CS) contacted Cape Breton Regional Police to address concerns relating to absent Health Information Transfer (HIT) form. CS staff will require Health Information Transfer form on an offender's admission to the correctional facility from transferring authority.	Case management teams (case managers, social workers) will identify high-risk opioid users through criminogenic needs assessments and case planning	Correctional Services and NSHA are in discussion concerning the joint investigation process that respects patient confidentiality and privacy concerns protocols. Currently drafting a Memorandum of Understanding.
CS management conducted "lessons learned" sessions with nine staff in relation to search procedures, rounds, etc.	Supervision and audits of search practices are now in place to improve competence and confirm policy compliance	CS considering based on this experience how to create capacity to provide better response and support to families who have lost a loved one. Such responses will need to be tailored to needs and circumstances of each case.
CS participated in the Law Enforcement Working Group on Opioid Misuse. The working group identified key items considered critical in response to the opioids issue	Body scanner (x-ray technology) tender awarded on January 31, 2018 to strengthen drug interdiction efforts.	CS will soon be able to provide take home naloxone kits to offenders identified as high risk on release from custody
Ninety-nine (99) correctional facility managers across the province have taken Naloxone Nasal Spray Administration training from CPKN.	CS provided offenders educational programming on the risks of opioid misuse. Offenders learned to be aware of signs and symptoms of an opioid overdose.	Participants agree to facilitate knowledge sharing about this process with other corrections/criminal justice stakeholders looking to respond restoratively to similar matters.
Train the Trainer on Opioid Misuse education provided to ten (10) staff, including two from CBCF	CS conducting cross-jurisdictional research to determine best practice standards in response to drug overdoses in correctional facilities.	
CS provided Naloxone to corrections staff to allow for an immediate response to an Opioid medical emergency	CS has committed to a three year (up to $2,000 per year) educational bursary to train staff in the area of addiction services/treatment. Bursary will be offered in Jason LeBlanc's name.	
	CS working to consider the adoption of a restorative approach in institutions, where appropriate, as a response to promote accountability and resolve conflict.	

Conclusion

The parties have agreed that Sean Kelly will update the LeBlanc family in June and December 2018 as Correctional Services and NSHA continue to work on the issues raised and plans made. At the end of the process the parties had the opportunity to reflect on their work together. Parties expressed sincere gratitude for the commitment shown to ensure that the process was possible and went well. The facilitators were impressed by the significant patience and goodwill of the parties to support the development of this process. There was an appropriate level of care and caution given that this was a novel approach. However, the parties were sincerely committed to do the right thing for all of those involved. This process benefited from the experience and expertise Nova Scotia has developed as a national and international leader in restorative justice. It relied on the depth of this expertise in the community, government and at Dalhousie University to support design and implementation. The parties remain committed to learn from this process and to consider how it might be used for the benefit of others in the future. This report is evidence of their commitment to ensure that this justice process is shared more broadly to support future work in Nova Scotia and elsewhere.

Further Information/Contacts

Facilitation Team Members

Jennifer Llewellyn is a Professor at the Schulich School of Law at Dalhousie University and currently serving as the Scholar-in-Residence at the Nova Scotia Human Rights Commission. She has written and published extensively on the theory and practice of a restorative approach. Professor Llewellyn was the Director of the Nova Scotia Restorative Justice Community University Research Alliance (NSRJ-CURA), a collaborative research partnership between university and community partners focused on the institutionalization of restorative justice. She is currently Director of the International Learning Community on a Restorative Approach involving seven jurisdictions internationally. Professor Llewellyn advises and supports a number of projects and programs using a restorative approach in Nova Scotia and internationally. She has extensive experience with truth and reconciliation commissions including advising the Assembly of First Nations and Canadian Truth and Reconciliation Commission on the response to Residential School abuse. She previously worked with the South African Truth and Reconciliation Commission. She is currently appointed to the Council of Parties governing the Restorative Public Inquiry into the Nova Scotia Home for Colored Children. She was awarded the Ron Wiebe National Award for Restorative Justice from Correction Services Canada in 2015.

Jake MacIsaac is the Assistant Director, Dalhousie University Security Services, and focuses on promoting restorative approaches within campus security and with other campus stakeholders. Previously, Jake spent several years as the Lead Caseworker at Nova Scotia's largest restorative justice agency, overseeing case work staff and managing 700+ youth justice referrals from police, the prosecution service and the courts. He was part of a three-person facilitation team that oversaw the restorative justice process at Dalhousie's Faculty of Dentistry in 2015 addressing climate and culture within the Faculty of Dentistry. He was also a co-author of the "Report from the Restorative Justice Process at the Dalhousie University Faculty of Dentistry" https://cdn.dal.ca/content/dam/dalhousie/pdf/cultureofrespect/RJ2015-Report.pdf.

Heather McNeil is the director of Island Community Justice Society in Sydney, NS. The agency is one of the nine community partners with the NS Restorative Justice program. She works collaboratively with government and community agencies to deliver the restorative justice program to offender, families, victims and their communities. In recent years, she and the agency have expanded beyond the traditional restorative justice program by supporting and creating opportunities for others outside of a criminal context through a restorative approach in community. The work to support a restorative approach in schools and the CATCH program (Children at the Critical Hour) have been successful in supporting community members to create positive relationships and have meaningful conversations to decrease the impact of harm within the community and avoid overuse of the criminal justice system.

Process Planning Team Members

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Contacts

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Jennifer Llewellyn regarding general information about the restorative process – email: jennifer.llewellyn@dal.ca