



**JAMAICANS FOR JUSTICE**

# **Report on The Situation of Children in The Care of The Jamaican State**

Presented to: The Inter American Commission on Human Rights

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## **I. Introduction**

Jamaicans For Justice (“JFJ”) is reporting to the Inter-American Commission on Human Rights to bring to its attention that the Government of Jamaica is in gross violation of its obligations to respect and ensure the rights of children who are in the custody of the Jamaican State. Jamaica is in violation of its obligations evidenced by the documentation of the gross abuse children are suffering while in the care and the custody of the State. This report was deemed necessary when these abuses became tragically acute in May 2009 with the deaths of seven (7) girls who perished in a fire at a juvenile correctional facility; and also because we have reported these violations to the Commission before and the State continues to violate its obligations.

Jamaica is violating its own domestic legislation regarding children, *The Child Care and Protection Act*. It is ignoring its international human rights obligations in regards to the protection of children in the custody of the State, under Articles 19 (Rights of the Child), 3 (Right to Juridical Personality), 4 (Right to Life), 5 (Right to Humane Treatment), 25 (Right to Judicial Protection), 26 (Right to Progressive Development) and 1 (Obligation to Respect Rights) of the *American Convention on Human Rights*, and the *United Nations Convention on the Rights of the Child*; it is also thwarting the guidelines established by instruments such as the *United Nations Rules for the Administration of Juvenile Justice*, *United Nations Rules for the Protection of Juveniles Deprived of Their Liberty*, the *United Nations Declaration of Commitment on HIV/AIDS*, and the *United Nations Principles for the Protection of Persons With Mental Illness and the Improvement of Mental Health Care*.

We will illustrate how Jamaica is violating its obligations by describing a deeply disturbing and tragic event that occurred at the Armadale Juvenile Correctional Centre (“Armadale”) in St. Ann, Jamaica in May 2009; following up on our submission and our presentation in October 2006 on the “Report on the Situation of Children in The Care of The Jamaican State”; and elaborating on the Commission’s own observations of the plight of children within the care of the Jamaican State as detailed in Press Release No. 59/08.

## **II. Armadale Juvenile Correctional Centre Tragedy – May 22, 2009**

On May 22, 2009 there was a fire at the Armadale Juvenile Correctional Facility in St. Ann, Jamaica in which seven young girls died from injuries sustained as a result of the fire. The Prime Minister of Jamaica, the Honourable Orrett Bruce Golding (“PM”) ordered an investigation to determine the cause of the fire, and a Commission of Enquiry (“Enquiry”) began on June 30, 2009 and ended on September 10, 2009; the Commissioner’s report is pending. The Commissioner did not indicate at the end of the Enquiry when he would issue his report. Under the *Commissions of Enquiry Act*, the Commissioner’s duties and powers are “to make a full, faithful and impartial enquiry into the matter specified in such Commission, and to conduct such inquiry in accordance with the directions (if any) in the Commission” and to “make such rules for [his or her] own guidance, and the conduct and management of proceedings before them...not inconsistent with [his or her] Commission, as [he or she] may from time to time think fit.”<sup>1</sup>

The Commissioner’s mandate was to investigate the cause of the fire and to issue a report. Notwithstanding the fact that the Commissioner is expected to issue a report, JFJ believes as we stated in our Executive Report to the IACtHR in 2003 that, “[r]eports, analyses, and recommendations mean nothing if they are not put into force.”<sup>2</sup> There have been many reports issued regarding the status of children in custody of the Government of Jamaica and too little done to date to remedy the many, many inadequacies plaguing the childcare system. While establishing the Enquiry was a step in the right direction, JFJ believes that the Enquiry is an inadequate remedy as a corrective and restorative measure for the girls and the families of the girls who suffered through this tragedy and as an impetus for substantial improvement in the childcare system as the Commissioner’s power under the *Commissions of Enquiry Act* is only to “enquire into the conduct or management of [a] department of the public service.”<sup>3</sup> The Commissioner has no coercive power to effectuate concrete change in the childcare system, to press charges against those who may be criminally liable or even to make recommendations for improvements within the system.

The Terms of Reference for the Enquiry were:

1. The causes and circumstances of the fire on the night of Friday, May 22, 2009 at the Armadale Juvenile Correctional Centre at Alexandria in the parish of St. Ann;
2. The response by the management of the institution to the outbreak of the fire including established evacuation procedures and the availability and readiness of fire prevention and fire-fighting equipment at the institution;

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<sup>1</sup> Government of Jamaica, *The Commissions of Enquiry Act*, §§7, 9, available at <http://www.moj.gov.jm/law/search?lawSearch=commissions> (last visited on October 15, 2009).

<sup>2</sup> Jamaicans For Justice, *Report to the Special Rapporteur on the Rights of the Child: Inter-American Commission On Human Rights*, 10 (June 26, 2003).

<sup>3</sup> Government of Jamaica, *supra* note 1, § 2.

3. The behaviour of the juvenile detainees occupying the institution before and at the time of the fire, the response of the emergency services including the police, fire and medical services and the effect these had on the origin, control and consequences of the fire.<sup>4</sup>

The Armadale fire is controversial not only because it occasioned the deaths of seven (7) children who were in the custody of the State but because there are two (2) accounts of the how the fire allegedly started:

1. There are allegations that the girls started the fire in the dorm room themselves in an effort to escape; and
2. There are allegations that a policeman threw a flammable object (allegedly a tear-gas canister) into the room, which ignited a fire and caused the blaze.

These conflicting narratives both deeply disturbing form part of the reason the PM promptly ordered the Commission of Enquiry. The questions that arise from the differing accounts of the causes of the fire point, in both cases, to deficiencies in the childcare system. In one case, how could the girls who were being supervised in a State facility gain access to and be in possession of flammable material? In the other scenario why would police, who form a part of the State's mechanism for the protection of children, and who must be deemed knowledgeable about the special protocol to be adhered to when dealing with children, throw tear-gas into a locked room full of children?

#### A. The Incident

Seven (7) girls died as a result of a fire on May 22, 2009 at the Armadale Juvenile Correctional Centre in St. Ann, Jamaica. Five (5) girls perished in the fire and two (2) girls died subsequently from severe injuries they sustained in the blaze. Three (3) girls were seventeen (17) years old, two (2) were fifteen (15) years old, one was sixteen (16) years old the age of one (1) girl is unknown.

According to reports in the country's main newspapers covering the Enquiry, the girls had to be rescued through the barred windows of the make-shift dormitory (the "dormitory" was a room in an office building) in which they were locked, as the keys to the main doors of the dormitory could not be located during the fire.

Ms. Hortense Higgins, who was a correctional officer at Armadale and was a supervisor on duty on May 22, 2009, testified at the Enquiry on July 30, 2009 saying the girls at the facility had started three fires in 2008 and despite these incidents there were no fire drills conducted, no fire extinguishers placed in the dormitories, nor were there any standard procedures put in place for the staff to follow in the event of a fire.<sup>5</sup>

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<sup>4</sup> Ministry of National Security – Secretary to the Commission, *Commission of Enquiry: In the Matter of the Fire at the Armadale Juvenile Corrections Centre – The Terms of Reference* (July 13, 2009) on file with the author.

<sup>5</sup> Tanesha Mundle, *Girls Started Three Fires at Facility in '08, Says Correctional Officer*, THE JAMAICA OBSERVER, August 4, 2009, available at <https://www.jamaicaobserver.com/news/html/20090804T000000>

Caldene Shaw-Slack, correctional officer on duty at the facility on May 22, 2009 testified at the Commission of Enquiry on July 29, 2009, *indicating that she had not received training in fire rescue procedures. She said she had not known of a fire extinguisher on the property, had never received training in the use of a fire extinguisher, never engaged in fire drill at Armadale despite having worked there for one (1) year and nine (9) months up until the date of the fire and had never received a manual as to what to do in case of an emergency.* Ms. Shaw-Slack had been on duty at Armadale for over twelve (12) hours just prior to the incident.

Mrs. Spence-Jarrett the Commissioner of Corrections said in testimony to the Enquiry on September 4, 2009, *There is no manual for emergencies. We have standing orders. I can't say if Miss Higgins was directed to any documents. There was no fire training held recently. No fire drills in recent times. I am not sure if any of the officers were prepared to deal with a fire.*

B. “Lock-Down”

“Lock-down” was a practice at Armadale similar to lock-down at high security prisons. It consisted of wards not being allowed to go outdoors, not being allowed to go to the dining room for meals but instead having meals in their dormitory (where they were forced to eat with their hands as no utensils were allowed in the dormitory), and no access to bathrooms after a certain time in the evening (the girls were given buckets to relieve themselves).

When girls first came to the facility they were placed on “lock-down.” One girl at the Enquiry testified saying, *When you first go there you get lockdown and you stay two weeks before you can come out. I alone was on lockdown – everybody else could leave the dorm – the others who came same time also on lockdown. One was [another girl], me and her came same night, she stayed in dorm with me. The others went to class.*

The girls in the dormitory where the fire took place had reportedly been in “lock-down” for one month (from April 21, 2009) prior to that fateful night. In this “dormitory” which was actually a pitifully small office measuring **twelve feet by twenty feet (12ft. x 20ft.)**, there was a severely inadequate number of beds as there were seven bunk (7) beds for twenty-three (23) girls.

Ms. Shaw-Slack testified that during the week prior to May 22, 2009, *the girls were in “lock-down” and as such were allowed in the hallway outside of the office that had access to the bathroom, but not outside the building. They were also not allowed to go to classes. The girls got their supper in the dormitory between 4:30 p.m. and 5:00 p.m. and after that they were no longer allowed in the hallway leading to the bathroom, but were*

*given one or two buckets in which to relieve themselves. The dormitory doors were locked at around 6 p.m. (and not opened again until 6 a.m. the following morning).*

In the Armadale Correctional Facility's *Sanctions for Infractions Committed by Wards as Approved by the Disciplinary Committee* "lock-down" is not listed as an approved disciplinary action. The sanction for going through the gate or climbing over the fence is "recommendation for immediate transfer."<sup>6</sup> The girls who were on "lock-down" "in the dorm that burned had been in lock-down from April 21, 2009. One girl said in her testimony, *On April 20 a girl ran away and the whole of us on lockdown.*

#### C. Conditions of the Facility – "Grossly Inappropriate and Overcrowded"

Mr. Neilson Anderson, acting property manager for the Department of Correctional Services testified before the enquiry on August 24, 2009 stating that the conditions at Armadale were "grossly inappropriate and overcrowded"<sup>7</sup> and that the facility had been in need of "immediate attention since 2007."<sup>8</sup> Mr. Anderson testified to having visited Armadale early in 2009 with the then Acting Commissioner of Corrections, Mrs. June Spence-Jarrett who also observed the allegedly deplorable conditions of the home. Mr. Anderson also said he received a letter in December 2008 requesting the servicing of four fire extinguishers at the facility and eight additional fire extinguishers. Mr. Anderson admitted that the requests for the fire extinguishers to be serviced and for the provision of additional extinguishers had not been met.<sup>9</sup>

*I don't know how many working fire extinguishers were on the Armadale property on May 22, 2009. In November/ December 2008 I asked for accounting of fire extinguishers. Armadale said they needed four (4) and that the ones they had needed servicing. I contacted 'Comprehensive' and asked them to service them, it was an oral request I don't remember the date. That property ought to have at least ten (10) working fire extinguishers. They didn't have an adequate number on my watch. I didn't report this need to my superiors. The fire extinguishers are to be serviced at least every four (4) months, that is the responsibility of the Supervisor of the institution, not my responsibility.*

The conditions at Armadale fell far below safety requirements, including not having operable fire extinguishers. After the fire on May 22, 2009, the PM ordered the immediate closure of Armadale, describing the conditions of the home as deplorable and that there was no option but to close the facility; he said, "The facilities here are clearly not adequate, and it is possible that that might have contributed, to some extent, to the

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<sup>6</sup> Armadale Juvenile Correctional Centre, *Sanctions for Infractions Committed by Wards as Approved by the Disciplinary Committee*, on file with the author and received by the author on October 13, 2009 from the Ministry of National Security.

<sup>7</sup> Kimesha Walters, *Armadale Enquiry: Fire Extinguishers Needed*, THE JAMAICA GLEANER, August 25, 2009, available at, <http://jamaica-gleaner.com/gleaner/20090825/lead/lead6.html> (last visited on August 25, 2009).

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

tragedy, but given the severity of the tragedy and given the casualty that we have suffered – five of our girls having died – it is something that warrants investigation at the highest level.”<sup>10</sup>

#### D. Health Concerns

##### i. *HIV/AIDS Infections*

Dr. Micas Campbell, who was the attending physician for Armadale, testified at the Enquiry on September 9, 2009, and revealed that two of the girls who perished in the fire were infected with the Human Immunodeficiency Virus (HIV). Dr. Campbell also explained that she recommended that the infected girls be transferred to facilities where they could be better cared for and for the safety of the other girls, Dr. Campbell said: “[t]hey weren’t exactly careful. They were exposing the other girls to their illness.”<sup>11</sup> Dr. Campbell explained that two (2) of the girls had been found in compromising sexual positions with each other where bodily fluids were exchanged. Dr. Campbell’s recommendation for these two (2) girls to be transferred was ignored. One girl was undergoing anti-retroviral treatment and the other girl was slated to begin treatment.<sup>12</sup>

*I spoke with the Superintendent of Armadale regarding my concerns about the HIV positive girls. This was the same week of the fire (the 19<sup>th</sup> May). I told the Superintendent I was going to call Dr. Pow as we felt it would be best if this patient left to get new housing. However, she was not relocated. Dr. Pow was told that the ward could not be moved. I told Mrs. Ferrerira what Dr. Pow said, Mrs. Ferreira was not satisfied but said there was nothing we could do – the girl remained.*

##### ii. *Severe Mental Illness*

Dr. Campbell testified that in her opinion ninety percent (90%) of the girls at Armadale were in need of psychiatric treatment.<sup>13</sup> *I had concerns regarding psychiatric health of the girls. A lot of the girls showed psychotic features, some with personality disorders. Many of the girls were hallucinating, hearing voices talking to them, believing strange things. Some of the girls were showing symptoms such as sociopathic, anti-social, borderline personality disorders. Over ninety percent (90%) were showing such*

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<sup>10</sup> Alesia Edwards, *Tragedy: Juvenile Centre Ordered Closed After 5 Girls Perish in Fire*, THE JAMAICA OBSERVER, May 24, 2009, available at, [http://www.jamaicaobserver.com/news/html/20090523T200000-0500\\_152107\\_OBS\\_TRAGEDY\\_.asp](http://www.jamaicaobserver.com/news/html/20090523T200000-0500_152107_OBS_TRAGEDY_.asp), (last visited August 25, 2009).

<sup>11</sup> Kimesha Walters, *Armadale Enquiry: More Startling Revelations Turn Up – Two Girls Were HIV Positive, Others Had Psychotic Episodes*, THE JAMAICA GLEANER, September 10, 2009, available at <http://www.jamaica-gleaner.com/gleaner/20090910/lead/lead7.html> (last visited on October 13, 2009).

<sup>12</sup> Tanesha Mundie, *Recommendation To Transfer HIV-Infected Wards Ignored*, THE JAMAICA OBSERVER, September 10, 2009, available at [http://www.jamaicaobserver.com/news/html/20090910T000000-0500\\_159332\\_OBS\\_RECOMMENDATION\\_TO\\_TRANSFER\\_HIV\\_INFECTED\\_WARDS\\_IGNORED.asp](http://www.jamaicaobserver.com/news/html/20090910T000000-0500_159332_OBS_RECOMMENDATION_TO_TRANSFER_HIV_INFECTED_WARDS_IGNORED.asp) (last visited on October 13, 2009).

*symptoms. This was a matter of grave concern to me and I reported these to Dr. Pow and Dr. Terrence Bernard.*

Mrs. June Spence-Jarrett's testimony also highlighted the severe lack of attention paid to the mental health of the girls at the rehabilitation centre when she explained on September 8, 2009, that there were no nurses or psychologists at the facility.<sup>14</sup> **In fact there was only one psychologist who was employed to the entire Department of Correctional Services.**<sup>15</sup> The Department of Correctional Services is comprised of seven (7) Adult Correctional Centres, one (1) Adult Remand Centre, four (4) Juvenile Centres, and seventeen (17) Community Service Offices (Probation Offices) located island wide all under the directorship of the Department's chief executive officer, the Commissioner of Corrections.<sup>16</sup>

Mrs. Spence-Jarrett testified on September 4, 2009 saying, *I didn't have enough psychologists for Armadale. This was brought to my attention time and time again. There is an establishment of just one psychologist for the Correctional Department.*

Dr. Campbell saw the girls at Armadale, once per week. She requested additional days to attend to the girls but her request was denied.<sup>17</sup> Dr. Campbell testified that she felt the girls' conditions worsened because they were unable to get their medications at the prescribed times because the medical orderly who was to administer the medications was on-call for too short a period each day.<sup>18</sup>

*I would say a doctor would need to go at least 3 times per week in respect of the psychiatric problems...Some girls were on medication for depression, psychosis and anxiety. I monitored whether girls were receiving their medication. They were not receiving it as they should have been receiving it. I was told only the medical orderly could give the medication and she was not available 24 hours so the medications couldn't be given round the clock as prescribed. The medication was on the premises, but not given to the girls. Without their medication, the girls could decompensate, could become violent or aggressive.*

The Department of Correctional Services issued a Standing Order on February 18, 2008 that indicated that psychological services were to be provided for wards at every correctional centre. The order reads: "A psychologist shall be assigned to each Juvenile Centre for psychological care of the Wards. The psychologist shall have sessions with

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<sup>14</sup> Tanesha Mundle, *Spence-Jarrett Says Juvenile Centre Was Understaffed*, THE JAMAICA OBSERVER, September 9, 2009 available at, [http://www.jamaicaobserver.com/news/html/20090909T020000-0500\\_159302\\_OBS\\_SPENCE\\_JARRETT\\_SAYS\\_JUVENILE\\_CENTRE\\_WAS\\_UNDERSTAFFED.asp](http://www.jamaicaobserver.com/news/html/20090909T020000-0500_159302_OBS_SPENCE_JARRETT_SAYS_JUVENILE_CENTRE_WAS_UNDERSTAFFED.asp) (last visited on October 13, 2009).

<sup>15</sup> *Id.*

<sup>16</sup> Department of Correctional Services of Jamaica: Administration, *Juvenile Correctional Services: Aims and Objectives*, available at <http://www.dcsj.net/dcsj/juveniles.htm> (last visited on October 15, 2009).

<sup>17</sup> Kimesha Walters, *supra* note 11.

<sup>18</sup> Tanesha Mundle, *supra* note 12.

the wards at least once per week.”<sup>19</sup> The lack of mental health care for the girls at Armadale was in violation of the Department of Correctional Services’ own Standing Order.

iii. *Unsanitary, Unhealthy and Undignified Conditions*

After 6 p.m. the girls at Armadale who were in lock-down in the Office Dorm had no access to bathroom facilities. They were given one (1) or two (2) buckets for excrement to be used amongst the twenty-three (23) girls who shared the room.

Dr. Campbell’s testimony spoke to the unsanitary conditions the girls endured she said, *[t]o share a bucket with 22 other girls for 12 hours for excrement would not be hygienic. It would exacerbate vaginal infection. If no running water to wash hands, this would make it even worse. To keep excrement in plastic bags or newspaper for hours is not safe from a medical or other point of view. If my advice had been sought, I would have advised against it. I was never asked my opinion regarding isolation or confinement of any ward for 24 hours or more.*

A girl testified at the Enquiry on August 20, 2009, and said of the conditions, *There was one bathroom in Office Dorm. They would lock the door and give you buckets to use in nights and sometimes during the days – where the children defecate inside, it would smell up the dorms. Sometimes two buckets and sometimes one...the bucket would be emptied in the mornings, the bucket did not have a cover.*

Mrs. Spence –Jarrett said of the bathroom facilities at Armadale while testifying on September 4, 2009, *I personally took no steps regarding the bathroom facilities in Office Dorm. There was nothing else we could have done immediately. There are serious financial problems. 73% goes to salaries, 27% goes to feeding and facilities etc.* This blatant admission from the Commissioner of Corrections is incredible and demonstrates the scant regard those in authority had for the children who were kept at Armadale.

E. Education Provided- Inadequate

Mrs. Spence-Jarrett testified on September 8, 2009, that for approximately **two (2)** years, (since 2007) the Armadale facility had had only **one (1)** teacher to teach **sixty-one (61)** girls. The teacher also assisted with the duties of a welfare officer for the facility. For the **four (4)** juvenile correctional facilities in Jamaica there were **eight (8)** teachers.<sup>20</sup>

Mrs. Spence-Jarrett said in testimony during the Enquiry on September 4, 2009, *No one*

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<sup>19</sup> J.N. Spence-Jarrett, *Commissioner of Corrections Standing Order: Standard Operational Procedures for the Control and Restraint of Disruptive Wards Within the Department of Correctional Centres*, 3, (February, 18, 2008) on file with author.

<sup>20</sup> Tanesha Mundle, *Armadale Enquiry: Lack of Officers Added to List of Flaws*, THE JAMAICA GLEANER, September 9, 2009 available at, <http://jamaica-gleaner.com/gleaner/20090909/lead/lead6.html> (last visited on October 13, 2009).

*was employed or assigned to teach science. That was for the Superintendent to do, to run the education programme. Based on the reports there were some inadequacies that we are trying to address. I was not sure if Science was being taught at the time, I really didn't make any enquiries. One teacher was assigned to teach all the subjects in primary education. This was for all girls up to 16.*

According to Mrs. Spence-Jarrett's testimony the curriculum for the girls at Armadale was very basic, the subjects taught were Social Studies, Mathematics and English. Mrs. Spence-Jarrett was unable to say whether or not Science was taught at the school. She also believed there were instructors who taught practical subjects like, Home Economics and Sewing at Armadale.<sup>21</sup> The Department of Correctional Services has a *Literacy Based Programme Syllabus and Guide for Students in Juvenile Institutions* in which the subjects to be taught to children in the juvenile correctional facilities are outlined and these are: Language Arts, Social Studies, Mathematics, History, Religious Education and General Science, alongside vocational areas like Woodwork, Auto Mechanics, Welding, Clothing and Textile/Tailoring, Home Management, Electrical Management, Electrical Installation, Cosmetology and Art/Craft.<sup>22</sup>

Ms. Shaw-Slack (correctional officer at Armadale) testified that when girls were in lock-down they were not allowed to attend classes. One of the aims and objectives of the Department of Correctional Services' juvenile facilities is to "provide a range of educational and vocational training to enhance the juveniles' educational status."<sup>23</sup> The girls at Armadale did not receive enough of an education to raise their "educational status" and during lock-down, which was frequent, received no instruction at all.

One girl who testified at the Enquiry on, July 12, 2009, said, *No classes, no teaching in lockdown...not for any girls. Not normal for girls to be taken out during lockdown for teaching – didn't see it for other girls – never happened for me.*

Another girl who testified at the Enquiry on July 14, 2009, arrived at Armadale on May 1, 2009 and had never attended classes while at the institution. *From mi go deh mi neva go classes – not allowed to leave the dorm for any other reason. (From I got there I never attended classes.)*

According to the Standing Order issued by the Commissioner of Corrections wards were to receive not less than twenty (20) hours per week of educational and vocational training.<sup>24</sup> From the testimony received at the Enquiry this did not seem to be the case for the children at Armadale.

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<sup>21</sup> *Id.*

<sup>22</sup> Department of Correctional Services, *Literacy Based Programme Syllabus and Guide for Students in Juvenile Institutions*, 2, on file with author.

<sup>23</sup> Department of Correctional Services, *supra* note 16.

<sup>24</sup> J.N. Spence-Jarrett, *supra* note 19.

F. The State's Response: "Incident Could Have Been Prevented", Mary Clarke – The Children's Advocate

The Children's Advocate of Jamaica (an appointment pursuant to the *Child Care and Protection Act, 2004*) Mrs. Mary Clarke, issued a statement after the tragedy saying, "We made recommendations across the board for children in correctional institutions and Armadale was one of those institutions."<sup>25</sup> The Children's Advocate stated that the tragedy could have been avoided had the recommendations made by her office been heeded. She also said she has no desire to "knock the correctional services who have been trying their best with limited resource," Clarke said, "more is needed."<sup>26</sup>

We respectfully submit that the response of the Office of the Children's Advocate (OCA) was lacking as the OCA is the State institution responsible for 'reviewing the adequacy and effectiveness of law and practice relating to the rights and best interests of children and services provided for children by relevant authorities.'<sup>27</sup> We are not certain what concrete recommendations were made by the OCA and what efforts were made to implement them or how they may have related to the occurrences at Armadale. The Children's Advocate said at the Enquiry that she had not visited Armadale prior to the fire; she said that members of her staff had visited Armadale on two (2) or three (3) occasions for very specific reasons; none had involved an inspection of the facility. The frequent excuse of inadequate or limited resources is unacceptable and this should have been acknowledged by the OCA.

Mrs. Clarke testified before the Enquiry on September 4, 2009, about the general state of facilities where wards of the State are housed, *We brought to the attention of the relevant authorities – overcrowding, lack of privacy (in adult institutions), lack of opportunity for rehabilitation, lack of space, lack of leisure activity. This was brought to attention every time we held meetings. Meetings were started in 2006 and are still held to this date.*

The PM, who personally visited the facility on the day after the tragedy, on Saturday, May 23, 2009, publicly condemned the condition of Armadale and ordered its immediate closure.

Under the *Childcare and Protection Act* the Minister of Health is responsible for the well-being of all Jamaican children a mandate administered by the Child Development Agency of the Ministry and the Minister of National Security and Justice is responsible for the operation of all juvenile rehabilitation centres as they fall under the category of a 'detention centre.' As such JFJ wrote letters to the offices of both Ministers asking for

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<sup>25</sup> Alicia Dunkley, *Children's Advocate Says Armadale Tragedy Could Have Been Prevented*, THE JAMAICA OBSERVER, June 3, 2009, available at [http://www.jamaicaobserver.com/news/html/20090602T210000-0500\\_152769\\_OBS\\_CHILDREN\\_S\\_ADVOCATE\\_SAYS\\_ARMADALE\\_TRAGEDY\\_COULD\\_HAVE\\_BEEN\\_PREVENTED.asp](http://www.jamaicaobserver.com/news/html/20090602T210000-0500_152769_OBS_CHILDREN_S_ADVOCATE_SAYS_ARMADALE_TRAGEDY_COULD_HAVE_BEEN_PREVENTED.asp) (last visited on August 25, 2009).

<sup>26</sup> *Id.*

<sup>27</sup> Government of Jamaica, *The Childcare and Protection Act, 2004*, First Schedule, Part II, ¶ 11(1) (a), available at [http://www.cda.gov.jm/downloads/Child\\_Care\\_and\\_Protection\\_Act\\_2004.pdf](http://www.cda.gov.jm/downloads/Child_Care_and_Protection_Act_2004.pdf) (last visited on October 15, 2009).

clarification as to the exact mandates of each of their respective offices in the wake of the Armadale tragedy given the lack of clarity as to who was accountable for the conditions in which the children were housed and for the injuries and deaths that occurred on May 22, 2009. JFJ has not received a response to either letter to date.<sup>28</sup>

### **III. Follow-up to Our Submission in October 2006 and Hearing at the 126<sup>th</sup> Session – *Report On the Situation of Children in the Care of the Jamaican State***

In October 2006, Jamaicans for Justice submitted an assessment of Jamaica's children's homes to the Commission and attended the Commission's 126<sup>th</sup> Hearing to report on Jamaica's violations of its obligations regarding the rights of children in the custody of the State. Recent events have tragically illustrated that there has been little or no improvement in the conditions that children in the custody of the Jamaican State experience.

JFJ reviewed recent monitoring reports, like those we analyzed for the October 2006 report submitted to the Commission and we have found many of the same flaws that we observed and reported in our October 2006 submission to the Commission.

JFJ requested monitoring reports from five (5) children's homes, the SOS Village Boys Youth House – Stony Hill, SOS Village Children's – Barrett Town, Alpha Boys Home, Maxfield Park Children's Home, and the Windsor Girls Home, for the years 2008 - 2009. This review was initiated by way of applications under the Access to Information Act.

JFJ believes that the process of evaluation and monitoring reports developed by the Child Development Agency (which has been revised since 2006) is not sufficiently guaranteeing that the children in care are being provided with the highest quality of care and treatment. Though the CDA has some efforts to improve the process of monitoring Children's Homes, far more extensive improvements are needed in terms of the evaluation of the safety and well being of all children in the care of the Government.

Our findings have shown an inefficient and inadequate monitoring system that ultimately results in a lack of follow-up or corrective action for issues being faced within the homes. In fact, many of the same problems reported in our 2006 report are recurrent in the 2008 - 2009 reports we received. These are:

- No requirements to detail accounts of the nature of critical incidents;
- No requirements to interview all involved in critical incidents;
- No requirements to interview absconders as to determine the reason why the ward absconded;
- Little to no space available to detail any reactive “Actions taken by Monitoring Officer” in response to neglect and abuses observed;

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<sup>28</sup> Jamaicans For Justice, *Press Release: No Answers Yet to Letters to the Minister of Health and the Minister of National Security Regarding the Armadale Tragedy*, September 10, 2009 on file with author.

- No requirements to interview the staff as to what attempts and efforts are being made to help or control the behaviour of the children;
- No requirements to target specific documentation of the ineffectiveness of the staff’s methods of ensuring the safety and well being of the children.

The monitoring officer’s ability to document and improve the general well being of the wards is limited by the structure of the reports.

#### **A. Specific Cases of Inadequacy of Monitoring System**

##### i. *SOS Village Boys Home, Stony Hill, St. Andrew*

One of the cornerstones of the CDA’s childcare system is the implementation of a ‘Care Plan’ for each child who enters the system in order to ensure that each child receives the care necessary to keep them healthy and on track to becoming responsible and well-adjusted citizens.

The December 12, 2008 monitoring report was undertaken to follow up on the implementation of recommendations made on previous visits, observe condition of the physical plant, amenities and equipment, to identify issues relating to standards of care which require immediate intervention and/ or follow up actions and to report on the number of new placements. In the report it is noted under the ‘Breaches of Standards Observed/ Noted’:

- Care Plans are missing from case file. Case Conference to be planned and executed and Care Plans developed. (Timeline for Action – February 30, 2009 [please note this date does not exist]).

In the *Child Development Agency Guidance and Standards of Care for Residential Childcare Facilities*<sup>29</sup> Rule 38 states, “On the admission of a child, a written plan of care, based on their individual needs shall be formulated by the superintendent in collaboration with the case officer and thereafter be implemented. The care plan shall be subjected to review on a regular basis.”

The monitoring report dated November 25, 2008, a new case of physical abuse is reported with the notes:

- Case of physical abuse involving.....was reported only to the Office of the Children’s Registry and not the Stony Hill Police as required. No medical attention was sought.

In the section of the form where the question is asked of the monitor, “Did you observe any signs of abuse?” The monitor marked “No” and the section which asks ‘what action

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<sup>29</sup> Child Development Agency of Jamaica, Guidance and Standards of Care for Residential Childcare Facilities (May 2005) on file with author.

was taken by the monitoring officer' the answer is "n/a." The Monitoring Officer took no action in a clear case where abuse had occurred.

In the report dated June 24, 2008 one of the comments of the Monitoring Officer is that the death of a child was not recorded in the Critical Incident Log Book. The report also notes that the focal point of visit was: "Meeting with Manager Mr. Sean Foskin to acquaint him with the Different Protocols on managing Critical Incidents, Absconding and the Administration and Control of Medicines, and to reinforce the value of Record Keeping." The death of a child was not recorded in the records of the home, which goes against the CDA's own protocol as outlined in the *Standards of Care* Rule 62, "The Home shall ensure the maintenance of individual files for each child and therein record all information on the care and services rendered and all activities and occurrences within and without the Home in relation to the child."

ii. *SOS Village Children's Home, Barrett Town, Montego Bay, St. James*

Only two reports were received from this home. In the report dated March 24, 2008, the report lists under General Comments:

- Some staff members are not able to properly manage some children and some display inappropriate behaviours.

There is no follow up to this comment in the Regional Director's comments, where the Director only asks:

- What is the type/level of inappropriate behaviour? Some specifics are needed in order to address issue properly."

This comment is dated April 20, 2008, a month after the report was made with no indication that any action was taken by the Monitoring Officer and shows the Regional Director is still attempting to ascertain information about a situation where inappropriate behaviour towards children by staff in a residential facility has been reported. Rule 12 of the *Standards of Care* states, "The Home shall ensure that before the appointment of any staff member (including volunteers and any other adult with significant contact with the children) each is formally and systematically instructed on the values, policies, procedures, practices and standards of the Home and of its organizational structure. In this regard, particular attention must be paid to methods of care that are not injurious to the physical or psychological welfare of the child." It is against the CDA's own protocol to have staff members who are not trained properly to deal with children.

iii. *Alpha Boys Home, Kingston*

The monitoring reports received from this home show a high incidence of boys absconding from the facility: of the five (5) reports received from the facility, four (4) of the reports include incidents of missing children. The monitoring reports do indicate that missing persons reports were lodged with the police. These reports are worrisome, however, because children having the opportunity to abscond points to inadequate

supervision. In the CDA's *Standards of Care*, Rule 15 states, "The home shall have as many employees on duty at all times so as to ensure adequate supervision for children twenty four hours a day and as may be needed to properly safeguard the health, safety and welfare of residents as required by regulations."

All five (5) reports include in the 'Summary of Action' section the need for "increased case management." We do not know what this means as there is no expansion in the Monitoring Officer's notes or in the Regional Director's notes. We believe, however, that this could include the fact that in three (3) of the reports received the Monitoring Officer noted that there were a number of boys who were not engaged in any educational or vocational programmes. Rule 54 of the *Standards of Care* states, "The Home shall be committed to ensure that child has access to good quality education and/or training at a local school as required by the Regulations. Where attendance at a school is not appropriate, it shall provide education and/or training on site, within the facility."

In the report dated January 13, 2008, the Monitoring Officer noted in the 'General Comments' that, "An inadequate Menu Plan was shown deficient in fruits and vegetables. Supply of these said to be dependent on the produce from the Farm." Rule 50 of the *Standards of Care* states, "The Home shall ensure that all meals and snacks provided must be of sufficient quantity and quality to meet the nutritional needs of each child." A diet lacking in fruits and vegetables is not healthy and does not meet the nutritional needs of a child.

iv. *Windsor Girls Home, St. Ann's Bay, St. Ann*

The safety of children in the Homes is perhaps the most important duty with which the operators of the Homes are charged with while taking care of these children. In the reports from this facility dated May 27, 2008, May 13, 2008 and April 24, 2008 the Monitoring Officer notes that there are complaints that the security guards let men onto the compound to see the girls and that men are hanging around outside the dormitories of the girls and speaking to them through the windows. The presence of men who are not attached to the facility, related to the girls, or conducting legitimate business at the facility is completely unacceptable. This is so not only because it compromises the safety of all the girls on the compound but because it could lead to inappropriate, possibly even criminal, interaction between troubled young girls in the care of the state and strange men. In fact other reports which document a pregnant ward of the state, indicate that this was indeed a problem. The section of the forms labelled, 'Action Taken By Monitoring Officer' is blank, despite the clear danger and Rule 65 which states, "There shall be regular monitoring visits...during which Monitoring Officers...shall review the standard of care offered at the facility and make recommendations for how this might be improved to promote the well being of the children."

In the monitoring report dated April 7, 2008, the Monitoring Officer reports that the Manager of the Home was unaware that a pregnancy qualified as a 'Critical Incident' and had not reported it. This lack of reporting on the welfare of the children in the custody of the Home goes against Rule 62, which states, "The Home shall ensure the maintenance of

individual files for each child and therein record all information on the care and services rendered and all activities and occurrences within and without the Home in relation to the child.” In the April 21, 2008 report it is noted that a letter was sent to the police regarding the situation.

In the September 15, 2008 report the Monitoring Officer noted that:

- A few girls complained of not going to regular school; they find the lessons offered on the compound not challenging.

And in the June 16, 2008 report it was noted:

- Lack of finances to send clients to school sometimes.

Rule 54 of the *Standards of Care* outlines the duty of a Home to ensure that the children who live there have access to a proper education. The children at Windsor were not receiving a “good quality education.”

Also in the June 16, 2008 report it is noted under ‘General Comments’:

- Most of the new clients admitted are discovered with serious mental health problems which fluctuates during intervention and at times exacerbated by inappropriate responses from caregivers.

Rules 46 and 47 of the *Standards of Care* state accordingly, “The Home shall be committed to promoting the good health of each child...” and “The Home shall make provisions for all children to have medical examination no later than one month after admission then annually and upon leaving or discharge.” The Monitoring Officer’s observation that the children who are in the Home are mentally disturbed speaks to the lack of attention paid to the health of the children in the care of the Home and is important to point out because mental health and stability is an important aspect of the welfare of any person. The fact that the children’s mental health is worsened due to the action of caregivers is even more cause for concern. In the September 15, 2008 the Monitoring Officer notes in the ‘Long Term Plan of Action’:

- Facility needs behaviour therapist.

In a report dated April 21, 2008, in the section relating to new entries of critical incidents, the Monitoring Officer noted, “Client is to receive follow up intervention at mental health clinic.” There is no description of the incident. This again points to the skeletal descriptions that the Monitoring Officers include in these reports and this is problematic because it does give the CDA much information as to the state of the Home or the welfare of the children, despite the *Standards of Care* noting the importance of record keeping in Rule 62 which states, “The Home shall ensure the maintenance of individual files for each child and therein record all information on the care and services rendered and all activities and occurrences within and without the Home in relation to the child.”

The April 7, 2008 report and the September 15, 2008 report both note that the facility experiences food shortages regularly. The Monitoring Officer noted accordingly:

- Food continually short on a weekend.
- One child who came from school late complained hat there was no food for her; she went to a staff member who told her that cooking was not on her job description; and

The April 21, 2008 report stated, “Food shortage to be addressed by Manager.” The matter of a food shortage recurs in the report in September and this shows a lack of proper follow up on the part of the Manager of the facility and a lack of consideration for the nutritional needs of the children. The recurring nature of this most basic of violations speaks volumes about the absence of an acceptable standard of care for the children on the part of the home and the CDA who placed those children at the facility. This is yet another violation of the *Standards of Care* Rule 50.

v. *Maxfield Park Children's Home, Kingston*

The medical care of children in the custody of the State is vital, especially within the areas of the administration of medication and the keeping of medical records. The *Standards of Care* make clear the importance of proper medical care in Rules 44, 48, and 62 which state accordingly:

- All medications, including prescription drugs, should be kept securely locked in a cupboard and administered or used only by a Supervisor or other competent designate. A treatment administration chart will be provided for the purpose which shall record the date and time of administration, the child's name, and dosage of medicine. In addition such use or administration shall also be entered the child's file with all such facts as related to the necessity for such use or administration of medication or treatment;
- The Home shall ensure that there is on duty at all times, at least one staff member who is trained in first aid and nominated as a first responder.
- The Home shall ensure the maintenance of individual files for each child and therein record all information on the care and services rendered and all activities and occurrences within and without the Home in relation to the child.

In the March 3, 2009 report received by JFJ the Monitoring Officer reported in the ‘Action Required’ section of the form:

- First Aid training for staff to be implemented.

There were no staff members who were trained in First Aid at the home and this need was noted in previous reports dated, January 29, 2009, December 12, 2008, and November 21, 2008. The follow through on implementing this recommendation was slow and as such put the children in the care of the facility in danger.

The reports also include the need to have the medical journals updated. This recommendation is reiterated in the monitoring reports dated, April 29, 2008, May 28, 2008, July 27, 2008, December 12, 2008 and January 29, 2009. Finally, in the monitoring report of March 29, 2009 it is noted that the “Medical journal was updated.” This critical component of childcare, proper medical records, was not addressed for almost one (1) full year and is a clear example of the lack of attention and scant regard that that authorities in charge of the facility paid to the recommendations of the Monitoring Officer.

The Monitoring Officer also noted that there was insufficient supervision for all the children who were living at the home in the monitoring report dated, December 12, 2008 the Officer notes:

- This visit was done in the night and was quite revealing. Thirty-one (31) children were seen: thirteen (13) in the Toddler Section, ten (10) in the Nursery 1 and eight (8) in Nursery 2 that houses the young babies. Check of the Attendance Register revealed that six (6) caregivers should be on duty, however, only two (2) were present supervising the three (3) sections with thirty-one (31) children. Manager was informed of the discovery and asked to take corrective measures to ensure that the children are adequately supervised at all times.
- Staff leaving the facility almost two (2) hours before their shift was over.
- Staff leaving the children before the caregiver from the next shift comes to relieve them.

Inadequate supervision of toddlers and infants is clearly irresponsible and dangerous as is evidenced in the report dated, November 21, 2008 where a child was lodged in a defective crib and was further injured in the attempts to extricate the child from the crib the Monitoring Officer reported:

- Staff at the facility are in need of first Aid training. This came to the fore when a child was fastened in a crib. The way the child was dislodged did more harm to the child. Caregiver also took several hours before seeking medical attention for the child.

There is no indication in the monitoring report of any action taken against the caregiver who was supervising at the time of the incident and who was responsible for not seeking immediate medical attention.

#### B. Child Development Agency Has Statutory Responsibility for Children in Custody of State

The Child Development Agency (CDA) is the government agency vested with the responsibility of overseeing the care of children in Children’s Homes and juvenile correctional facilities. The CDA is mandated to conduct thorough monitoring and inspection of all facilities housing children and to address any issues arising from such monitoring and inspection.

Notwithstanding the responsibility of the administrators of the homes, the CDA has the ultimate responsibility to fix the problems in the system. The evidence of failure to address the issues, including those documented by personnel from the homes clearly indicates that the CDA has failed to effectively carry out its function. The CDA's website reads, “[t]he Agency has statutory responsibility for children who are in need of care and protection i.e. those abused, neglected or abandoned as well as for children who are experiencing behavioural problems.”<sup>30</sup>

The *Child Care and Protection Act* says:

The objects of this Act are....to recognize that child services should be provided in a manner that (1) respects the child's need for continuity of care and for stable family relationships; and (2) takes into account physical and mental differences among children in their development.<sup>31</sup>

The CDA's management, administration and oversight of Jamaica's children's homes does not provide adequate care and protection as both domestic and international law requires and is its mandate under law.

#### C. Children in Adult Detention Centres

JFJ has documented evidence of two instances that occurred in June and July 2008 where three children, between the ages of thirteen (13) and fourteen (14) spent the night in jail cells in a notoriously dangerous prison while awaiting their court appearances. It is unclear as to whether the boys were separated from the adults or not, but, even if they were this is an extremely worrisome and disturbing trend because there are well-documented inherent problems with Jamaica's jail system and they are not places for children to be housed.

Additionally, a newspaper report on October 21, 2009, entitled *Advocate Probes Children Being Locked Up at Adult Centres*, reported that, “[the] Office of the Children's Advocate (OCA) will be investigating complaints that children are being held at police lock-ups...according to Children's Advocate Mary Clarke, these complaints have come from members of the Jamaica Constabulary Force (JCF) and other citizens...In a release yesterday, Clarke said the complaints have indicated that there was not enough room at the places of safety under the jurisdiction of the Child Development Agency (CDA).”<sup>32</sup>

The *United Nations Convention on the Rights of the Child* Article 37 (c) makes it clear that children are to be housed separately from adults, “[in] particular, every child deprived of liberty shall be separated from adults...”

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<sup>30</sup> Child Development Agency, *About Us*, available at [http://www.cda.gov.jm/noflash/about\\_us.php](http://www.cda.gov.jm/noflash/about_us.php) (last visited October 30, 2009).

<sup>31</sup> Government of Jamaica, *supra* note 27, §3 (c).

<sup>32</sup> The Jamaica Gleaner, *Advocate Probes Children Being Locked Up at Adult Centres*, October 21, 2009, THE JAMAICA GLEANER, available at <http://jamaica-gleaner.com/gleaner/20091021/lead/lead9.html> (last visited on October 25, 2009).

#### D. Very Little Achieved Since the Keating Report

*The Keating Report: A Review of Children's Homes and Places of Safety* commissioned by the Government of Jamaica's Ministry of Health in May 2003 (and incorporated in JFJ's presentation to the Commission in 2006) made forty-six recommendations to the Government of Jamaica as to how to improve conditions for children who are in the custody of the State. In July 2008, the Child Development Agency made a special report to the Minister of Health regarding the progress that the Agency has made in implementing those recommendations; the report listed the completion of a number of the recommendations, such as "intake procedures overhauled" as in accordance with Keating Recommendation 12. JFJ has investigated many of these claims including the 'overhaul of intake procedures' and has found that in many instances the claimed completion of recommendations amount to little more than a new form designed to collect information that is not being used to properly address the problems of the children entering the State's child-care system. New forms do not amount to new policies nor do they translate into improvements in the well being of the children in the custody of the State.

Six (6) years after the Keating Commission JFJ maintains its claim that very little has been done to improve the State's childcare system and more particularly, the welfare of the children, despite the establishment of the Child Development Agency. The work that has taken place has resulted in little or no progress and little improvement. Children in the custody of the State, continue to be subjected to inhumane and degrading treatment, to be at risk of physical, psychological, emotional and sexual abuse and to be deprived of their basic rights to protection and care.

JFJ is aware of specific instances (under the cover of confidentiality but which we can substantiate) where the CDA was asked repeatedly by the administrator of a children's Home, to intervene, assist, advise about and quite literally come to the rescue of children and there was no action taken by them. Some of these cases are outlined below and these all occurred between July 2008 and January 2009:

- A fifteen-year-old boy residing at a Children's Home was sent to spend holidays with his family. The CDA did not inform the Home, however, that the boy was to have remained on trial with his family after the holidays. No information was sought from the Home as to the boy's special needs (he was illiterate and had behavioural problems) nor was a meeting had with the administrator of the Home to discuss whether this move was in the best interest of the child. Efforts to get any meaningful information from the CDA as to the child's status were unsuccessful.
- A thirteen (13) year old child was placed in a home with no accompanying case file from CDA (no birth certificate or other form of identification), and no information about his family. This child was illiterate. Despite numerous attempts to get more information about the child so as to assist the Home in

developing a care plan, this was never forthcoming from the CDA. Eventually, too this child was sent to live with his family with no input from the Home.

- The lack of communication between the CDA and the administrators of Homes is detrimental to children who ‘fall through the cracks’ because there is no continuum or follow-up as to what should happen with them, no next steps outlined in a Care Plan.
- In another case the CDA decided to take a child, who was found to be suicidal, out of a Home where he was becoming adjusted and place him in foster care, again without the advice or consent of the relevant administrators.
  - This case indicates a serious breakdown in communication between the CDA and the administrators of the Home who are the people who are caring for this child and best able to give information as to the possible impact of changes on the child, and what if any problems foster parents would need to be aware of and/or be prepared to get treatment for.
- One particularly alarming case involved a child who had been diagnosed with ‘attachment disorder.’ He was cruel to animals and small children, sexually inappropriate with younger children, consistently disruptive in all social situations like in class and at meals and displayed aggressive and violent behaviour. He was adopted briefly and returned to the custody of the Government. The CDA had been receiving reports about this child and his disturbing behaviour from the time he was very young and these reports continued for over eight (8) years. The CDA, however, just moved this boy from children’s home to children’s home with no sustained effort to give this child concentrated help in the form of mental health care.
  - The CDA had information regarding the dangerous and alarming behaviour of this child for over eight (8) years before there was any serious intervention to help him or to prevent him from harming other children.
- One of the major concerns regarding children who go through the State’s childcare system is that the system is not adequately preparing children who are to function efficiently and productively in society with few skills and little socialization. This is a great disservice to the children as once they turn eighteen (18) years old they are expected to fend for themselves with very few life skills. Skills that the ‘Care Plan’ is supposed to ensure they develop. The “Care Plan” that the CDA uses as the blueprint of a child’s life in many cases does not include pertinent details about the child’s life, for example, what his skills are or level of education, likes and dislikes, his or her personal aspirations. An example of the jarring rift turning eighteen (18) creates for these ill-prepared children is:
  - A young man who was in the care of a Home turned eighteen (18) and had to leave the facility. The administrator was in touch with the CDA asking for information and advice as to what the next steps would be for him. The CDA did not respond. The administrators at the home helped the young man to find a job, but

he was fired from the job in less than a week. He returned to the Home but had to be sent to his family as he was no longer a “child” and could no longer stay at the Home.

- JFJ is also gravely concerned about the medical care and the record keeping within the CDA. In one instance at this Home, a child came to them who had undergone a very invasive and serious surgery two years before being placed in the Home. The boy arrived at the Home with no information regarding his overall health; except a list of the procedures and operations he had undergone. There was no accompanying monitoring reports or history included in his ‘Care Plan.’ This is irresponsible record keeping on the part of the CDA that endangers the welfare of every child who is in the custody of the State.

The stories about these children are just a few instances from one children’s home in Jamaica, and sadly these heinous examples are repeated over and over throughout the State’s childcare system. The welfare of these children is the reason this petition to the Commission asking for change and improvement within the State’s system is so urgent.

#### ***IV. Human Rights Violations***

Jamaican children are legally protected both by domestic legislation, **The Child Care and Protection Act**, and by the treaties to which Jamaica is a party, including the:

- **American Convention on Human Rights;** and the
- **United Nations Convention on the Rights of the Child.**

Jamaica is also guided and directed by other international agreements, declarations and recommendations which provide and establish human rights for Jamaican children including the:

- **United Nations Minimum Rules for the Administration of Juvenile Justice;**
- **United Nations Rules for the Protection of Juveniles Deprived of Their Liberty;**
- **United Nations Declaration of Commitment on HIV/AIDS;** and the
- **United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.**

#### **A. The Child Care and Protection Act, 2004 (Jamaica)**

Under Jamaican law a “child” means a person under the age of eighteen (18) years.

#### **B. American Convention on Human Rights**

Jamaica ratified the American Convention on Human Rights on July 19, 1978.

##### ***Article 19***

Children are guaranteed the rights that are inherent to every person under the Convention and specifically, “Every minor child has the right to the measures of protection required by his condition as a minor on the part of his family, society and the state.”

##### **THE ARMADALE TRAGEDY**

Article 19 imposes special obligations on Jamaica to respect and protect the rights of children and it violated these rights in regards to the children who died in the fire at Armadale on May 22, 2009.

In “*Juvenile Reeducation Institute*” v. *Paraguay* where the Commission filed an application to the Inter-American Court on Human Rights for the Court to determine whether the state of Paraguay had violated its obligations under the American Convention when ten (10) children perished at a fire at a juvenile centre and one (1) child died of a gunshot wound sustained at the centre. The centre had three (3) fires between January 2000 and July 2001.<sup>33</sup>

The Court held in *Juvenile Reeducation* that when the victims of violations are children Article 19 imposes added obligations on the State. “The Court must point out that...the alleged victims of a significant number of the violations being claimed are children who like adults “have all the same rights as all human beings [...] also special rights derived from their condition, and these are accompanied by specific duties of the family, society and the State.”<sup>34</sup>

##### **JAMAICA’S CHILDCARE SYSTEM**

The Government of Jamaica has the duty of ensuring the safety, emotional well being and welfare, and fulfilling the fundamental needs of the children in the custody of the State. The Jamaican State continues to violate these responsibilities to protect the rights of children in its care as JFJ reported in 2006 and as the sampling of monitoring reports JFJ received from five (5) children’s homes in August 2009 demonstrate.

It is clear from the monitoring reports that repeatedly document deficiencies and abuses that processes of the CDA are not sufficiently addressing the problems within the

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<sup>33</sup> Inter-American Court of Human Rights, *Case of the "Juvenile Reeducation Institute" v. Paraguay*, Preliminary Objections, Merits, Reparations and Costs. Judgment of September 2, 2004. Series C No. 112, ¶¶1, 13-18 available at, [http://www.corteidh.or.cr/expediente\\_caso.cfm?id\\_caso=101](http://www.corteidh.or.cr/expediente_caso.cfm?id_caso=101) (last visited on September 14, 2009).

<sup>34</sup> *Id.* at ¶ 147.

children's homes thus compromising all of the rights of the children who live in these facilities. These are breaches of duties owed to the most vulnerable in the society without corrective action being taken by the State in whose care they are abused, and who has the duty to ensure the protection of these rights.

#### **Article 4**

Article 4 (1) states, "Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life".

#### **Article 5**

Article 5 states, "(1) Every person has the right to have his physical, mental, and moral integrity respected. (2) No one shall be subjected to torture or to cruel, inhumane, or degrading punishment or treatment... (6) Punishments consisting of deprivation of liberty shall have as an essential aim the reform and social readaptation of the prisoners.

#### **THE ARMADALE TRAGEDY**

Children at the Armadale Juvenile Correctional Facility were subjected to "lock down" for weeks at time where they were not allowed to go outside of the room they were housed in, made to use one or two open buckets as a toilet amongst twenty-three (23) girls. There was not adequate treatment of widespread mental problems suffered by the girls nor were wards protected against infection by other wards known to have HIV/AIDS despite the fact that girls were known to be taking part in sexual activities among themselves. The children at Armadale were subjected to degrading punishment, which may aptly be described as 'cruel, inhumane and torturous.'

The Court in *Juvenile Reeducation* evaluated Paraguay's violations of its Articles 4 and 5 obligations jointly saying, "there is a special relationship and interaction of subordination between the person deprived of his liberty and the State; typically the State can be rigorous in regulating what the prisoner's rights and obligations are, and determines what the circumstances of the internment will be; the inmate is prevented from satisfying, on his own, certain basic needs that are essential if one is to live with dignity."<sup>35</sup>

This relationship between the person deprived of his liberty and the State is an especially important relationship to be maintained and monitored when considering cases of the children who have been deprived of their liberty, as children have special rights derived from their condition - as children; their family, society and the State owe them specific duties including satisfying their basic needs as they are unable to satisfy those needs on their own. "The right to life and the right to humane treatment require not only that the State respect them (negative obligation) but also that the State adopt all appropriate measures to protect and preserve them (positive obligation), in furtherance of the general obligation that the State undertook in Article 1 (1) of the Convention."<sup>36</sup>

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<sup>35</sup> *Id.* at ¶ 152.

<sup>36</sup> *Id.* at ¶ 158.

The Government of Jamaica did not undertake ‘all appropriate measures to protect and preserve’ the rights to life and to humane treatment of the girls at Armadale. This is seen throughout the testimony of government officials, like the Commissioner of Corrections who said during testimony on September 4, 2009 at the Enquiry, “*The dorms were not built to house children. Out of desperation they had to be placed there, so specifications would not meet the international agreements... I had no place to put the children. It was not safe in terms of exit and entrance in case of a fire.*” It was the responsibility of the Commissioner of Corrections to ensure that the girls who were housed at Armadale slept in adequately safe dormitories; she did not fulfill her duty.

In *Reeducation Institute* when it had been proven that the State had not taken the appropriate fire safety measures the Court said, “in its role as guarantor, the State has an obligation “to design and apply a crisis-prevention prison policy,” the kind of crisis that could threaten the fundamental rights of inmates in the State’s care and custody.”<sup>37</sup> The Court concluded that the State’s failure to prevent resulted in the death of a number of inmates...this is gross negligence on the State’s part, virtue of which it is responsible for violation of Article 4 (1) of the American Convention, in relation to Article 1 (1) thereof, read in combination with Article 19 of the Convention.”<sup>38</sup>

JFJ believes the Government of Jamaican was grossly negligent in its operation of the Armadale Juvenile Correctional Facility.

The Court said in *Reeducation Institute* of a State’s supreme duty to protect a child’s rights to life and humane treatment:

In the case of the right to life, when the person the State deprives of his or her liberty is a child, which the majority of the alleged victims in the instant case were, it has the same obligations it has regarding to any person, yet compounded by the added obligation established in Article 19 of the American Convention. On the one hand, it must be all the more diligent and responsible in its role as guarantor and must take special measures based on the principle of the best interests of the child. On the other hand, to protect a child’s life, the State must be particularly attentive to that child’s living conditions while deprived of his or liberty, as the child’s detention or imprisonment does not deprive the child his or right to life or restrict that right.<sup>39</sup>

One girl testified at the Enquiry on August 20, 2009, and in giving her account of what happened on the night of the fire said, *I helped one of the girls and her skin start come off. I help them with water and help one take off her brassiere because she said she was swelling...I saw one of the police officers with a fire extinguisher, but it was actually empty – some police was catching water...I didn’t get burn or injured that night – just a little scrape. I didn’t have to go to the hospital I slept in the dining room that night.* This horrifying account is exactly the kind of painful mental suffering the Court described as in violation of a child’s Article 5 right to protection from cruel treatment, it said, “The burns, wounds and smoke inhalation that the children...suffered as a result of the

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<sup>37</sup> *Id.* at ¶ 178, 179.

<sup>38</sup> *Id.*

<sup>39</sup> *Id.* at ¶ 160.

[fire]...constitutes treatment in violation of Articles 5 (1) and 5 (2) of the American Convention in relation to Articles 1 (1) and 19.”<sup>40</sup>

#### JAMAICA’S CHILDCARE SYSTEM

In the sampling of reports received by JFJ in August 2009 even the skeletal descriptions of the critical incidents and notes made documenting the conditions in which children live in five (5) of the State’s children’s homes indicate violations of these children’s rights under Article 5. Where there are reports of physical and sexual abuse and where there are numerous ‘critical incidents’ noted but not expanded on in the monitoring reports, this is treatment that is violation of the children’s Article 5 rights to have their physical integrity respected.

#### **Article 25**

Article 25 states, “Everyone has the right to simple and prompt recourse, or any other effective recourse, to a competent court or tribunal for protection against acts that violate his fundamental rights recognized by the constitution or laws of the state concerned or by this Convention, even though violation may have been committed by persons acting the in the course of their official duties.”

#### THE ARMADALE TRAGEDY

Though the State timorously ordered a Commission of Enquiry to investigate the circumstances leading to the death of the girls, it did not begin until June 27, 2009. Upon completion of the Enquiry on September 10, 2009, no indication was given as to the period of time the Commissioner required to review the evidence to determine the cause of the fire. Further the Terms of Reference of the Enquiry were inadequate as the Commissioner is not even charged to make recommendations.

During the Enquiry it became apparent that there may have been a criminal act on the part of an agent of the State which started the fire. The criminal act would have been the throwing of a tear-gas canister into the small room by a police officer which could have started the blaze. **Additionally, testimony given by firemen and personnel who were present during the fire at the Enquiry indicates that no checks were made to see if the girls who were assumed to be dead inside of the burnt dorm room were actually dead.**<sup>41</sup> There have been no charges filed in relation to either the alleged throwing of combustible material or omitting to check if the girls were still alive. In fact, it is not clear whether there is an ongoing investigation by the police into the incident.

The Commissioner of Corrections in her testimony on September 4, 2009, said that she had never made the girls at Armadale aware of their right to complain to the Office of the Children’s Advocate (OCA), she said, *I visited Armadale from time to time. I sometimes*

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<sup>40</sup> *Id.* at ¶ 188.

<sup>41</sup> Kimesha Walters, *Armadale Enquiry: No Checks Made On Whether Girls Were Still Alive in Burnt-Out Room*, THE JAMAICA GLEANER, September 2, 2009, available at <http://www.jamaicagleaner.com/gleaner/20090902/lead/lead7.html> (last visited on October 14, 2009).

*spoke with wards. I never received any complaints from wards re their living conditions. I know the role of the OCA is to interview, visit and address complaints. I had not made the children aware of their right to complain to the OCA. I am not sure if anyone at Armadale told of about this right.*

The Children's Advocate was aware of that there were problems at Armadale because in March 2008 an investigator from her office went to Armadale. She explained in her testimony to the Enquiry on September 2, 2009, *In March 2008 our investigating officer, Mr. Courtney Berry went to Armadale to investigate a complaint of physical abuse of a ward of the state... We used the opportunity of the visit to hear from the girls...and asked the girls to write "A Day in My Life at Armadale." We noted the complaints...and we wrote [then] Commissioner of Corrections, Major Reece, with all the information on abuse and asked him to handle it – that was the most flagrant example of abuse....We reminded Major Reece that we were waiting on the response; then the change over of Commission of Corrections, then I went on extended leave and that interrupted follow-up.* The Children's Advocate was aware of problems occurring at Armadale over **one (1) year** before the fire and instituted no adequate recourse for the abuses that were occurring at the facility.

#### JAMAICA'S CHILDCARE SYSTEM

The monitoring reports afford little space for the children residing within the homes to broach issues regarding their living conditions to the Monitoring Officers. Moreover the children are limited in the ability to appeal to those outside of the facility's staff for help regarding their welfare.

Jamaicans for Justice reported that the monitoring reports analyzed in our 2006 showed that the voices of the children were missing in those reports regarding their welfare. In monitoring reports ranging from March 2008 to March 2009, in all the reports from the five (5) homes JFJ requested information from only one (1) report from a Monitoring Officer to one home indicated 'receiving complaints from the children' as a purpose of the visit.<sup>42</sup>

And while there are sketches of critical incidents noted in the monitoring reports, there is no evidence of corrective or preventative actions taken by the Monitoring Officers in these reports and no documentation of suggested follow-up measures.

#### **Article 26**

"[T]he full realization of the rights implicit in the economic, social, educational, scientific, and cultural standards set forth..."

#### THE ARMADALE TRAGEDY

Jamaica has violated its obligations under Article 26 to the girls at Armadale in similar ways that the Representatives in *Reeducation Institute* alleged that Paraguay had violated its obligations.

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<sup>42</sup> Child Development Agency Checklist for Monitoring of Residential Child Care Facilities, *Windsor Girls Home*, on file with author.

JFJ contends that Jamaica failed in its obligation to ensure that adequate treatment was given to adolescents suffering from mental disorders; and did not provide an educational programme to the children at Armadale that was designed for rehabilitation. The girls at Armadale were in a highly vulnerable situation as children deprived of their liberty and the State failed to ensure even the minimum enjoyment their rights to education and dignity.<sup>43</sup>

Armadale had only one (1) teacher who also doubled as a welfare officer, for sixty-one (61) girls for over two (2) years. The range of subjects and the quality of education the girls received fell below even the Jamaican Department of Correctional Services own standards for education, which was in itself woefully inadequate to fully cater to the needs of the wards and to ensure that when the wards left the homes, they would be able to fully integrate into society and function adequately. There was also no indication of the format of the classes or whether attendance was mandatory. When the girls were in lock-down, which was frequently, they were not allowed to attend classes. These conditions are a gross violation of the ‘full realization of rights implicit in...educational standards.’

#### **JAMAICA’S CHILDCARE SYSTEM**

In monitoring reports received from the five (5) children’s homes, there are consistent reports of truancy, which indicates a lack of adequate supervision and lack of emphasis on the importance of education on the part of the administrators of the homes.

At the Windsor Girls Home the girls complained that the lessons they received at the facility were not challenging; at the Alpha Boys Home three (3) of the five (5) reports received note that there were numerous boys who were not engaged in any meaningful educational or vocational training but were instead observed to be simply watching television.

These instances of a lack of formal engagement in any educational or vocational activity deny the children the opportunity for the full realization of the “rights implicit in the economic, social, educations, scientific and cultural standards set forth.”

#### **Article 1**

State Parties to the Convention are required to “undertake to respect the rights and freedoms recognized herein and to ensure to all persons...the free and full exercise of those rights and freedoms, without any discrimination.”

#### **THE ARMADALE TRAGEDY**

The status of the group of children who are experiencing violations of their rights are wards of the State; the children who perished in the fire at Armadale were children in conflict with the law, and in the custody of the State. As such the Child Development

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<sup>43</sup> Inter-American Court on Human Rights, *supra* note 33 at ¶ 253.

Agency an executive government agency, and the Department of Correctional Services bore full responsibility for their well-being. They patently failed to ensure the rights and freedoms of these children who perished in an avoidable tragedy and those others who were subject to cruel and degrading treatment.

#### JAMAICA'S CHILDCARE SYSTEM

Children are owed rights under the American Convention of Human Rights and violations of these rights are even more heinous as there is a greater obligation to ensure the rights of children under Article 19. The monitoring reports received by JFJ outline where the State has violated the obligations it owes to children in its custody in instances of physical and sexual abuse and untrained personnel.

#### C. United Nations Convention on the Rights of the Child

Jamaica ratified this Convention on May 14, 1991 and has the obligation to ensure that the rights of every child as set out in the Convention are respected without distinction of race, colour, sex, language, religion, political views, nationality, ethnic or social origin, property, disability, birth or any other status of the child, its parents or its legal guardians.<sup>44</sup> "Any other status" necessarily includes children who are in the custody of the State.

#### *Article 2*

(1) States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status. (2) States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

#### THE ARMADALE TRAGEDY

The children who lost their lives at Armadale lost their lives as a result of their status as children in conflict with the law.

#### JAMAICA'S CHILDCARE SYSTEM

The children who are in the custody of the State continue to be in grave danger as JFJ reported to the Commission in March 2004 in our request for precautionary measure as to all juvenile homes in Jamaica.<sup>45</sup> While the Commission denied this request for

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<sup>44</sup> Inter-American Commission on Human Rights, *supra* at note 33.

<sup>45</sup> Jamaicans For Justice, *Request by Jamaicans For Justice to the Inter-American Commission on Human Rights, Organization of American States for Precautionary Measures as to All Juvenile Homes in Jamaica*, March 2004.

precautionary measures the problems in the childcare system highlighted in that report including continued and constant exposure to verbal, physical and sexual abuse and deprivation of the children's verbal, physical and mental integrity still exist. This has been shown in the monitoring reports that the JFJ received from the CDA including reports of physical abuse at the SOS Village in St. Andrew and sexual abuse reported at another SOS Village home in April 2008. Additionally in December 2006 two young children died from smoke asphyxiation when a fire gutted the dorm room of the Children's home where they were sleeping; the other children in the dorm escaped serious injury.<sup>46</sup>

### **Article 3**

Article 3 establishes "the best interests of the child" as the standard that is to be applied in all matters concerning children. Article 3 further says, "(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. " And, " (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."

### **THE ARMADALE TRAGEDY**

Jamaica has passed appropriate domestic legislation regarding the welfare and rights of children in *The Child Care and Protection Act, 2004*; however, the Child Development Agency (CDA), the agency established to implement the provisions of the law and to ensure the well being of children in the care of the State, has proven itself to be woefully inadequate at its job. The CDA's mandate is to ensure the implementation of its *Guidance and Standards of Care* in Jamaica's children's homes. The continuing stream of abuses and inadequacies in its administration illustrates the agency's incompetence in caring for the children and supervision of the homes documented by its own monitoring reports, the facts of the Armadale fire and the reports in the newspapers and from private sources.

The CDA issued two statements after the Armadale fire. In the first, the agency denied responsibility for children in juvenile correctional facilities and after a public outcry it issued another statement acknowledging responsibility for children in correctional facilities.<sup>47</sup> There is a woeful lack of accountability by the State as the entity "legally responsible" for the wards of the State.

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<sup>46</sup> The Gleaner Editorial, *The State and Children's Homes*, THE JAMAICA GLEANER, December 22, 2006, available at <http://www.jamaica-gleaner.com/gleaner/20061222/cleisure/cleisure1.html> (last visited on October 15, 2009).

<sup>47</sup> Alison Anderson, *CDA Clarifies Position*, THE JAMAICA GLEANER, August 5, 2009, available at <http://www.jamaica-gleaner.com/gleaner/20090805/letters/letters9.html> (last visited on October 28, 2009).

The Office of the Children’s Advocate of Jamaica was established under the *Child Care and Protection Act* and is an independent position. Mrs. Mary Clarke has been the Child Advocate since 2006 when she was appointed. Mrs. Clarke’s testimony during the Enquiry made it clear that her office, up until the time of the fire at Armadale has been more reactive than proactive. She stated that she was *aware of minimum standards for children in juvenile facilities in Jamaica. And also aware of minimum education requirements for children in juvenile facilities – to provide them with education and life skills to survive in outside world*, and yet even with this knowledge and the knowledge that there are many violations of these guidelines has continued to just have “meetings” regarding all of these violations. *We brought to the attention of the relevant authorities – overcrowding, lack of privacy (in adult institutions), lack of opportunity for rehab, lack of space, lack of leisure activity. This was brought to attention every time we held meetings. Meetings were started in 2006 and are still held to this date.* Mrs. Clarke as the Children’s Advocate of Jamaica is the relevant authority to deal with these violations of the human rights of the children who are in the custody of the State.

Armadale itself did not conform even to the standards established by the Department of Correctional Services as is evidenced by the testimony by numerous personnel who testified at the Enquiry, especially in the areas highlighted by the Convention like safety, health, number and suitability of staff who were unable to provide competent supervision.

#### JAMAICA’S CHILDCARE SYSTEM

The “best interests of the child” standard does not appear to be in place throughout Jamaica’s childcare system as the status of the monitoring reports indicated. There is very little information included in the reports as to what is happening in the homes and no documentation provided that evidences changes or improvements on the few occasions where there are recommendations made by the Monitoring Officers. There is no evidence that anything is being done to correct the documented abuses and inadequacies.

#### **Article 4**

Article 4 makes it clear that the State must do all that it can to implement the rights contained in the Convention.

#### THE ARMADALE TRAGEDY

During the Enquiry the testimony of Government employees and officials indicated that there was very little that was done to protect the rights of the girls at Armadale, even with the knowledge that their efforts were below domestic and legal standards for the operation of a juvenile correctional facility.

#### JAMAICA’S CHILDCARE SYSTEM

Jamaica is overtly in violation of this obligation and this has been documented and reviewed in numerous reports, analyses and even the Commission’s own observations of the childcare system in its visit to Jamaica in December 2008. “[The] Jamaican government’s child-care system suffers from disturbing levels of sexual, physical and mental abuse of children at the hands of caregivers, and urgently requires reforms and

additional resources...”<sup>48</sup> Children in the custody of the Government of Jamaica are not and have not been receiving care in accordance with international standards

### **Article 6**

Article 6 states that every child has the inherent right to life, and the State has an obligation to ensure the child's survival and development.

#### **THE ARMADALE TRAGEDY**

The deaths of seven (7) children at Armadale as a result of a fire, in a dormitory which was a fire hazard and breached even basic fire-safety principles, during which proper fire evacuation protocol was not followed and fatal and severe injuries ensued is in violation of Article 6.

#### **JAMAICA'S CHILDCARE SYSTEM**

In one monitoring report received from SOS Children's Home, Stony Hill dated June 24, 2008, the death of a child is noted that was not recorded as a critical incident by the home. There is no expansion in the report as to the circumstances or cause of death of the child. This is inadequate record keeping as to the circumstances under which a child lost his or her life are important to be aware of and to report on.

In 2006 at least four children died in children's homes two of them in a fire at the SOS Children's Home in St. Andrew, one child from ingesting prescription medication, and another child under suspicious circumstances where an autopsy could not determine the cause of death.<sup>49</sup> These deaths strongly suggest Article 6 violation.

### **Article 24**

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

#### **THE ARMADALE TRAGEDY**

The attending physician at Armadale testified at the Enquiry that she believed that ninety per cent (90%) of the girls who lived at that facility were in need of mental health care. She also indicated that when the girls did not receive their medication on time and in the correct dosages it exacerbated their conditions. She also requested additional days to come and attend to the girls and was denied. The rights of all the children receiving inadequate care, inadequate medication, and inadequate treatment from the appropriate

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<sup>48</sup> Inter-American Commission on Human Rights, Press Release No. 59/08, *IACtHR Issues Preliminary Observations on Visit to Jamaica*, December 5, 2008, available at

<http://www.cidh.oas.org/Comunicados/English/2008/59.08eng.htm> (last visited on August 31, 2009).

<sup>49</sup> Edmond Campbell and Daraine Luton, *Fatal Fire Mars Christmas at Children's Village*, THE JAMAICA GLEANER, December 20, 2006, available at <http://jamaica-gleaner.com/gleaner/20061220/lead/lead3.html> (last visited on October 30, 2009).

professionals were violated. Even the Department of Correctional Services' own rules were broken, everyone knew the girls required more attention and no one did anything to provide it.

There were also two girls at Armadale who were infected with HIV/AIDS and only one of whom was receiving the anti-retroviral medication, the other girl was supposed to begin treatment but had not yet begun. While the right of the girl who was not receiving medication for her known condition was being violated, even more recklessly and in disregard of all obligations to protect the health of children in its care the State housed these HIV/AIDS infected with girls who were not infected without strict protective procedures in place and against the advice of a physician in circumstances where the girls' condition could be passed on to the other wards.

#### **JAMAICA'S CHILDCARE SYSTEM**

Reports from one home in particular, the Maxfield Park Children's Home, were enlightening as to how medical care is administered and the lack of importance that is placed on it within the childcare system. The staff in the facility had never received any first aid training and the medical journals documenting the medications the children were to receive were not updated for eleven (11) months. This is in violation of the State's duty to ensure the 'highest attainable standard of health.'

#### ***Article 28***

1. States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity...

#### **THE ARMADALE TRAGEDY**

The girls at Armadale were not receiving a proper education under any standards, including the Department of Correctional Services own guidelines.

#### **JAMAICA'S CHILDCARE SYSTEM**

In a monitoring reports received from the five (5) children's homes, there are consistent reports of truancy, which indicates a lack of supervision and emphasis on the importance of education on the part of the administrators of the homes. Experiences like those of the girls at Windsor Girls Home and the boys at the Alpha Boys Home who were not actively enrolled in a meaningful educational programme are too frequently documented. These instances of a lack of formal engagement in any educational or vocational activity deny the children the opportunity for the full realization of the "rights implicit in the economic, social, educations, scientific and cultural standards set forth."

#### ***Article 29***

1. States Parties agree that the education of the child shall be directed to:

(a) The development of the child's personality, talents and mental and physical abilities to their fullest potential;

(b) The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations;

#### THE ARMADALE TRAGEDY

The children at Armadale received a very basic education when they did attend classes, as there were periods, such as during “lock-down” when they were not allowed to attend classes at all.

#### JAMAICA’S CHILDCARE SYSTEM

The monitoring reports received from children’s homes indicate that there are many instances when children did not attend school because of a lack of transportation or lack of finances. It is the responsibility of the administrators of these homes (and the CDA above them) to ensure that the proper infrastructure is in place to ensure this most vital right of the children in their care, the right to education.

#### **Article 31**

1. States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.

2. States Parties shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity.

#### THE ARMADALE TRAGEDY

The girls at Armadale were not allowed outside during periods of “lock-down.” These periods of lock-down occurred when the girls first arrived at the home and as a form of punishment. This is in complete violation of Article 31.

#### **Article 37**

No child shall be subjected to torture, cruel treatment or punishment, unlawful arrest or deprivation of liberty. Both capital punishment and life imprisonment without the possibility of release are prohibited for offences committed by persons below 18 years. Any child deprived of liberty shall be separated from adults unless it is considered in the child's best interests not to do so. A child who is detained shall have legal and other assistance as well as contact with the family.

#### THE ARMADALE TRAGEDY

The terms of “lock-down” which included twenty-three (23) girls being locked in a small room (12 feet x 20 feet.)<sup>50</sup> for multiple days, being forced to eat with their hands<sup>51</sup>, and to

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<sup>50</sup> Tanesha Mundie, *Requests for Additional Space at Juvenile Centre Were Ignores, Says case Manager*, THE JAMAICA OBSERVER, August 5, 2009, available at [http://www.jamaicaobserver.com/news/html/20090804T210000-0500\\_156807\\_OBS\\_REQUESTS\\_FOR\\_ADDITIONAL\\_SPACE\\_AT\\_JUVENILE\\_CENTRE\\_WERE\\_IGNORED\\_\\_SAYS\\_CASE\\_MANAGER.asp](http://www.jamaicaobserver.com/news/html/20090804T210000-0500_156807_OBS_REQUESTS_FOR_ADDITIONAL_SPACE_AT_JUVENILE_CENTRE_WERE_IGNORED__SAYS_CASE_MANAGER.asp) (last visited on October 14, 2009).

use one or two buckets as a toilet amongst a large number of people objectively amounts to cruel treatment, if not to torture.

Immediately following the fire at Armadale some the children who were housed there were transferred to an adult institution, the Horizon Remand Centre, despite the fact that Children's Advocate had received complaints in March 2008 about wards being physically abused at this facility.<sup>52</sup> Mrs. Clarke said in testimony at the Enquiry on September 2, 2009, *The complaints were not as strong from Armadale as those from Horizon and Fort Augusta [another adult facility]. Complaints were about poor food quality and the abuse. At Horizon and Fort Augusta, the wards were physically abused. Complaints were sent to the Director of Public Prosecutions.* In spite of the Children's Advocate's knowledge that children are being put in compromising and dangerous conditions in adult facilities, authorities including the CDA continue to send children to these facilities and children are often kept in these facilities for prolonged periods.<sup>53</sup>

#### JAMAICA'S CHILDCARE SYSTEM

There continues to be an extremely worrisome and disturbing trend of placing children in adult facilities.

#### **Article 40**

A child in conflict with the law has the right to treatment, which promotes the child's sense of dignity and worth, takes the child's age into account and aims at his or her reintegration into society. The child is entitled to basic guarantees as well as legal or other assistance for his or her defence. Judicial proceedings and institutional placements shall be avoided wherever possible.

#### THE ARMADALE TRAGEDY

The girls at Armadale endured treatment that did not 'promote their sense of dignity and worth' not the least of which was being forced to use one bucket for excrement amongst twenty-three (23) girls. This is treatment that denigrated the children's sense of dignity and self-worth.

One of the girls from Armadale testified on July 12, 2009 at the Enquiry and said, *The bathroom we could use had a bath and toilet, no face basin – twenty-three (23) of us had to use that bathroom...One (1) hour for everybody to shower and then they turned off the pipe – the staff sometimes they would give you a chance if soaped up to wash off, sometimes not...After dinner the dorm door was locked – we were not able use bathroom – on or off lock-down this was so. Had to use the bucket at night, we didn't have our own*

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<sup>51</sup> Gleaner/ Power 106 News, *Armadale Ward Attest to Overcrowding, Deplorable Conditions at the Facility*, THE JAMAICA GLEANER, August 19, 2009, available at [http://go-jamaica.com/news/read\\_article.php?id=11815](http://go-jamaica.com/news/read_article.php?id=11815) (last visited on October 14, 2009).

<sup>52</sup> Howard Campbell, *Armadale Girls Get Fresh Start – New Home at Diamond Crest, Manchester*, THE JAMAICA GLEANER, May 31, 2009 available at <http://www.jamaica-gleaner.com/gleaner/20090531/lead/lead8.html> (last visited on October 28, 2009).

<sup>53</sup> The Jamaica Gleaner, *supra* note 32.

*personal bucket, it was always at the side of the door, sometime two (2), sometimes one (1). Some girls didn't use bucket, they used other things – newspaper. Bucket never got full some nights. I used the bucket. I didn't feel comfortable using the bucket. I feel bad in myself; sometimes I wish I had never been born.*

**D. United Nations Standard Minimum Rules for the Administration of Juvenile Justice (“The Beijing Rules”)<sup>54</sup>**

**1. Fundamental Perspectives:**

1.1 Member States shall seek, in conformity with their respective general interests, to further the well-being of the juvenile and her or his family.

1.3 Sufficient attention shall be given to positive measures that involve the full mobilization of all possible resources, including the family, volunteers and other community groups, as well as schools and other community institutions, for the purpose of promoting the well-being of the juvenile, with a view to reducing the need for intervention under the law, and of effectively, fairly and humanely dealing with the juvenile in conflict with the law.

**THE ARMADALE TRAGEDY**

The Department of Correctional Services of the Government of Jamaica does have as one of its purposes and objectives, “[t]o provide an array of rehabilitation programmes to all wards so as to effect positive change in their behaviour”,<sup>55</sup> however, this mandate was not followed through in relation to the girls at Armadale who suffered indignities and mistreatment at Armadale which ultimately resulted in the deaths of seven (7) children.

As Mrs. Spence-Jarrett’s testimony illustrates there was not enough attention paid to implementing positive measures to provide a safe and rehabilitative environment for children in conflict with the law who were in the custody of the State. In her testimony on September 4, 2009 she said, *There should be fire alarms and formal drills to ensure safety of juveniles. Standards regarding sleeping should have small groups. With what we had at Armadale couldn't have that because of inadequacy of structure...I was mainly an overseer to see things went well on the ground. I expected those below to do their jobs.*

The girls at Armadale were sharing beds as one child testified on July 12, 2009 and said, *Sleeping was two (2) girls in a bed sleeping next to each other. A decker is a bunk, top and bottom, four (4) girls slept to a decker.* It is against the Department of Correctional Services’ own rules to assign more than one girl to a bed.

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<sup>54</sup> UN General Assembly, *United Nations Standard Minimum Rules for the Administration of Juvenile Justice (“The Beijing Rules”)*: resolution / adopted by the General Assembly, 29 November 1985, A/RES/40/33, available at: <http://www.unhcr.org/refworld/docid/3b00f2203c.html> (last visited on September 10, 2009).

<sup>55</sup> Department of Correctional Services of Jamaica: Administration, *supra* note 16.

There is no accountability amongst the relevant authorities in charge of Jamaica's childcare system from the very top of the managerial ladder to the Ministers in charge of the respective ministries. JFJ sent letters to the Ministers of National Security and Health asking for clarification as to which branch of the Government of Jamaica is responsible for the welfare of children in conflict with the law once they are in the custody of the State to date we have not received a response.<sup>56</sup>

## **17. Guiding Principles:**

17.1 The disposition of the competent authority shall be guided by the following principles:

( a ) The reaction taken shall always be in proportion not only to the circumstances and the gravity of the offence but also to the circumstances and the needs of the juvenile as well as to the needs of the society;

( b ) Restrictions on the personal liberty of the juvenile shall be imposed only after careful consideration and shall be limited to the possible minimum;

( c ) Deprivation of personal liberty shall not be imposed unless the juvenile is adjudicated of a serious act involving violence against another person or of persistence in committing other serious offences and unless there is no other appropriate response;

### **THE ARMADALE TRAGEDY**

One girl who was fourteen-years-old (14 years old) from Armadale testified on August 8, 2009, about why she was at Armadale and said, *I went to Armadale just a few weeks before the fire. I was taken before a court, but not accused of any offence. They saw me wandering in the town and took me to the police station.* This girl was not charged with an offence but was still placed in a juvenile correctional facility, while this girl was at Armadale she was stabbed by another girl, *The day after Sports Day I got stab up. They never had any investigative hearing about it. I never started it. It was not really a fight. The girl who stabbed me up was not punished.*

This young girl was never accused or charged with a 'serious act or offence' and yet was placed in a juvenile correctional facility where she suffered an act of violence against her. While this young girl was found wandering the streets, another more 'appropriate response' would have been to place her in a children's home.

The Children's Advocate testified on, September 2, 2009 and said, *At Armadale girls were all put together, whether they were there for care and protection, girls with correctional orders and girls on remand. This was so in September 2007. We would then have a separation of categories as is required.* This separation of categories did not happen in the case of this child who got stabbed.

Placing a young girl who has not been charged with an offense in a juvenile correctional facility with children who have presumably been charged with serious offences or

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<sup>56</sup> Jamaicans For Justice, *supra* note 28.

committed serious acts involving violence is irresponsible and goes against the Guiding Principles.

## **26. Objectives of Institutional Treatment:**

26.1 The objective of training and treatment of juveniles placed in institutions is to provide care, protection, education and vocational skills, with a view to assisting them to assume socially constructive and productive roles in society.

26.2 Juveniles in institutions shall receive care, protection and all necessary assistance-social, educational, vocational, psychological, medical and physical-that they may require because of their age, sex, and personality and in the interest of their wholesome development.

### *Commentary*

Medical and psychological assistance, in particular, are extremely important for institutionalized drug addicts, violent and mentally ill young persons.

### THE ARMADALE TRAGEDY

The girls at Armadale did not receive the assistance they required in many of the areas the Beijing Rules outline as necessary for wholesome development, including ‘educational, vocational, psychological, medical and physical’ care they required.

Armadale’s training programmes did not fulfil the Department of Correctional Services own guidelines as to what was necessary for a balanced education. The girls at Armadale were not receiving ‘care, protection, education or vocational skills’ that would help them to develop into responsible citizens.

The *Commentary* indicates the Government of Jamaica has a heightened responsibility to ensure that medical and psychological assistance is provided for mentally ill young persons. Dr. Micas Campbell, the attending physician providing weekly care at Armadale, indicated that in her opinion ninety per cent (90%) of the girls at Armadale were in need of psychological treatment and the timely administration of medication, which many of them did not receive.

In *Reeducation Institute* the Court said of the conditions at the Institute, “the subhuman and degrading detention conditions that all the inmates at the Centre were forced to endure inevitably affected their mental health, with adverse consequences for psychological growth and development of their lives and mental health.”<sup>57</sup>

The children at Armadale who came to the facility with undiagnosed and untreated mental health issues were forced to endure conditions that could conceivably have exacerbated those conditions, in direct contravention of the Objectives of Institutional

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<sup>57</sup> Inter-American Court on Human Rights, *supra* note 33 at ¶ 168.

Treatment and as the Court condemned in *Reeducation Institute* would have ‘adverse consequences.’ The State did nothing to improve the deplorable conditions which existed at Armadale.

**E. United Nations Rules for the Protection of Juveniles Deprived of Their Liberty<sup>58</sup>**

**3.** The Rules are intended to establish minimum standards accepted by the United Nations for the protection of juveniles deprived of their liberty in all forms, consistent with human rights and fundamental freedoms, with a view to counteracting the detrimental effects of all types of detention and to fostering integration in society.

**THE ARMADALE TRAGEDY**

The children at Armadale were not protected and some lost their lives and others suffered through a horrific experience in the fire of May 22, 2009, because the State did not implement these ‘Rules for the Protection of Juveniles Deprived of Their Liberty.’

**12.** The deprivation of liberty should be effected in conditions and circumstances which ensure respect for the human rights of juveniles. Juveniles detained in facilities should be guaranteed the benefit of meaningful activities and programmes which would serve to promote and sustain their health and self-respect, to foster their sense of responsibility and encourage those attitudes and skills that will assist them in developing their potential as members of society.

**THE ARMADALE TRAGEDY**

There was a Sports Day held at Armadale on or about April 21, 2009 for the girls and this was a ‘meaningful activity’ as this rule describes, promoting health and self-respect. This single activity, however, could in no way counterbalance the many degrading and dehumanising conditions that imposed on the girls at Armadale such as being punished in “lock-down” for weeks at time without ever being allowed outside of the dormitory.

The children at Armadale were not guaranteed even the most basic of meaningful activities and programmes that served to promote rehabilitation and this is in violation of this Rule.

**13.** Juveniles deprived of their liberty shall not for any reason related to their status be denied the civil, economic, political, social or cultural rights to which they are entitled under national or international law, and which are compatible with the deprivation of liberty.

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<sup>58</sup> UN General Assembly, *United Nations Rules for the Protection of Juveniles Deprived of Their Liberty*: resolution/ adopted by the General Assembly, 14 December 1990, A/RES/45/113, available at <http://www.un.org/documents/ga/res/45/a45r113.htm> (last visited October 26, 2009).

#### **THE ARMADALE TRAGEDY**

The juveniles at Armadale were denied their ‘civil, economic, political, social or cultural rights’ as is evidenced in the testimony that emerged during the Enquiry such as not receiving a standard education and being given buckets to be used as toilets while in confinement with many other children.

- 14.** The protection of the individual rights of juveniles with special regard to the legality of the execution of the detention measures shall be ensured by the competent authority, while the objectives of social integration should be secured by regular inspections and other means of control carried out, according to international standards, national laws and regulations, by a duly constituted body authorized to visit the juveniles and not belonging to the detention facility.

#### **THE ARMADALE TRAGEDY**

There is an unclear division of authority between the government agencies of the Ministry of Health and the Ministry of National Security and Justice regarding the administration and oversight of the juvenile correctional facilities in Jamaica. The Commissioner of Corrections is apparently the official in ultimate control over the juvenile correctional facilities, but the Child Development Agency has responsibility for the welfare of all children who are in the care of the state even those housed in these facilities. JFJ has not been able to determine the exact responsibilities of each department as it relates to State juveniles institutions like Armadale.

Under the *Child Care and Protection Act*, however, the Office of the Children’s Advocate is to act as an independent body overseeing the welfare of all children who are in the custody of the State, presumably including protecting the rights of children in conflict with the law who are in the custody of the State. The Children’s Advocate testified at the Enquiry and in her testimony on September 2, 2009, described a meeting held at her office with personnel from the Department of Correctional Services held on September 24, 2007, at which issues concerning the juvenile correctional centres were discussed. At that meeting, the then superintendent of Armadale raised concerns for the need for specialist staff, counselling for the girls, a case-worker and the lack of direct supervision of girls in the nights. During this meeting the problem with space was also discussed. The Children’s Advocate was aware of administrative problems at Armadale for over one (1) year before the fire in May 2009, and apparently did nothing more than conduct meetings and make recommendations as it related to these to these concerns.

- 28.** The detention of juveniles should only take place under conditions that take full account of their particular needs, status and special requirements according to their age, personality, sex and type of offence, as well as mental and physical health, and which ensure their protection from harmful influences and risk situations. The principal criterion for the separation of different categories of juveniles deprived of their liberty should be the provision of the type of care best suited to the particular needs of the

individuals concerned and the protection of their physical, mental and moral integrity and well-being.

#### THE ARMADALE TRAGEDY

The conditions at Armadale were deplorable and did not take into account the needs or special requirements of children placed in a juvenile correctional facility and in need of rehabilitative care. The care and attention necessary to protect children, most of whom were mentally disturbed did not exist at Armadale. Even rudimentary precautions to ensure the safety of the girls, such as regularly searching the dormitories for contraband and paraphernalia which the girls could use to harm themselves and others (especially in light of past occurrences) were not implemented. A girl from the facility who testified at the Enquiry on July 13, 2009, said *They used metal things and broken glass to do bad things to each other. The staff knew of this. They came and do dorm search and found these things. Girls would use them in fights and got cut and injuries. Dorm search - not regular. When fight and somebody get cut they would do dorm search - not other times.*

**29.** In all detention facilities juveniles should be separated from adults, unless they are members of the same family. Under controlled conditions, juveniles may be brought together with carefully selected adults as part of a special programme that has been shown to be beneficial for the juveniles concerned.

#### THE ARMADALE TRAGEDY

In February 2008, some girls from Armadale were transferred to an adult correctional facility because of “security reasons” and according to the testimony of the Children’s Advocate given on September 3, 2009, because of over-crowding at Armadale. Mrs. Clarke said, *The Department of Correctional Services sought permission to send children to Fort Augusta [an adult institution]. My office never conducted a physical inspection of Armadale. We were concerned about girls being placed in adult facilities. Visited time and time again to keep in line with conventions and rights. That was our primary concern - where we got the horror stories from.*

In the testimony of a child given on August 13, 2009, she said, *I went to Armadale on May 1, 2009. Before Armadale I used to go to school, but I was at a police station for a month before I was sent to Armadale.* This child was kept at a police station lock-up for weeks before being transferred to a facility

#### JAMAICA’S CHILDCARE SYSTEM

The *Child Care and Protection Act* includes a provision allowing for children in conflict with the law to be placed in adult detention centres. In the section entitled, ‘Methods of Dealing with Child Offenders,’ § 76 (6) of the *Act*, it reads, “The court may, notwithstanding anything to the contrary, direct that the child be detained in such place (including an adult correctional centre) and for such time, not exceeding the unexpired portion of the period during which he could have been detained in the juvenile

correctional centre under the authority of that order, and on such conditions as the court may think fit.” JFJ believes this provision in the *Act* may be in contravention of both international law spelled out in the Convention on the Rights of the Child, Article 37 and *jus cogens* where children in conflict with the law are to be housed separately from adult offenders.

**31.** Juveniles deprived of their liberty have the right to facilities and services that meet all the requirements of health and human dignity.

**THE ARMADALE TRAGEDY**

The standard of the conditions at Armadale were far below the conditions that would allow for the maintenance of human dignity.

Some girls at Armadale were also housed in the “Bathroom Dorm” (essentially a bathroom into which beds had been placed) where other children had to come and use the facilities under the gaze of the girls who lived in that “dorm”, there was no privacy afforded to these girls. One girl testified at the Enquiry on August 20, 2009, and said *I was in the Bathroom Dorm. The room was like exactly in the bathroom. I don't remember how many beds. No cupboards in Bathroom Dorm. Two (2) toilets were in there. Neither toilet worked. You had to use water to flush it, sometime it bung up. Two (2) showers in there. One (1) big one with lots of pipes and a small one and two (2) face basins. All the showers worked. Nothing divided the different pipe sections from each other. Several girls used the big shower at same time. Nothing to block off the shower, nothing to hide, no curtain. If someone is lying on bed, they can see person in shower, can stand up and look on them. There was a shower curtain for the small shower. Those who lived in Bathroom Dorm would be in there when girls using shower and toilets. The water from the big shower wet up the floor and place get easily dirty.*

The girls at Armadale also only got one (1) hour in the mornings when the bathroom would be opened with running water. These demeaning actions are in violation of Rule 31.

**32.** The design of detention facilities for juveniles and the physical environment should be in keeping with the rehabilitative aim of residential treatment, with due regard to the need of the juvenile for privacy, sensory stimuli, opportunities for association with peers and participation in sports, physical exercise and leisure-time activities. The design and structure of juvenile detention facilities should be such as to minimize the risk of fire and to ensure safe evacuation from the premises. There should be an effective alarm system in case of fire, as well as formal and drilled procedures to ensure the safety of the juveniles. Detention facilities should not be located in areas where there are known health or other hazards or risks.

**THE ARMADALE TRAGEDY**

The Commissioner of Correctional Services testified during the Enquiry that the physical infrastructure of Armadale was unsuitable to accommodate the needs of the children who

were housed there. She said in her testimony, *The dorms were not built to house children. Out of desperation they had to be placed there, so specifications would not meet the international agreements.* Notwithstanding that there had been previous fires, there were no fire drills, no operable fire extinguishers and no apparent systems in place for alarms.

**33.** Sleeping accommodation should normally consist of small group dormitories or individual bedrooms, account being taken of local standards. During sleeping hours there should be regular, unobtrusive supervision of all sleeping areas, including individual rooms and group dormitories, in order to ensure the protection of each juvenile. Every juvenile should, in accordance with local or national standards, be provided with separate and sufficient bedding, which should be clean when issued, kept in good order and changed often enough to ensure cleanliness.

#### THE ARMADALE TRAGEDY

Even under the local standards, those established by the Department of Correctional Services, the sleeping arrangements at Armadale were inappropriate. The children at Armadale did not have separate or sufficient bedding. One girl testified at the Enquiry on July 12, 2009, said of the sleeping arrangements, *Sleeping two (2), two girls in a bed, sleeping next to each other. A decker is a bunk, top and bottom, four (4) girls slept to a decker..*

**34.** Sanitary installations should be so located and of a sufficient standard to enable every juvenile to comply, as required, with their physical needs in privacy and in a clean and decent manner.

#### THE ARMADALE TRAGEDY

The girls at Armadale were given buckets to use at night as a toilet whether the punishment of “lock-down” was in effect or not. And as Dr. Micas Campbell testified at the Enquiry these conditions were unhealthy.

**37.** Every detention facility shall ensure that every juvenile receives food that is suitably prepared and presented at normal meal times and of a quality and quantity to satisfy the standards of dietetics, hygiene and health and, as far as possible, religious and cultural requirements. Clean drinking water should be available to every juvenile at any time.

#### THE ARMADALE TRAGEDY

The girls at Armadale during “lock-down” were forced to eat their meals in their dormitories and were made to eat with their hands.<sup>59</sup> These conditions are not in keeping with cultural standards in Jamaica. People eat with utensils in Jamaica and to be deprived of eating utensils is a degrading exercise and would lower a person’s self-dignity. Not

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<sup>59</sup> Gleaner/ Power 106 News, *supra* note 51.

only is this practice a breach of cultural standards but was an even more egregious practice in light of the unsanitary conditions at Armadale.

**38.** Every juvenile of compulsory school age has the right to education suited to his or her needs and abilities and designed to prepare him or her for return to society. Such education should be provided outside the detention facility in community schools wherever possible and, in any case, by qualified teachers through programmes integrated with the education system of the country so that, after release, juveniles may continue their education without difficulty. Special attention should be given by the administration of the detention facilities to the education of juveniles of foreign origin or with particular cultural or ethnic needs. Juveniles who are illiterate or have cognitive or learning difficulties should have the right to special education.

#### THE ARMADALE TRAGEDY

The children at Armadale did not receive educational opportunities that met even the most basic standards set by the Department of Correctional Services.

**47.** Every juvenile should have the right to a suitable amount of time for daily free exercise, in the open air whenever weather permits, during which time appropriate recreational and physical training should normally be provided. Adequate space, installations and equipment should be provided for these activities. Every juvenile should have additional time for daily leisure activities, part of which should be devoted, if the juvenile so wishes, to arts and crafts skill development. The detention facility should ensure that each juvenile is physically able to participate in the available programmes of physical education. Remedial physical education and therapy should be offered, under medical supervision, to juveniles needing it.

#### THE ARMADALE TRAGEDY

During “lock-down”, which was frequent, the girls at Armadale were not allowed to go outside of the dormitories at all, much less given time to enjoy the outdoors and to exercise. Even outside of lockdown there is little evidence of any physical or recreational activity.

**49.** Every juvenile shall receive adequate medical care, both preventive and remedial, including dental, ophthalmological and mental health care, as well as pharmaceutical products and special diets as medically indicated. All such medical care should, where possible, be provided to detained juveniles through the appropriate health facilities and services of the community in which the detention facility is located, in order to prevent stigmatization of the juvenile and promote self-respect and integration into the community.

#### THE ARMADALE TRAGEDY

The attending physician at Armadale, Dr. Campbell, saw the girls at Armadale once a week. She requested additional days to attend to the girls but her request was denied.<sup>60</sup>

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<sup>60</sup> Kimesha Walters, *supra* note 11.

The girls were not receiving adequate medical care as Dr. Campbell's testimony at the Enquiry indicates.

**51.** The medical services provided to juveniles should seek to detect and should treat any physical or mental illness, substance abuse or other condition that may hinder the integration of the juvenile into society. Every detention facility for juveniles should have immediate access to adequate medical facilities and equipment appropriate to the number and requirements of its residents and staff trained in preventive health care and the handling of medical emergencies. Every juvenile who is ill, who complains of illness or who demonstrates symptoms of physical or mental difficulties, should be examined promptly by a medical officer.

#### THE ARMADALE TRAGEDY

In the opinion of Dr. Micas Campbell over ninety percent (90%) of the girls at Armadale were mentally disturbed; however they were not receiving the mental health care that they needed.

**53.** A juvenile who is suffering from mental illness should be treated in a specialized institution under independent medical management. Steps should be taken, by arrangement with appropriate agencies, to ensure any necessary continuation of mental health care after release.

#### THE ARMADALE TRAGEDY

The Commissioner of Corrections explained in her testimony given at the Enquiry that there was only one (1) psychologist assigned to the entire Department of Correctional Services and this was the reason the girls at Armadale were unable to receive adequate mental health care. Armadale did use sessional personnel to attend to the needs of the girls but these sessions were woefully inadequate to meet their needs as Dr. Campbell pointed out repeatedly in her testimony.

**66.** Any disciplinary measures and procedures should maintain the interest of safety and an ordered community life and should be consistent with the upholding of the inherent dignity of the juvenile and the fundamental objective of institutional care, namely, instilling a sense of justice, self-respect and respect for the basic rights of every person.

#### THE ARMADALE TRAGEDY

The disciplinary measure of "lock-down" consisted of horrific practices that would erode the dignity of any human being, much less to be inflicted upon vulnerable children. The general inadequacy of the physical infrastructure of the buildings at Armadale and the mismanagement of the facility in terms of staff shortages contributed to the degrading and cruel treatment the girls who lived at Armadale. There was no sense of justice, self-respect instilled in the girls who lived at Armadale and their very basic human rights were violated as a result.

**67.** 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. The reduction of diet and the restriction or denial of contact with family members should be prohibited for any purpose. Labour should always be viewed as an educational tool and a means of promoting the self-respect of the juvenile in preparing him or her for return to the community and should not be imposed as a disciplinary sanction. No juvenile should be sanctioned more than once for the same disciplinary infraction. Collective sanctions should be prohibited.

#### THE ARMADALE TRAGEDY

The Commissioner of Corrections was aware that solitary confinement was a practice that occurred at Armadale under the name of “isolation.” In her testimony on September 8, 2009, *I am aware of a holding area to isolate disruptive wards.... In a series of monthly meetings attendants were reminded that the children were not to be put in isolation for more than 72 hours. No specific reasons for this constant reminder. I was not aware of lock down at Armadale for weeks or any isolation for week. We have an orientation on admission not isolation.*

The very nature of “lockdown” was collective. One of the girls attempted to run away on Sports Day and all the girls were placed on lockdown and seven girls attempted to run away in May and all the girls received lockdown.

**79.** All juveniles should benefit from arrangements designed to assist them in returning to society, family life, education or employment after release. Procedures, including early release, and special courses should be devised to this end.

#### THE ARMADALE TRAGEDY

While vocational courses are part of the curriculum prescribed the Department of Correctional Services the girls at Armadale were not actively engaged in any such activities on a regular, consistent basis.

#### F. United Nations Declaration of Commitment on HIV/AIDS<sup>61</sup>

**15.** Recognizing that access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;

#### THE ARMADALE TRAGEDY

One of the girls who was infected with HIV/AIDS did not receive medication to treat her infection. The Government of Jamaica clearly violated its duty to provide medication for

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<sup>61</sup> UN General Assembly, *United Nations Declaration of Commitment on HIV/AIDS*: resolution / adopted by the General Assembly, 27 June 2001, S-26/2, available at <http://www2.ohchr.org/english/law/hiv.htm> (last visited on October 13, 2009).

the girl, as the relevant authorities were aware she was infected and had knowledge of how to obtain the medication as the other girl who was infected was already receiving treatment in the form of anti-retroviral medication.

**16.** Recognizing that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS;

#### THE ARMADALE TRAGEDY

The Government of Jamaica wilfully ignored the recommendation of the physician for Armadale, Dr. Micas Campbell, when she recommended the transfer of the girls who were HIV/AIDS-positive to another institution where they would be cared for properly and would not be in danger of infecting others.

The full realization of human rights and fundamental freedoms of the children at Armadale was not fulfilled when the girls who were HIV/AIDS-positive remained at the institution against the recommendation of the physician and the other girls were knowingly placed in danger of becoming infected with the virus because the girls who were infected ‘were not being careful.’

**17.** Acknowledging that prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic, and that prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic;

#### THE ARMADALE TRAGEDY

The relevant authorities at Armadale were not employing a ‘comprehensive approach’ to a situation they knew about where two girls were infected with HIV/AIDS.

### G. United Nations Principles for the Protection of Persons With Mental Illness and the Improvement of Mental Health Care<sup>62</sup>

#### **Principle 1: Fundamental Freedoms and Basic Rights**

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.

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<sup>62</sup> UN General Assembly, *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*: resolution/ adopted by the General Assembly 17 December 1991, available at <http://www2.ohchr.org/english/law/principles.htm> (last visited on October 13, 2009).

#### **THE ARMADALE TRAGEDY**

The testimony of Dr. Micas Campbell, the treating physician at Armadale, clearly highlighted the breaches of this Principle, when she said treatment was neither routinely nor adequately provided to the wards at Armadale.

#### **Principle 2: Protection of Minors**

Special care should be given within the purposes of these Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.

#### **THE ARMADALE TRAGEDY**

“Special care” for mentally ill minors is to be provided under international law and the Jamaican *Child Care and Protection Act*. The girls at Armadale were not provided with the mental health care they needed and which was recommended by the attending physician.

#### **Principle 8: Standards of Care**

1. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.
2. Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.

#### **THE ARMADALE TRAGEDY**

The Jamaican Government is in violation by failing to provide medical treatment to the mentally and physically ill wards at Armadale. Medical attention was not given as frequently as was required and treatment was not consistently and routinely given according to the prescription of the attending physician.

## **V. Recommendations**

JFJ hopes that the Commission will endorse these further recommendations In addition to the recommendations made in our 2006 report to try and align Jamaica’s childcare system with the human rights obligations Jamaica has undertaken to uphold for the nation’s children. These recommendations are:

- To include information and critical statements made during this hearing in your country report on Jamaica due in 2010;
- To include in your annual report for 2009 in the chapter on Children’s Rights the precise recommendations you make to the State;
- To strongly encourage the State to enact measures within its childcare system to ensure compliance with its responsibilities and obligations under the *American Convention* and the *UN Convention on the Rights of the Child*, both of which it is a signatory to and is bound by;
- To forcefully remind the State of the guidelines established by the *UN Minimum Rules for the Administration of Juvenile Justice, UN Rules for the Protection of Juveniles Deprived of Their Liberty, UN Declaration of Commitment on HIV/AIDS*, and the *UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*;
- To urge the State to take measures similar to those ordered by the Court in *Reeducation Institute*<sup>63</sup> to:
  - Carry out a public act of acknowledgement of international responsibility for the Armadale tragedy;
  - To issue new State policies on the matter of children in conflict with the law that fully comports with Jamaica’s international commitments, including, beginning to refer to “juveniles” as “children in conflict with the law”;
    - These new policies are to be presented by high-ranking State officials in a public ceremony wherein Jamaica’s responsibility for the substandard detention conditions at Armadale is acknowledged.

## **VI. Conclusion**

As the Commission has noted, “the Jamaican government’s child-care system suffers from disturbing levels of sexual, physical and mental abuse of children at the hands of caregivers, and urgently requires reforms and additional resources...[and the] Commission received information that the conditions of detention of juveniles in...detention centres fail to comply with international standards”<sup>64</sup> JFJ believes that the Armadale tragedy that resulted in fatalities is an absolute marker of just how desperately Jamaica’s childcare system is in need of substantial and swift reform.

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<sup>63</sup> Inter-American Court on Human Rights, *supra* note 31 at *Operative Paragraphs ¶¶¶ 11, 12, 13.*

<sup>64</sup> Inter- American Commission on Human Rights, *supra* note 47.