REPORT TO THE ATTORNEY GENERAL

PUBLIC INQUIRY

THE FATALITY INQUIRIES ACT

CANADA
PROVINCE OF ALBERTA

A Public Inquiry into the death of [redacted] was held at Didsbury and Calgary, Alberta before M. Delong, a Provincial Court Judge. A jury was not summoned.

The Inquiry was held on October 14, November 18, 25, 1994, February 27, March 1, 2, April 10, May 8 and 9, 1995. The following findings were made:

1. **Date and Time of Death:** June 17, 1994, between 7:00 P.M. and 9:30 P.M.

2. **Place:** Quest Ranch, Cremona, Alberta

3. **Medical Cause of Death:** Asphyxia due to, or as a consequence of, hanging

4. **Manner of Death:** Suicide

5. **Circumstances Under Which Death Occurred:**

Between September 14, 1993 and June 17, 1994, [redacted] boy who was the subject of a Permanent Guardianship Order in favour the Director of Child Welfare of the Province of Alberta, resided at an outreach home associated with the Quest Ranch. Quest Ranch is a private agency that contracted with the Department of Family and Social Services (the "Department") to provide residential care for [redacted] as well as others.

On June 16, 1994, a substitute teacher found [redacted] journal open on his desk at a page on which [redacted] had written:

> Last Note
> If I am dead when you read this, I'm sorry for having to leave this way I might not be mad or upset when I kill myself. But I decided a long time ago that I would do it because I won't be anything.

The note was not dated. It was immediately brought to the attention of Don Hale, the owner of Quest Ranch and Program Director of the residential care program carried out on the ranch. He, in turn, advised Darren Cornforth, [redacted] key worker on the ranch, and David Hale, a son of Don Hale and the Manager of the Outreach Program of Quest Ranch. After a brief discussion concerning the note and the inquiry that should be made of [redacted] to assess the seriousness of his threat to commit suicide, Darren Cornforth and David Hale met with [redacted] and discussed the note with him. [redacted] stated he did not intend to commit suicide, he did not have a plan to kill himself and the note had been written weeks before. Darren Cornforth and David Hale accepted this explanation and subsequently advised Don Hale of the result of their discussion with [redacted] regarding the note.

Immediately prior to the news of the note, [redacted] had been meeting with Darren Cornforth and David Hale concerning an altercation in which [redacted] had been involved earlier that day with another student in his class. In addition, they were preparing and waiting for a telephone conference call with Donna Samagalski, a Child Welfare social worker and [redacted] case manager. The telephone conference was to deal with [redacted] future placement because the Quest Ranch placement would ordinarily have ended on June 30, 1994. During the days and weeks prior, [redacted] had been vacillating between the options open to him concerning his future placement. [redacted] was expected to inform Ms. Samagalski of his decision during this telephone conference.

There is conflicting evidence and a great deal of concern registered by Don Hale, Quest Ranch staff, Ms. Samagalski and the Department of Family and Social Services about whether the suicide note was brought to the attention of Ms. Samagalski on June 16, 1994 at the end of this meeting (after [redacted] had left the discussion), or, in the morning of June 17, during a telephone call between Ms. Samagalski and David Hale. If notice was given to Ms. Samagalski on June 16, Quest Ranch staff would have complied with the requirements of their contract which provided that the social worker be contacted as soon as possible in the event of a critical incident such as a suicide threat or attempt: Exhibit 12, para. 1.1.10. If notice was not given until June 17, it is suggested a breach of the requirements had occurred and the late notice on June 17 resulted in the suicide note not receiving the attention it would have had the day before.

In my opinion, it is wishful thinking, with the benefit of hindsight, to suggest earlier notification of the note would have resulted in other steps being taken. The advice provided on the morning of June 17 concerning the finding of the note, some ten to twelve hours before [redacted] death, would have allowed preventive action to have been taken, yet no steps were taken. I am not satisfied Ms. Samagalski would have acted differently had she been advised of the note on June 16.

In fact, everyone involved with [redacted] was of the view [redacted] did not represent a significant risk of committing suicide. The explanation given by him on being confronted was accepted at face value and [redacted] future placement was then seen as the next order of business. Those involved with [redacted] were concerned with the need to have some decision in place and acted on at the end of the Quest Ranch program scheduled for June 30, i.e. within two weeks. This concern, regarding his placement, in the context of

his earlier vacillation as to that placement, what appeared to be his final decision on June 16, and [redacted] apparent good mood and high spirits on June 17, appears to have caused everyone to let down their guard.

The outreach parents were not told of the note on June 16. However, on June 17, during the usual early morning meeting of the Quest Ranch staff, Gary Ayre, a teacher at the ranch and [redacted] outreach parent, was told of the finding of the note and the discussion with [redacted] [redacted] was not considered at risk of committing suicide by anyone at the meeting.

During the evening of June 17, 1994, [redacted] was left at his outreach home to baby-sit Gary and Elaine Ayre's two children. At some time between 7:00 and 9:30 P.M., [redacted] left the two children in the home watching television. He indicated he was going out to catch a horse that was being broken by the Ayres. At approximately 9:30 P.M., he was found by Gary Ayre's nephew in the horse shelter, hanging from a joist by a rope around his neck.

During the investigation into [redacted] death, his journal was located and another entry was found, this one was dated June 16, 1994. It states:

> When I first got to Quest I could care less and I regret it now. If I don't get this placement again and I'm screwed. I will know then I wasn't made for this earth. I wanted to be a great hockey player I could be boy dies from news. [redacted]

[redacted] like all the children involved in the Quest Ranch program, had been encouraged to keep a journal on the understanding that his privacy would be respected by the staff. Not having come to anyone's attention before June 17, this entry, particularly noting the date, cannot be considered as relevant to any

recommendations. It was not available for consideration by anyone at any relevant time.

6. Recommendations for the Prevention of Similar Deaths:

The issues raised in this inquiry involve, among others: what role the number and quality of the placements experienced by [redacted] played; what risk of suicide [redacted] represented at the time of his entry into the Quest Ranch program; who was informed of the finding of the suicide note on June 16, 1994, the day before his suicide; what was done and by whom regarding the threat of suicide, and what training and experience in suicide assessment and prevention the parties involved had.

1. [redacted] Placement History

[redacted] was born on [redacted] On July 18, 1981, at almost three years of age, he was apprehended by the Government of Alberta due to the arrest and incarceration of his mother and the living conditions in which he and his older brother were found. He remained a ward of the Province until his death.

Between the age of three to fifteen years, that is, from his initial apprehension to his placement at Quest Ranch, [redacted] experienced at least nineteen placements, three of which were unsuccessful attempts at adoption. I refer to "at least" nineteen placements because [redacted] committed a number of criminal offenses and spent some time in open and closed custody within the young offender system. I have counted the time spent in custody within the young offender system as one placement although [redacted] was moved among various facilities within that system.

Everyone involved with [redacted] agrees, and it is clear from his behaviour, that he had difficulties relating to other people. A number of placements were unsuccessful or had to be ended earlier than planned due to [redacted] behaviour.

Dr. Bryan Tanney, a psychiatrist and a professor with the Department of Psychiatry at the Faculty of Medicine of the University of Calgary, having over twenty years of clinical and academic experience focusing on suicidal behaviour, reviewed [redacted] case, provided a report and testified at this inquiry. Dr. Tanney, stated in his report (Exhibit #75, at p. 4):

> [redacted] had learned early on to be wary of the permanency of any (adult) support systems.. remembering that a healthy distrust was appropriate, he would approach each new placement with an expectation that it would eventually prove inadequate. As a result, he tested each situation, often severely to see if his "life script" of being abandoned (see Kinkaide consultation of 12/88) would be repeated.

The reference to Kinkaide is significant. As early as January 19, 1988, Dr Alexandra Kinkaide, a psychologist, described [redacted] as a "very conflicted, emotionally withdrawn boy whose unresolved feelings affect his capacity to establish a healthy psychological bond...unless some of the underlying conflicts are resolved, [redacted] will exhibit major difficulties in adolescence. Individual counselling is recommended." (Exhibit 50, Nykiforuk report, June 29, 1994, p. 11) [redacted] was nine years old at the time of this report. Action was taken only after another failed placement occurred several months after this report. Some therapy with Dr. Kinkaide was entered into between December, 1988 and April 1991, however [redacted] placement at the Parkland Clinical Treatment Centre ended this relationship; he was then twelve years old and entering into his seventeenth placement.

Dr. Tanney testified the number of placements is not as important a factor as the quality and timing of the placements. The quality of the placement would include the purpose of the placement, the interaction of the child and the caregiver during the placement, the duration of the placement and the reasons for ending it. With respect to the timing of placements and the need to give careful consideration to the impact of unsuccessful placements, Dr. Tanney testified a child at the stage of first entering school, usually at four or five years of age, and later at around 11 years of age was particularly susceptible to being impacted by a series of failed placements.

I accept that a recommendation based on a formula specifying a major review process be initiated on a given number of failed placements is not reasonable. However, when a child in care is seen to experience repeated failures in otherwise good placements due to a difficulty in bonding with adults, a review of the underlying problem is clearly called for.

I agree with Dr. Tanney that there must be a multi-layered approach to children such as [redacted] who prove to be resistant to efforts to place according to Departmental policy. I also agree with Dr. Tanney's position that a policy allowing and providing for consistency within the context of a treatment and therapy program should be adopted in addition to continuing further placement efforts. Dr. Tanney testified that poor behaviour may terminate placements but consistency and stability in the therapist would allow the issues that cause the behaviour to continue to be addressed with the child between placements. Continuity and consistency in therapy would reduce the impact of what is a repeated separation of important and significant figures in the life of a child by failed placements. This is particularly so during the first ten or eleven years in the life of a child.

Recommendation #1

I recommend the Department review its policies and procedures to ensure continuity of treatment and therapy is stressed, particularly when dealing with a child in care who has proven resistant to permanent placement.

Mary S. Nykiforuk, the District Office Manager of the Stettler District Office, who was asked by the Red Deer District Manager, Lorne McEwen, to review [redacted] case, also made this recommendation, see Exhibit #50, page 13. More will be said about the placement\therapy issue under the heading "Conflict of Philosophy - Social Work or Individual Case Work".

2. Training of Caregivers in Suicide Prevention

On June 27 1984, [redacted] a seventeen year old ward of the Province of Alberta, killed himself by hanging. This case attracted a great deal of public and media attention. The Department of Social Services and Community Health engaged Dr. R.J. Thomlison, M.S.W., D.S.W., Professor and Dean of the Faculty of Social Welfare of the University of Calgary to review the Department's handling of [redacted] Dr. Thomlison's report was submitted in September, 1984.

Dr. Thomlison recommended the Department "develop a statement and a set of criteria for the recognition of a child at risk. This should be accompanied by a clear statement of procedures for helping such children": Recommendation #5. He also recommended the Department consider "contracting with the Suicide Prevention and Training Program to train staff in the recognition

of the indicators of suicide and methods of intervention": Recommendation #10(d).

In addition to Dr. Thomlison's review, in November and December, 1984, the Honourable Judge W.G.W. White conducted a public inquiry under the Fatality Inquiries Act into the death of [redacted] In his report to the Attorney General, Judge White recommended:

> "That all child care workers be required to participate in a course or courses relating to ...suicide, and depression.": (Recommendation #2),
>
> "That in cooperation with Foster Parent Associations the Department institute mandatory programs of education, for all foster parents with content on depression, and suicide ...": Recommendation #3, and
>
> "That courses for the Bachelor of Social Work Degree, have included within them, mandatory studies of ...suicide and depression.": Recommendation #10.

Following these recommendations, in the late 1980's the Department established a number of workshops for Child Welfare staff on suicide assessment. In addition, Child Protection Service training and the Foster Parent Training Programs now include a suicide assessment component which is required of all Department staff and those who wish to be certified as foster parents.

There has been a great deal of effort directed toward foster parents and Department staff in suicide awareness and assessment, however, it appears contracted agencies like Quest Ranch have not been included or invited to participate in these programs. Although specific reference is made in the recommendations of Dr. Thomlison and Judge White to Department

staff and foster parents, Judge White also recommended all child care workers undergo such training.

It is inherent in this recommendation and it is a logical extension of these recommendations that the Department should ensure that staff of contracted agencies have the same level of training in this area as Department staff. The failure to do so exposes children placed with contracted agencies to a lower level of care than others. Such children may well be in greater need of caregivers trained in suicide awareness because the very nature of their difficulties has been the reason for their placement with such contracted agencies.

There may well be an attitude within the Department that contracted agencies should be aware of the needs of their clients and take steps on their own to ensure they are able to provide the services they have contracted to provide. This approach is apparent, to some extent, in the handling of [redacted] case.

[redacted] Departmental case worker, who had extensive training and experience in suicide awareness and assessment, assumed that Quest Ranch had trained staff and that they conducted a proper suicide risk assessment. She did not ask to have [redacted] note read to her nor did she determine whether the assessment had been done to her satisfaction based on the level of her knowledge or experience. The Quest Ranch Manager of Therapy, who had less experience and training than the case worker,but more than the key worker and Manager of the Outreach Program who conducted the assessment, assumed the key worker and the manager had adequate training and knowledge in suicide awareness and assessment and, again, did not conduct a detailed review of the assessment process. In fact, the key worker and the Manager of the Outreach Program had minimal training in suicide awareness and assessment.

The need to have adequate training provided to all child caregivers whether employed or contracted by the Department is clearly demonstrated in this case.

Recommendation #2

I repeat Assistant Chief Judge W.G.W. White's recommendation made in 1984 "that all child care workers be required to participate in a course or courses relating to suicide". This should include contracted agencies.

How this will be achieved will differ from agency to agency, however, I recommend this requirement, at the very least, be included as a performance standard through the contracting process.

3. Policies, Procedures and Protocols

Quest Ranch staff had limited training in suicide awareness and assessment. The only material provided to Quest Ranch staff during in-house training sessions before June, 1994 was identified by the Quest Ranch Manager of Therapy as excerpts of larger studies or training sessions prepared by other agencies: Exhibits #13 and 21. Dr. Tanney confirmed this and raised concerns about the appropriateness of considering these documents as "training material". Although this material might be useful in raising suicide awareness to some degree, distributing such material could not and should not be allowed to take the place of proper training and proper risk assessment by qualified personnel.

Exhibit #27 was tendered by Mr. Hale as an additional assessment tool which was distributed to Quest Ranch staff after [redacted] death as they attempted to address their training needs. Exhibit #27, entitled, "Important - Keep This In Your Locker - Signs of Suicide", is a document which was distributed to school children in the Cremona area to raise their awareness of the signs of suicide that might be seen in school friends who may be at risk. On March 2, 1995, Exhibit #67, entitled "Suicide - Quest Staff Development Handbook" was tendered by Mr. Hale as evidence of Quest Ranch's continuing efforts to address their training needs. On April 8, Exhibit #69, entitled "Draft - Standards: Program Q-2 - Clients At Risk Of Suicide" was provided by Mr. Hale as a draft of yet another training document for Quest Ranch staff.

Very early in this inquiry, it became apparent Quest Ranch staff were struggling with the task of preparing material to properly address their training needs. On May 8, 1995, almost eleven months after [redacted] death and seven months after the beginning of this inquiry, I learned from Dr. Tanney that the Province of Alberta funded an agency called the Suicide Information and Education Centre, formed in 1982, which attempts "to collect all the written materials about suicide that has been produced in the English language in the last 40 years". Dr. Tanney testified there are four or five agencies that he is aware of that have "remarkably well done protocols, policies and guidelines at the level of community agency being able to provide adequate if not exemplary services to children at risk", all of which are available from the Centre.

Dr. Tanney testified the Centre had the ability and, in fact, the mandate to work with other agencies to prepare and develop programs and policies on suicide.

In his report in 1984, Dr. Thomlison made note of this Centre and recommended the Department engage it in establishing a proper training program of suicide awareness and assessment. Child Welfare documentation also refers to this Centre: Exhibit #63, CWS-05-01-06, 01/07/94, CW612G.

I was both heartened and dismayed by this evidence. It was heartening to learn that there is an excellent resource available to the Department and to contracted agencies which would assist them with the preparation and development of policies and procedures in suicide awareness and assessment. I was dismayed, however, to learn the Department was aware of this resource and no one advised Quest Ranch staff of its existence in spite of their obvious need for such assistance.

In addition to concerns about the quality of the material presented by Quest Ranch, Dr. Tanney raised some concerns about the quality of the material prepared for the Department in this area.

Recommendation #3

I recommend the Department engage the assistance of the Suicide Information and Education Centre to review its policies, procedures and training programs and those of its contracted agencies.

Recommendation #4

I also recommend the Department refer contracted agencies to the Centre if the Department is unable to assist them in their programs, particularly when a problem is identified.

4. Quest Ranch's "No Suicidal Clients" Policy

On a number of occasions during the inquiry, Mr. Hale referred to Quest Ranch's policy of excluding children who represented a risk of suicide. This reference was in conjunction with his position that the Department failed to fully disclose to Quest Ranch staff [redacted] history which included a number of incidents in which suicidal behaviour was suspected. Mr. Hale overstates Quest Ranch's criteria, fails to recognize the inconsistency between this policy and the handling of [redacted] case by Quest Ranch staff, and misunderstands the nature of suicide and the troubled young men for whom his agency offers services.

Quest Ranch's policy reads "Candidates with a history of dangerous violent behaviour, those assessed as seriously at risk of suicide, and those having chronic addiction problems will not be considered" (emphasis added; Schedule "A" to the Agreement between the Province of Alberta and Don and Carol Hale, operating Quest Ranch, page 11, "IV. Client Information: A. Entrance Criteria": Exhibit #12). This wording is repeated in the 1994 - 1995 Program Design faxed on June 9, 1994 by Kent Hale, another son of Don Hale, to Lorne McEwen, District Office Manager: Exhibit #58.

Without a specific definition of "seriously at risk of suicide", [redacted] could not be seen to have been seriously at risk when he was first placed at Quest Ranch.

Mr. Hale stressed the importance of the Department's failure to properly identify a material condition in [redacted] past which he identified as a precondition to acceptance into the Quest Ranch program. By writing the note, [redacted] demonstrated suicide

ideation, yet no action plan, presumably based on this exclusion from the program, was considered. Not even incidental monitoring was instituted. Mr. Hale's concern for the lack of information of earlier suicide ideation is after the fact.

That [redacted] constituted a risk of suicide was inherent in his personal history as made known to Quest Ranch staff during placement committee discussions. Dr. Tanney testified [redacted] represented a chronic and ongoing risk. Using the Department's "Sad Child Plan" as found in the "Trainer's Manual, Qualified Training Suicide Awareness" (Exhibit #76), Dr. Tanney testified [redacted] "met the significant risk criteria for ten or more" of the fourteen risk factors at any time during the last two years of his life.

Unfortunately, many of the young people who are welcomed into the Quest Ranch program must be considered as suicide risks. The "Entrance Criteria" of Quest Ranch states: "Typically the adolescents served by Quest are those who through family, community and school related problems have failed to reach levels of maturity and development which would enable them to function appropriately within society. These children are best described as behaviourally disabled" (emphasis in original). Mr. Hale described the children that Quest Ranch deals with as "very damaged". These children represent a risk of suicide. Mr. Hale's attempt to lay blame on the Department for failing to disclose material information is hindsight analysis and reveals a lack of understanding of the nature of suicide.

In my opinion, the Department should consider whether an agency that attempts to limit its program in this way is an appropriate resource for such troubled children. This condition may be an admission by the agency that it is not capable of

handling such cases. This condition may also suggest the agency will be complacent concerning this serious condition, one which is a significant factor for such children.

If an agency is accepted with such a condition, the Department must have an action plan in place in the event a child in its care, who enters a program without this status, changes during the placement. Presumably, an immediate removal from the program would then be in order. Certainly, a review of the suitability of the program would be mandatory.

Recommendation #5

I recommend the Department review all contracted agencies that have included such a condition in their admission criteria to determine the suitability of the agency for children at risk and that the Department develop an action plan for those agencies that are not suitable but are to be utilized nonetheless.

5. Departmental Response To Suicide

In the event of suicide, the Department should have in place a plan for an immediate response team consisting of trained specialists to review the case management history, the events leading up to the suicide, and the agency's response to it. That team should recommend preventative action and provide immediate support for the program and the children still in the program.

In her report dated August 25, 1994, Ms. Wertzler expresses concern that no arms length review of [redacted] case had been initiated to that date in spite of repeated requests.

Presumably, Ms. Morrison O'Hara's report submitted on January 23, 1995 is in response to this request. The need for a timely and complete review by specialists in the area is crucial if other children in care at the same agency, or others like it, are to be properly protected. A Fatality Inquiry is not a substitute for a proper response by the Department.

Recommendation #6

I recommend the Department develop an appropriate response plan to immediately investigate a suicide by a child in care and to ensure proper support thereafter is available for the program and the children remaining in the program.

6. Classification and Identification of Suicide Risk

Quest Ranch's entrance criteria referred to "those assessed as seriously at risk of suicide". The Child Welfare Handbook makes reference to high and moderate risk of suicide in the Introduction to the "Suicidal Child": CWH-05-01-06, page 1, Exhibit #17. Different opinions were expressed by child care workers who testified at this inquiry as to whether [redacted] represented a high or moderate risk on the finding of the suicide note. There are no instructions which relate to children who might be designated at risk but represent a low risk, assuming these classifications to be valid.

Question #14 of the Department's "Application For Admission To Residential Resource" requires the social worker to "number six points in order of importance that apply" to the child with "suicide risk" and "self harm" being listed as two of twenty-

four points. This system of ranking factors and limiting the number to six results in hiding any history of or concern for suicide ideation and may lead a placement committee to fail to take this into account when deciding the suitability of a placement.

Recommendation #7

I recommend the Department review its policies and procedures, with input from the Suicide Information and Education Centre, to determine whether classification of suicide risk is valid and useful and whether suicide risk should be identified independent of other issues of importance that apply to a child being considered for placement.

7. Conflict of Philosophy - Social Work or Individual Case Work

Dr. Tanney expressed a concern about the Department applying a social behavioural philosophy to children in care to the exclusion of all other approaches. He described this approach as based on the premise that people grow and become who they are largely as a result of the people around them, their environment, and their interaction with those people and their social circumstances. He testified this was a valid and accepted approach and is often successful in dealing with children in care. This approach is found in the Department's emphasis on finding placement homes with the hope the placement family will offer stability and provide proper role models for the child. This approach is easily found manifested in the nineteen placements experienced by [redacted]

Dr. Tanney's concern springs from his perception that the Department applies this philosophy even in cases when that approach

has proven to be inadequate time and time again. He suggests that when a child is resistant to this approach it may be evidence of a condition that requires a different approach, instead of, or often in addition to, the social behaviouralist model.

With regard to [redacted] this opinion is supported in the manner in which the Department dealt with the psychological assessment of Dr. Kinkaide in 1988 and the termination of the therapy program [redacted] entered into with Dr. Kinkaide. This was done in the face of the frequently expressed description of [redacted] as unable to bond with others due to his unresolved personal issues. The Department's answer was to continue to attempt to find a placement that would meet all his needs without attempting to determine what his unstated personal issues were and assisting him in resolving them. These placements were destined to be unsuccessful because, as Dr. Tanney put it, [redacted] tested each placement to see if "his life script of being abandoned would be repeated".

A further example of this approach is found in Ms. Wertzler's report (Exhibit #71). I recognize Ms. Wertzler's report was prepared shortly after the incident when the feelings of those involved were still strongly experienced. Ms. Wertzler may have felt the need to defend her office's handling of the case and come to the support of her co-worker. The tone of her response is defensive and Ms. Wertzler was clearly offended by the review completed by Ms. Nykiforuk. However, her report demonstrates the firmly held commitment to the social behaviouralist approach: "the abundance of social welfare research and literature which absolutely indicates the primacy of attachment, I am unable to accept that for a child there are 'other issues' which could possibly be more important than a sense of belonging"; Exhibit 71, p. 3, (emphasis added). Later she writes: "when a P.G.O. [child

subject to a Permanent Guardianship Order] fails to secure a committed adoptive placement or a significant meaningful relationship with a caregiver, Child Welfare should aggressively pursue re-establishing former linkages with the family of origin": Recommendation #3.

Dr. Tanney suggests the aggressive attempts to locate family members and arrange contact with family members were in fact destructive in that the failure of members of his family to measure up to his idealized view of his family represented another failure in [redacted] relationship with significant persons in his life. Some children are better off receiving assistance in accepting the facts concerning their family relations rather than continuing to experience failure in family reunification efforts.

The medical profession opened itself to accepting other forms of treatment as it adopted a wholistic approach to treating illnesses, particularly those resistant to traditional medical treatment. The education profession accepted the need to approach each child's educational growth at an individual pace and level. The Department should be open to different approaches to provide for the needs of the many different children that come into its custody and control. When one philosophy is applied to human relations to the exclusion of others, rather than as one of a number of recognized alternatives, it becomes the application of dogma as policy without the recognition of individual differences.

Recommendation #8

I recommend the Department review its policies and procedures to ensure that child care workers are encouraged to

consider all available solutions to cases that have proven resistant to the Department's general approach.

8. Devolution of Government Child Welfare Services

Although it is difficult to predict what the end result of the Government of Alberta's plan to decentralize Family and Social Services will be, with reference to the issues raised in this inquiry, a serious concern must be registered that, with the contracting out of more and more services, the need to coordinate child care action will become even more essential.

Coordination and continuity of services will present greater challenges than when the Department provided day to day case management. Will contract agencies increasingly offer single models of care? Will each region have the same range of services available to children in care? Will there be a choice between different models of care available to children or will children in some regions be required to conform to the limited programs available rather than experience programs developed according to their individual needs?

Quest Ranch did not have a psychologist on contract to offer assistance to staff and children in their care. Brian Quigg was a clinical psychologist employed by Parkland Clinical Treatment Centre. Both agencies are private organizations which are, to some extent, in competition with each other in that they offer their services to the Department and contract with the Department to provide services to children in need of care.

Although the Service Plan completed to effect the move of [redacted] from the Parkland Clinical Treatment Centre to Quest Ranch

(Exhibit 35) described Mr. Quigg as a party to the plan, no specific tasks were assigned to him. That Mr. Quigg was included as a party to the plan has been described as indicative of an "obvious intent ... to maintain access to Mr. Quigg to the Quest Program", to maintain Mr. Quigg as "not only a consultant to the Quest program but as a direct resource to [redacted] should he choose to re-access" him: (Wertzler report, Exhibit #71, p. 2). Continuity of services was the stated goal.

One wonders whether the lack of specific duties for Mr. Quigg resulted in a perception that his services were not as committed to the Quest Ranch program as the case manager intended. The question arises whether it is realistic to expect a professional resource employed by one contracted agency to be available to another contracted agency without clearer lines of responsibility. I appreciate [redacted] was advised he could contact Mr. Quigg when and if he needed him. The issue is whether the agencies involved felt the same freedom to maintain contact. There was no contact between them even when the suicide note was found. During [redacted] ten month stay at Quest Ranch, Mr. Quigg did not call [redacted] nor did [redacted] call Mr. Quigg; they met informally only once.

The need to coordinate services will become even more acute if the decentralization and emphasis on contracting out materializes as expected by the Department's plan for the future.

Recommendation #9

I recommend the Department review any future plans to decentralize and contract out services to ensure the coordination of such services is preserved and continuity of services is maintained.

9. Life Book of Children in Care

The Department is committed to a philosophy of re-establishing a link between a child in care and that child's family. This is made more difficult with the passage of time between apprehension and the initiation of such efforts. Ms. Wertzler recommends Child Welfare attempt to obtain "photographs of significant family members, in addition to completing a family and social history" when a child comes into long-term care: Exhibit #71, Recommendation #2. Efforts to identify family members early in the Department's file creation activities and case management will avoid extraordinary efforts being required later.

Recommendation #10

I recommend the Department create a family and social history file on children who are taken into long term care to allow the child in later years to access information on his or her family sufficient to attempt to locate members when and if the child wishes to do so.

10. Fatality Inquiry Reports

Prior to and during this inquiry, efforts were made by Mr. L. H. Merryweather, counsel for the Attorney General, and Mr. C. Ford, counsel for the Department of Family and Social Services, to obtain copies of previous Fatality Inquiry Reports on children in care who committed suicide. The purpose in locating these reports was to avoid duplicating the efforts of other

inquiries, to review previous recommendations made, and to determine the Department's responses to them. Only nine reports were located: Exhibits #77 to 83. By these efforts, it has become clear that there is no filing system in place in either the Department of Justice or the Department of Family and Social Services which organizes the issues reviewed and recommendations made at such inquiries.

The Department of Family and Social Services instituted a number of changes as a result of the death of [redacted] Many changes can be expected in the future as the Government of Alberta decentralizes its work to community based committees. There is a danger that policies and procedures which were instituted in response to previous fatality inquiry recommendations will be changed without knowing the basis for the policies and procedures. The experience gained from reviewing suicides of children in care should not be totally dependent on the collective memory of Department employees. These reports should be easily available for future reference.

Recommendation #11

I recommend Fatality Inquiry Reports be organized such that they may be easily identified and recovered by subject matter and recommendations made. They should be easily available from the Department of Justice as well as any government department affected by the recommendations.

11. Dr. Bryan Tanney's Testimony and Report

A transcript of Dr. Tanney's testimony and written report (Exhibit #75) has been sent to Quest Ranch. A copy of Dr. Tanney's testimony and report is appended to this report to ensure his comments are available for future reference. I found his evidence extremely thought provoking and particularly enlightening. He raised several fundamental questions highly relevant to the provision of services to children in the care of the Government of Alberta.

If he is correct that the Department's philosophy is based on a social behaviouralist viewpoint to the exclusion of others, then his insight, as a psychiatrist with over twenty years experience, specializing in the study of suicidal behaviour, should not be overlooked simply because his views are inconsistent with those held by the Department.

Dated November 17, 1995
At Calgary, Alberta

M. Delong
A JUDGE OF THE PROVINCIAL COURT OF ALBERTA

L.H. Merryweather,	Agent for the Attorney General of Alberta
C. Ford,	Counsel for the Department of Family and Social Services
D. Hale,	Owner and Program Director of Quest Ranch

APPENDIX

To Fatality Inquiry
into the death of
[redacted]

No. 41345943-I-10101

IN THE CRIMINAL DIVISION OF

THE PROVINCIAL COURT OF ALBERTA

IN THE MATTER OF The Fatality Inquiries Act

IN THE MATTER OF The Death of

[redacted]

F A T A L I T Y I N Q U I R Y
(Excerpt)

Evidence of Bryan Lawrence Tanney

Calgary, Alberta
8th May, 1995
Court Recorders, Calgary

Excerpt of Proceedings taken in the Provincial Court of Alberta, Provincial Courts Building, Calgary, Alberta

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8th May, 1995

The Honourable Judge Delong	The Provincial Court of Alberta
L. Merryweather, Esq.	For the Crown
C. Ford, Esq.	For the Accused
D. M. Been, Ms.	Court Recorder

COURT CLERK: Continuation of the Fatality Inquiry of [redacted]

. . . . . .

BRYAN LAWRENCE TANNEY, sworn, examined by Mr. Merryweather:

THE COURT: How do you spell your middle name?

A Lawrence, L-A-W.

THE COURT: 'W'? Thank you.

Q MR. MERRYWEATHER: Dr. Tanney, you're a qualified psychiatrist?

A Yes, I am.

Q How long have you been a psychiatrist?

A 20 years.

Q And you're currently associated with the University of Calgary?

A Yes, I am.

Q What is your position there?

A I'm a professor in the Department of Psychiatry.

Q And how long have you been a professor in the Department of

Psychiatry?

A One year as a professor.

Q And you're also associated with the Calgary General Hospital?

A Yes, that's where my clinical appointment is. That's part of my academic responsibilities.

Q Okay. And can you briefly tell the Court what your academic responsibilities are and your clinical responsibilities?

A My academic responsibility is largely to be responsible for issues about suicide training, suicide intervention and some aspects of translating information and research about suicide into useable public programs. My clinical responsibilities have throughout been involved in direct patient care, the largest part of which has been working in the area of emergency psychiatry.

Q And in terms of the specific area of suicide, how long have you been working in that area?

A Since 1975.

Q When did you receive your medical degree, sir?

A In 1970.

Q And your specialization in psychiatry?

A In 1975.

Q Now, sir, have you ever testified as an expert in psychiatry in the Court of Queen's Bench or the Provincial Court of Alberta?

A Yes, I have.

Q Approximately how many times?

A Three -- three or four.

MR. MERRYWEATHER: Your Honour, I am seeking to have Dr. Bryan Tanney qualified as an expert in the area of psychiatry with a particular specialty in suicide.

THE COURT: Yes, I am prepared to hear Dr. Tanney's evidence in that area.

Q MR. MERRYWEATHER: Sir, we've entered as Exhibit 7 in these proceedings a copy of your report of May 4th, 1995. Could you tell the Court how you came to write this report, what you were asked to do by myself and what you reviewed in order to come up with the report?

A I was asked to direct myself to two particular questions. One was the impact and contribution towards the suicide of this young man by the number of placements that had been undertaken by the Child Welfare system, and in addition to that any other recommendations which I felt were appropriate.

To undertake that, I -- I obtained the -- the case file from Mr. Ford's office and undertook to review it at some length over the past several weeks.

Q And when you say Mr. Ford's file, that would be the files of the Department of Social Services respecting [redacted]

A Yes.

Q And did you also have the Quest file, which would consist of the red binder?

A Yes, I thought it was part of the -- yes, I had the Quest file.

Q That would be the -- the binder that I sent to you?

A Yes.

Q Okay. And did you review any other materials in order to come up with your opinion, sir?

A I had occasion to look at a couple of technical references.

Q And those are dealt with in your report?

A Yes.

Q Sir, the -- I'm looking at the second paragraph of your report in the first page. You indicate that:

> In summary, the number of placements and their nature, timing, duration and reasons for termination all contributed to this fatality.

Am I correct in understanding that those are all the -- the major factors that in your opinion contributed to [redacted] suicide?

A Those are the major factors -- what I was attempting to point out was that the issue of the number of placements that had been undertaken did contribute to his fatality. It was more than simply the number. Certainly his death was due to a large number of factors beyond the activities of Child Welfare Services.

Q And you highlight a couple of things. The first is the training, competency and the performance of the Quest staff in assessing and managing [redacted]

A I did.

Q And secondly, the -- you talk about the Nikiforuk recommendations?

A These -- I attempted -- in answering the questions you

placed to me, the first one was, "Did the -- did the number of placements have an impact?" Yes, they did. Other recommendations? Of a large number I think that -- that could be addressed but that leapt out at me were the issue of some controversy about the training of the Quest staff and the training effect of everyone who was involved in working with this young man over the years, and secondly and specifically, the -- the issue of the Nikiforuk case file review, and one of its recommendations. Those seem to me to be the major other issues that I felt I could address effectively.

Q Turning now to the second page of your report, Dr. Tanney, you talk about suicide being a consequence of a multiple of factors. Could you tell the Court what factors you identified in your review of the file that contributed to [redacted] suicide?

A I -- I did not specifically undertake to look at all of the factors. I think it's fair to say that this young man's life from his genetic predisposition, throughout his prenatal life, through the early years with his mother, and then his history with Protection Services, in a sense one -- one talks in this area that a suicide usually doesn't happen for one single reason. One of the more colourful perspectives on it now is that everyone has a pathway to suicide and that in some people this pathway can begin even before their birth. I think in [redacted] situation that's what happened.

Q And that would be what you're talking about as prenatal environment?

A Yeah.

Q And how does the prenatal environment of [redacted] start him on the pathway to suicide?

A Well, we know that there is a genetic contribution to suicide now. We know that his mother was in extensive mental health care earlier on in her life. We know at least by inference from several diagnoses that were given to her that she had certain conditions that we know can be passed on genetically, at least in some part, and that these predispose to suicide among children. We know in terms of prenatal environment that she was incarcerated, that she was a user of -- of significant illicit drugs, and the contribution that these can make to the development of the brain in the fetus may at the very beginning distort the capacities for learning and for emotion.

Q You identify, sir, in the second paragraph on Page 2 points that you emphasize. Two, you've talked about the genetic influence, the potential distress in his prenatal environment, and you go on and say, "The clear experiences of neglect and abandonment in his first three years of his life." That would be the first three years of his life with his -- his mother?

A With his natural parent and his natural family.

Q Okay. And the last point that you emphasize, this is the complete absence of a male adult/father figure in his life.

A But one of the emphases has been on neglect and abandonment and distortion of parenting by -- by his maternal parent, but one of the things we also have been increasingly coming to recognize is that the absence of two parents can have an impact, as well.

Q Would those four factors be the most important contributing factors to [redacted] suicide?

A I think the most important that I would add would be [redacted] himself, who had to be the repository of the sort of, the final common pathway for all of these factors and features.

Q And I take it, it's not a situation of one single factor being more acute than others. It's a cumulation of all the factors?

A And I think this is one of the important and most difficult things about understanding suicide, that it does occur usually as a result of a matrix of factors, which may vary in their contribution in any individual situation. But the other thing to be well aware of is that any individual person's death by suicide can probably be explained, using any one of -- any one of these five factors and probably 15 or 20 other ones that we could get from the literature. Suicide is said to be a behaviour that is multiply determined.

Q Looking at the -- the last complete paragraph before the subheading, "The Issue of Multiple Placements," you say:

> In [redacted] situation there is no identifiable crisis. Rather, his life was one of gradual and ongoing attrition of his internal and of the

system's external resources, resources which could serve and had served to sustain him whenever he was forced to confront his early issues of abandonment. Ultimately, both [redacted] and the system ran dry.

What do you mean by the last sentence, by [redacted] and the system running dry? What do you mean by that?

A I think it's fair to say that this young man had immense numbers of resources offered to him over -- over his life, and that tremendous efforts were made to place him and to restitute a severely disturbed young man, I believe largely based on the time before he came into the care of Child Welfare Services, and these efforts eventually had done all that they could do, and at that point when [redacted] was confronted by one more need to change and have things be different, he simply and the system simply did not have the resources to sustain him through it. Why did [redacted] not have the resources, you might enter into some more extended discussion.

Q Okay. You then, sir, in your report go on to talk about the issue of multiple placements, and I gather from what you said earlier, it's not merely the number of placements, but the quality and duration of the placements that are as important if not more important than the number.

A I think that there -- in the largest part, the agreement is that human beings can sustain a tremendous number of insults. It's the quality of the insults and the timing of the insults that may have more impact.

Q And what can you tell the Court about the quality and the

quantity and the duration of -- of [redacted] placements?

A Well, I -- I addressed each of these as separate features, but the quantity issue is that although he is said to have, and I documented these, there are sort of a number of people in the file, up to 20 odd placements. A significant number of these were simply placements for a few days or on an emergency basis. I felt that there were 10 significant placements in his life --

Q Okay.

A -- and that -- that these lasted longer than -- than two months. I think they ran from 2.8 months through to 48 months in total. And it's these 10 placements I think that [redacted] would have had to -- would have had an impact on [redacted] in terms of their quality and in terms of how long they lasted and in terms of what happened during and as a result of them. And to turn to that issue, I think that of the -- the placements that he had -- and we could look at these in the context of duration, the reason and -- and the timing of, these 10 placements, several of them were quite brief, several months. I think three of these were institutional placements that I don't think we should enter into a discussion about the quality of the placements. That would lead us into issues about having to look at the facilities themselves, and their philosophies.

Three of them were brief, two of them were longer and two of them were long term, and I think the two that were longer and the two that were long term -- and by "longer" I

mean six or more months, and by "long term" we're talking over -- over two years and four years in duration. The usual sense is that if -- if this young man were attempting to make an adjustment, the longer that he worked at making that adjustment, the more traumatic it would be when the adjustment failed. In fact there were -- there were four that I think that one would have to look at in some detail.

Q Okay.

A To turn to those, it's then important to look at why did the placements end? What happened to this young man's life in these placements. And I reflect that Dr. Kincaid (PHONETIC) made a comment with respect to four of them that we, referring to Child Welfare Services, made a mistake in the placements.

Q What was the nature of that mistake?

A I think the sense that -- that one gets from reviewing the file was that at least two of the placements were emergency placements, Andrews and Tange (PHONETIC), and that they didn't work out. One of them lasted several weeks. One of them lasted a few months. But they were both emergency placements and there's a -- there's a clear reflection in the file that they had to have a place to put this young man, that leaving him in an institutional environment was not going to be healthy for him.

Q Okay.

A So, the sense of the mistake was -- was simply that perhaps the -- the placement hadn't been thoroughly vetted or that

it's simply possible that the connection between this young man and the placement wasn't made in the way that the service had hoped that they would connect together. It's well worthwhile reflecting on the Van Gall (PHONETIC) placement, in which the department placed a tremendous number of resources, and it looked as if it was one of the -- a fine and perfect placement and it collapsed. It's a way of saying that no matter how well we vet the placement and no matter how well we support the family, there is still an interaction that goes on within that family that we really don't have a tremendous amount of control over.

That was my reflection and the -- the reason for the termination of the placement, some of them [redacted] just acted out and the placement simply said we don't need this kind of behaviour. Several of them might have been the short term ones in which the department made a miscalculation in what was needed. But I think the most significant ones, the longer ones, there was an opportunity for a significant and extended interaction in the family environment between this young man at various ages and the family he was going to live with. There was simply a decision made that the fit was not there. And so the termination of the placement I don't think could reflect at all on Child Welfare Services. I think it had to reflect simply on the person that [redacted] was and the family that he was trying to make a connection to.

Q He went through, depending upon whose count you use, either 20 something -- I like the expression meaningful placements.

He went through 10 meaningful placements, none of which lasted for as long as Child Welfare or presumably [redacted] would have liked, or perhaps I should just say as long as Child Welfare would have liked. Is there one underlying theme why all these placements failed, or is it dependent upon [redacted] age and -- and each family?

A I don't think there's an underlying -- I don't think there's a theme. It might be possible that, as Dr. Kincaid suggests, the placements weren't as well chosen as they could have been, perhaps because they were emergency. [redacted] acting out behaviour clearly ended several of the placements that could have been positive resources for the future and I think the two most important ones simply were a lack of connection.

Q Okay. So, it's not -- we can't reduce it to the black and white. This is just a case of the -- the families not having the abilities to address [redacted] special needs?

A I suspect that the -- the three placements that terminated because of [redacted] acting out behaviours and the two longer term placements, that might be a summary, but it's an extremely broad summary. [redacted] had remarkably special needs emotionally. I guess I'm concerned that what you're suggesting is that some -- that there was something about that they weren't well enough prepared, or that [redacted] was too much to handle. And in fact my own sense is that it was always the interaction. I think that there were families who he were placed with -- who he was placed with that, with

significant support from the department, simply wasn't enough.

Q That it -- was there something else that could have been done for the placement to work, or was it just sort of doomed to failure given [redacted] personality and his -- his emotional needs and this particular family?

A I think that there are -- there are some other things that could have been done that move us beyond the issue of the family that he was placed in, the choice of the placement, and [redacted] himself. My own belief, as I address later on under "The Conflict Over Treatment Therapy" moved into that issue.

Q Okay. Well, I'll get to that in a minute.

A Yeah. We could address -- your last question was about does -- in terms of the quality of the placements, does it matter when the placements ended, not why they ended and not how long they were, but when they ended. And it was notable that there were two clusters of failed placements, one of them when [redacted] was about six years old, and another one when he was about 11 years old, and in each of these instances there were three -- three of them failed and then four of them failed within the course of a year to 18 months. And behaviourally there's a -- there's an argument that putting that many failed experiences that closely together has more of a long lasting impact than having a placement that works out and then fails and then another one that works out and fails, but that these two clusters could be particularly dangerous. The dangerousness might arise because of the

time at which the failures came, around the age of six and around the age of 11.

Q Okay. And the age of six would be important, because that is when the child is first embarking on school?

A That's the idea, and [redacted] was a bit delayed. We knew that. And ordinarily it would happen at ages four to five. So, if we allow [redacted] some delay, this series of failed placements around the age of six when one would expect that he would be venturing out into the world, beginning school, for example, might make that -- those -- that series of failures very impactful on his future psychological development.

Q And what would be the significance of being approximately 11 years of age and having --

A Well, there's a lot of -- I -- I bailed out on this one, I have to be honest. I think that by the age of 11 there were so many other factors operative in [redacted] life, that any effort to say that the series of placements that failed when he was 11 years old, I think that to try to attribute something to them would have been unfair. I think that by that age so many other things had happened and that we didn't really know the state that [redacted] was in at the age of 11, that I would probably be remiss in speculation of that (INDISCERNIBLE).

Q Okay. Now, before I move on, Dr. Tanney, I just want to backtrack a little bit, because I missed some -- some parts of your report. I'm on Page 3, the first complete paragraph. The sentence says this:

> Child Welfare Services uses a social behavioural approach to reconstruct or mould the environment of persons who are in their care.

Could you tell the Court what you mean by "a social behavioural approach"?

A I have to share with you that this was not in the case file review, or in any official documents that I had a chance to -- to observe, but it came through in the reading of how files were constructed, the notations that were made of the sorts of care plans that were devised for this young man, and there was a very clear sense that -- that the way that people grow and become who they are is largely affected by the people and the environment around them, and by their interactions with that environment, by their behaviours and by the social circumstances in which they find themselves. This is one very well put forward and respected view of child development. It's not the only one.

Q Okay. You go on. Your next sentence is this:

> This approach can restitute deficits and is often successful.

A And there is no doubt that this is a accepted and effective approach --

Q Okay.

A -- to take young people whose lives are in difficulty and to put them into an environment that is -- that is caring and in some ways offers an emotional experience that can make up for things that they might not have had in earlier life, or that they might not have simply left on the streets.

Q And in this particular case it was not a success?
A If the measure of success is that this young man killed himself, I'd have to agree with you. If the measure of success is that the best efforts were made on his behalf, expending the resources that we have and the expertise that we do have, I think that they came close to doing as good a job as we can do. Came close reflects on the discussion I hope we can enter into later about the other perspectives on child development that might have been considered.
Q Okay. Okay. I think we're going to get into that now, sir.
A Sure.
Q On Page 6 of your report, you -- a heading, "The Conflict Over Treatment Therapy".
A Mmm hmm.
Q And you, I gather in your review, looked at the case file review that Mary Nikiforuk did?
A Yes.
Q And she made two recommendations. The first one would be that children in [redacted] situation have one therapist rather than a number for the sake of continuity.
A Yeah, that was the -- there were more than two recommendations, but they were priorized, and the first two that I thought were important, one of them was maintaining some continuity --
Q Okay.
A -- of the personal support that [redacted] received.
Q Okay. And from your point of view, sir, as a psychiatrist

who specializes in suicide and suicide risk assessment, what would it be -- what would be the benefit of having one therapist through a troubled child's life, as opposed to different therapists?

A I guess it's -- it's saying that's the closest we can come to providing them with a parent, and the continuity that goes with having a parent. A number of my colleagues who had a chance to meet this young man directly were very clear that -- that he needed the experience of a positive and nurturing therapist on an ongoing and continuing basis.

Q And is that -- that need, is that not something that could be satisfied with caring and loving foster parents?

A I think in many situations it is provided by caring and loving foster parents. I think in [redacted] situation there was the -- the difficulty that the first three years of [redacted] life had left him with an experience and what I would refer to here as an expectation that his life would run according to a repeating script of being neglected and abandoned, and that that made the issue of loving and caring sometimes not enough.

Q And Mary Nikiforuk's second -- second main recommendation was what, sir?

A It was -- it was hard to discern exactly what it was and I noticed that the file -- the review of that review written by the Department also scratched their heads about what she meant by it, but it seemed to say that -- that there were more -- there were issues in his life beyond giving a

permanent placement that might have been, and I quote, "more paramount" in considerations of what was good or useful --

Q Okay.

A -- for [redacted] at various times. And -- and the suggestion was that simply the finding a placement was not perhaps the only solution for this young man.

Q And based upon your review of your -- of the file, sir, what other things should have been done other than just finding a placement for [redacted]?

A Well, certainly a placement is a terribly important part of it, but in the first three months that [redacted] is in care, there is already a notation made by a play therapist at the Child Development Centre that he is significantly delayed. In the last week of his life we see the Quest staff making reference to the fact that their work with [redacted] was significantly impeded by the fact that he was, and I quote, "stuck on emotional issues." It seems clear that that issue of his delayed development and the distortions of his development from his early years may not have been fully addressed in an approach that said let's just put him in a placement and hope that loving, caring parents will mould and help him to grow past that distressing time in his early life.

Q Okay. You correct me if I'm wrong, Dr. Tanney, but if I understand you correctly, what you would have liked to have seen would have been I gather some sort of recognition that the reason there are a large number of placements, why

things aren't working, is because of some deep seated emotional problems that [redacted] has, we've got to get at those emotional problems rather than just trying to find him another placement?

A In addition to. Not rather than, in addition to.

Q Okay.

A And I -- and I would suggest that the Department recognized that, asked for consultation on several occasions and were clearly told that, and made some efforts to work towards meeting the emotional needs that he had. I think -- I believe that there was a very clear understanding of what was happening within [redacted] but I -- I don't believe that because of the -- because of the social behavioural approach that they were willing to entertain other means of dealing with this.

Q Okay. How does the social behavioural approach impede them from -- from dealing with the primary emotional problems?

A What -- the social behavioural approach philosophically believes that it's the -- it's the world around us and the behaviours that we have in interaction with the world that determine how we will get along. It doesn't address primarily what goes -- what is going on within the person, what is happening within the person in terms of their ability to use that environment, no matter how loving and caring, that's being provided around them. And this is where one needs to try to do both and there's no guarantee that either/or or both will be successful in restituting a

young man like this, who was this impaired.

Q Okay. Well, I think you indicated in your evidence that Child Welfare was certainly aware that [redacted] had emotional problems and they tried to deal with those, but they were -- they weren't dealt with in the end.

A There were assessments undertaken on the five occasions that I can recall. There was an opportunity for him to work with Dr. Kincaid, who knew him first in 1984 within a year of his initial placement, up until -- and with a hiatus, then worked with him again I believe on a contracted two-weekly basis for a period of almost two years, but as the problem grew and as the recognition grew that there was something within [redacted] that he wasn't able to use these placements that were made for him, some of which I believe were quite good, and were all strongly supportive, but that [redacted] behaviour in each of these placements became repetitious. He waited to be rejected. When it looked as if he would be accepted, he fought even more because he was afraid of what the consequences would be if he accepted that these people loved and cared for him. He'd had that once before in his life. He'd had it several times that people had said, "We love you and we care for you," and then they had sent him away.

Q In his latter years it seemed clear, at least from my review of the file and the evidence we've heard at this inquiry, that -- that he had considerable difficulty and actually refused to deal with these underlying emotional issues. How -- how do you go about treating the underlying issues if the

client, the patient, refuses to deal with them?

A In -- in a social behavioural approach that becomes remarkably difficult. In one of the other approaches, it simply is a matter of saying this is part of what's called the young person's resistance to addressing and confronting these immensely painful emotional experiences from early life, when in fact in that context, in that approach to dealing with this problem, creating a positive, nurturing relationship that was permanent and sustaining, essentially giving him a person that no matter what he did they were going to be around, it wouldn't be like a placement where a placement could say we can't handle this behaviour any more, that this person would not be that interested in his behaviour. They would be interested in the person who was undertaking the behaviour. And on that basis, I believe that this is another approach that could have been added in to the approach that was being used.

Q So, the added benefit then of one therapist during the course of -- of a large part of [redacted] life, aside from continuity, would be that therapist would be forcing [redacted] to deal with the emotional issues which were the root cause of his problems?

A "Unfortunately" I think is an appropriate word, it's the -- it's the force of the -- the dripping water of the glacier. It's not you have to do this. It's simply that that person is there and available and always has in mind a particular focus, that no matter what [redacted] has done out in the world in

his families, he's still a person inside who's doing it because he's in immense pain and if he could address that pain and its meaning, that he might then be able to move beyond it.

Q Sir, you -- you talk about a Foster Child Syndrome on Page 6 of your report. What do you mean by that?

A It -- this was a direct quote, and I -- and I --

MR. MERRYWEATHER: Excuse me, Your Honour. If we could just --

THE COURT: Yes.

MR. MERRYWEATHER: This is the file.

(DISCUSSION OFF RECORD)

MR. MERRYWEATHER: Sorry, Your Honour.

A I should assure you it's not a phrase that I use, but the -- the Foster Child Syndrome was reflected a number of times in the case review and it almost seemed to have become that the description of [redacted] behaviour, which was recognized by officials in the department as something that foster children show, the lack of trust, the testing, the same things as basically as stealing food was reflected on as a survival mechanism. "I don't expect to get very much. Everything I want I have to ask for," is another way it was framed as the definition of the Foster Child Syndrome.

That description of his behaviour in fact in the social behavioural approach can become the explanation for his behaviour.

Q So again, it's sort of rather than looking at the inner

cause is it's saying the cause is in fact the foster child system itself?

A Mmm hmm. Yes, even though it's the behaviours that he -- it's the behaviours that he has to adopt in order to survive within the foster child system.

Q Okay. Sir, at the bottom of Page 7, you talk about the -- the consequence of -- dire consequences of the Department's unwillingness to entertain an alternate helping perspective. First of all, what you mean by "an alternate helping perspective", I gather, is this one therapist continually who will force [redacted] to -- to deal with his deep emotional problems?

A Allow him the opportunity, if I might refrain your word "force".

Q Okay. And what are the consequences then of that not having been done?

THE COURT: Mr. Merryweather, before we go -- what page are you on, what paragraph?

MR. MERRYWEATHER: I'm sorry, Your Honour. Page 7 at the bottom.

THE COURT: Page 7. It is the last paragraph?

MR. MERRYWEATHER: Yes.

THE COURT: Thank you.

A May I go back just for a moment and --

Q MR. MERRYWEATHER: Certainly, Doctor.

A -- reflect the Department's efforts in this regard, because one -- I would not want to leave the impression that the

Department ignored this approach. They made assessments available. They asked for consultations, some of which were -- I think could bear further comment. When Dr. Kincaid in the summer of 1990 says, "It's time to stop worrying about his behaviour and where we're going to put him and start to worry about this young man himself," she -- and Dr. Kincaid at that moment is somewhat critical of the placements that have been made. This is where I think she made -- I believe she makes the comment, "We made some mistakes in some of the placements." Within six months Dr. Kincaid, who had known this young man for six years, is out of his life, and it was at this point that I began to wonder if -- how this had happened. Up until that time one had a sense that the Department was aware of the approach and was willing to work with this alternative approach of figuring out why [redacted] was so disturbed inside. Suddenly, the person who has known for the longest time is gone.

And I have -- I must share with you that there is a clear sense in reading the case file notes in some detail that it's -- and I cannot discern which it is, but it's either a personal decision that Dr. Kincaid isn't useful to him any longer or what came through to me more clearly, that Dr. Kincaid's suggestion that we move to a different helping model, away from the social behavioural approach of wishing to place him, that that approach was simply unacceptable, and as a result of that almost directly she was terminated.

As a consequence of that, the Department does offer a

further recognition that this young man is in distress and needs someone to talk to. A psychologist at the treatment centre he's in then takes up the responsibility of Dr. Kincaid. I was not able to access the case notes of the ongoing treatment between the social worker and the psychologist, Mr. Quig (PHONETIC), and [redacted] I think that they might have added significantly to this. But I think it is worth reflecting that the approach that was taken by Mr. Quig was -- there were a number of indications that he didn't follow the approach that had been suggested by Dr. Kincaid and later by Dr. Jeff Fisher that a positive, nurturing, supportive person who was directly available to [redacted] was what was needed at that time in his life.

I'm sorry to go back on that, but I think it's important to reflect that the Department didn't ignore it, but I had a sense that they made a clear decision at some point that because this approach doesn't fit with our philosophy, we'll go -- we won't use it.

And if I might address -- now, if I can turn to your -- to justify the unwillingness, the -- there is a significant difference in the -- in the social behavioural approach and this alternate approach about how one would handle issues, for example, of his continuing expression of wanting to get back to his mother, a relationship that was clearly an idealized relationship when we read the early case notes about what that relationship was like, but he speaks over and over and in fact says to two of his foster home

placements, "You aren't like my mother." We hear one of his foster home placements, an important one, saying that [redacted] is mother deaf, that whatever a mother person says to him, he doesn't hear because it isn't his mother, the in a sense what's been called the ideal mother that he had in his head that this woman who bore him was, even though we have clear evidence that it wasn't. He had a sense of what he wanted to have, and when he couldn't have it, sometimes he got angry and acted out a little bit.

There comes a time when one has to address this issue, and I -- and I think you can't do it before the age of about 10. There's some controversy in child development about this, but that there comes a time to grieve the loss of this relationship and to move on. And one can set up an environment of good placements in which this just happens naturally, but in a young man like [redacted] he held onto this and held onto it and held onto it, and by the time he reached 10 or 11, Dr. Kincaid said it is time to begin the process, the painful process for [redacted] of letting go of this family that he can never have.

The Department's approach, at least as far as can be discerned in the -- in the case file review, is that they -- they kept realistically trying to talk to him about well, let's find your mother. Let's go and talk to your grandparents. Let's go and talk to your aunt and see what we can find out about your mother. And this is an extension of the social behavioural approach that says let's go out

and see what this person really was like, hoping I believe that in seeing what she was really like and hearing about her, that he would give up the idealization, then grieve and then move on.

The evidence was that [redacted] said, "I won't do that," as you pointed out. He simply says -- if I might refer to my own notes here of the case file review, there's numerous pages in which [redacted] speaks about his unwillingness to do this, and they're all well quoted.

THE COURT: Go ahead, Dr. Tanney. You may refer to the notes.

A This will take me a moment. Excuse me. I'm glad that my notes were nowhere near as extensive as a file, but they still ran into some 30 pages, so I hope you'll excuse me while I attempt to find these.

[redacted] resistant, so we won't do it. He has a reluctance. He refuses. He's unable to handle it. He doesn't want to engage in it." These are the quotes. And at that point the Department was -- the representatives of the Department I think took an approach and it's a justifiable one within the context of the social behavioural approach, that this young man did not want to address these inner turmoils and so we won't make him do it. From the other perspective, it was only in doing this that he would have been able to move on.

The other thing that happens in Department policy I think that's worth reflecting on here is a clear

departmental policy that encourages contact of permanent wards, or situations in which there's a permanent guardianship, that they -- that there's a department policy that encourages contact with the family, with the natural family and contact with siblings. And I was -- eventually I have to share with you I was astonished that -- that the Department continued to encourage contacts between [redacted] and his elder brother [redacted], when, as one reviewed the file it was so painfully obvious that every time [redacted] had an exposure or a contact or even a hope for a contact with this older brother, that the pain of his abandonment was simply renewed and reinforced. There was a time in which it was appropriate to say it's time to let these go and to begin to deal with the pain of you as a person, and it's that particular issue that I believe wasn't as fully addressed within the Department's helping efforts as it could have been.

Q MR. MERRYWEATHER: If I heard you correctly, you thought the idea of [redacted] learning about his mother or going to his aunt and other members of his extended family and finding out about his mother was a good idea, because he would learn the truth about his mother and then begin the grieving process.

A Within the social behavioural approach that would have been the strategy and tactic to undertake.

Q And -- and that's a perfectly legitimate strategy?

A Very much so, until [redacted] said, "I don't want to do this any

more."

Q Okay.

A And as he did --

Q Okay.

A -- with his resistance and his reluctance and his "I am unable to handle it," et cetera.

Q Okay. And that's when you have to go to an alternate --

A I believe it's important then to recognize that what [redacted] is saying is making me confront this without letting me deal with what's happening inside and without letting me do it with a person who can help me through this period is the difficulty.

Q But on the other hand, [redacted] wants to meet his brother, part of the family.

A Mmm hmm.

Q And presumably learn something about his mother. Presumably this is part of the -- what they're trying to do, and he enjoys his visits with his brother, likes learning more about his brother, seems to exhibit a real need to identify with his brother. I'm having a little trouble comparing that -- you know, discouraging that, yet on one hand encouraging him to be more familiar with his extended family members to learn more about his mother.

A Well, I think that [redacted] sense is that his visits with his brother will be wonderful and they are -- they are -- his relationship with his brother is as idealized as what he thought his mother would be. It's worth noting that his

brother [redacted] says, "I will not tell you anything about your mother. You'll have to find out for yourself. I know things about her and --" I believe that he was saying I don't want to tell you this because it's going to hurt. I had a sense -- my own sense was that in the few quotes that were available, that came across clearly.

But the approach is a very appropriate one to say let him deal with the reality of what his early life was like and then he will be able to recognize that it wasn't good for him and move on. The trouble was that whenever [redacted] had to recognize that it wasn't good enough, anyone who told him that it wasn't good enough or anyone who gave him an experience that it wasn't good enough, for example his brother, he simply didn't want to see them any more. He was reluctant, refusing, unwilling, unable to deal with it.

Am I -- I have a feeling I haven't caught for you where we're at, what my perspective is on that.

Q Well, I think I understand, Doctor. I guess the difficulty I have, on one hand you're encouraging contact with the extended family, on the other hand you're saying he shouldn't have had any contact with the brother.

A But then perhaps that's where I needed -- in the social behavioural approach, one encourages contact with the extended family, and often through learning about that family the person says I have a place, I belong in the world, that isn't my place any more and I will move on. That's one -- one approach.

In this young man it was the approach that I believe the Department took, and in many instances it would have been successful and he would have been able to move on. I'm not suggesting that it was the only approach or that I agree with it. It was the approach that was tried. I believe that when the block came and it became apparent that [redacted] couldn't assimilate that experience, that even at the age of 12 and 13 and 14, he continued to maintain that -- that he wanted to be with his brother, that his mother, he wanted to know more about her and perhaps meet her, that he had idealized that relationship beyond anything that was real. It was at that point a fantasy for him. In fact, sometimes one believes -- one wonders if fantasy in order to avoid having to deal with having a placement, having to deal with another foster family.

And it was at that time when the resistance was apparent, that Dr. Kincaid saw when he was 12 in 1990, that it was time, and that Dr. Fisher saw in 1992, that it was time to stop that approach, to stop the issue of saying yes, we will follow department policy and encourage these efforts to get a hold of your brother and to say, well, this is your life now. How are we going to deal with it? And I think that the Department made significant efforts to do that, except in the area of what was going on inside [redacted] and I think that giving him a permanent, positive, supportive therapist would have allowed him to do that. And I think that -- I believe that the Department made a clear decision

against that on a philosophical basis.

Q I am going to ask you about a sentence on Page 8 of your report, sir, and I appreciate that you'll have to backtrack in order to -- to put it in context. About two-thirds of the way down the long paragraph, you say:

> The thesis put forward here is simply that the System had a clear bias against working with this facet of a fully integrated treatment model.

Does -- is that -- when you say "the thesis" is that the thesis that you presented here?

A That's mine.

Q Okay.

A That's mine.

MR. MERRYWEATHER: Your Honour, I wonder if we could take a break now. I have to get into that box for the next part of Dr. Tanney's evidence.

THE COURT: Well, that clock is obviously not working, Madam Clerk.

COURT CLERK: Five to eleven.

THE COURT: Five to eleven?

COURT CLERK: Yes.

THE COURT: 15 minute break.

MR. MERRYWEATHER: Thank you, Your Honour.

THE COURT: We will reconvene at ten after then. Thank you.

(WITNESS STANDS DOWN)

(ADJOURNMENT)

COURT CLERK: This inquiry is now continued.

BRYAN LAWRENCE TANNEY, previously sworn, examined by Mr. Merryweather:

Q Dr. Tanney, if we can -- actually before I ask you to talk about the risk estimation process, the alternate therapy program that you would like to have seen applied in this case, I take it there's no guarantee that that would have worked?

A Not at all. It was another possibility, and again, not so much an alternate as the efforts that this -- that the Child Welfare Services made were critical, that they had to be ongoing, but I am suggesting that it was an approach that could have been added on, not an alternate one.

Q Now, determining, sir, whether a person is at risk of suicide, assessing the risk of suicide, I gather, I think I'm quoting you somewhere, that it's more of an art than a science.

A It's not a quote, but it's certainly I think an appropriate comment.

Q Okay. And in your file review you noted only two occasions where the caretakers recognized the possibility of suicide. That would have been the fall of '91 and then the second after [redacted] placed in the Wetaskawin Hospital following the breakdown of the Burrell (PHONETIC) placement.

A Those were the only two times in which there was a clear indication in the opportunities that people had to sort of say was this man suicidal when they did the case reviews,

and there's a form that says -- there's a whole list of potential problems that this young man might have, and there is -- the very first one is, is there suicide risk, and the only two times it appears are after he leaves the Burrell home at a time in which he says why doesn't -- the consequence -- the issue is that he says to someone in the home, "Why don't the kids get a knife and stab me?" So, he doesn't -- you know, I'd like to be dead is the implication. And that's followed very quickly by a comment that he makes that appears to be hard to appreciate, that he's sitting in the car with Mrs. Burrell and her daughter and says, "I'd like to hurt her." And of course Mrs. Burrell immediately within several days has [redacted] removed from the home.

Q Okay.

A But that's the first one, and after that, the Department has Alberta Mental Health Services, Dr. Copus (PHONETIC) and -- and Ms. Lockington (PHONETIC) see this young man and undertake some play therapy with him.

Later on there is -- after he goes to Parkland, there is a number of instances in which [redacted] undertakes behaviour that I think has to be -- could be seen as being indirectly self-destructive, which is a term that we use. He has -- he has a car accident. He has an accident when his bicycle runs into someone else's vehicle. He gets made one day and pulls out light sockets, and there's some concern that this could be destructive. I think later on in that same year he -- there's one instance, in fact, when he comes out of a room

with his sweater around his neck and someone says, "What's this all about?" And he says, "I'm going to kill myself." And they go back in and look and he's -- he's turning at least a little pale colour from it and they get -- and this is all at Parkland. As a result of that, they ask for a psychiatric consultation.

But other than those two instances, as one looks at the regular case reviews and case planning procedures that go through where the opportunity to talk about his suicide risk is there, it simply doesn't appear. When he has to appear in Youth Court there's a predisposition report done. It doesn't mention suicide. And I think it's worth noting that even I think two days before his -- three days before his death at the placement committee meeting of the 14th, the report that's prepared that has an opportunity to reflect on suicide risk doesn't indicate that there's any suicide risk to be considered in a placement situation.

Q Okay. The -- the incidents with the Burrells, that would have been in about 1991, as well?

A No, the Burrell -- he was -- he's 5 1/2 --

Q Okay, I'm sorry.

A -- at that point.

Q Okay. Now, the incident when he's 5 1/2 and the other one in the fall of 1991 are the only two incidents where you noted that the possibility of suicide was recognized, and then, as you've indicated, there are after 1991 several opportunities for him to be identified as a suicide risk and

he is specifically not identified as one. And then you go on to say that is surprising. Could you tell the Court why you find that to be surprising?

A I -- it surprises me because although he doesn't manifest any direct suicidal behaviour or he doesn't say, "I'm going to kill myself," which is, one hopes is something that any caregiver would respond to. There is throughout a growing sense that this young man meets every psychological risk profile that we create. I'm not wishing to give you a long teaching program, but the idea of being alone and feeling worthless, feeling powerless and helpless, having a sense of hopelessness, these are the internal words, these are the words that describe the internal state of a person that we all associate with suicide.

Q Okay.

A And he met them. He met them throughout his life.

Q Okay. You, sir, in the course of your file review, had occasion to review a bulky document called "The Trainer's Manual, Qualified Training Suicide Awareness"?

A Yes.

Q And that's dated September 1993?

A Yes.

Q What was your understanding of what this document was, sir?

A It's my understanding that it was the document provided to some person who would be available to train approved foster parents who were contracted to Alberta Family and Social Services, to give them at least an awareness of issues of

suicide, risk assessment on an acute basis.

MR. MERRYWEATHER: Your Honour, I wonder if we might enter that as the next exhibit. I'm sorry, this is the only copy I have. I believe the next witness this afternoon may be able to comment on it, as well.

THE COURT: Very well. That will become Exhibit 76.

EXHIBIT 76 - THE TRAINER'S MANUAL, QUALIFIED TRAINING SUICIDE AWARENESS

MR. MERRYWEATHER: I wonder if you could show that to the witness, please. I think --

Q Unless, sir, you have the -- the --

A I have.

Q The Mnemonic Sad Children Plan, do you have that in another format in your notes?

A I have it, but I don't have all of the --

Q Okay. At --

A -- words written out.

Q At Page 92, sir --

MR. MERRYWEATHER: Your Honour, this would be Appendix 'G' or 'H', I believe.

A It's written out in some detail, yes.

Q Okay. I -- if you could -- I thought I had written down the -- the one page.

A Here it is, sir. It is Page 92.

Q If you can just show that to His Honour.

A Yes.

THE COURT: Thank you.

Q MR. MERRYWEATHER: And sir, could -- what was your understanding of what this particular document, Page 92, was?
A This was the -- a mnemonic, an attempt to remind caregivers about the features and factors that they should take into account in assessing the suicide risk in a young person who is in their care.
Q This would enable a foster parent to look at certain well recognized suicide indicators --
A Yes.
Q -- and then do an assessment, what we might call a risk assessment?
A Yes, it would in a sense cue them. These were the cues that they might use to undertake a risk assessment.
Q Okay. And did you use those cues to do a suicide risk assessment for [redacted]
A As -- as much as was possible, because one is always of course doing retrospect here.
Q Okay. And what was your -- what was the result of your assessment, sir?
A Well, there are 15 factors and one of them is -- is being a Native child, so being that, there's 14 left. And at any time I believe in the last two years of his life, at any time [redacted] met the significant risk criteria for 10 or more of those risk factors. Essentially what I am suggesting is that [redacted] was a young man of remarkably high risk of suicide using the Sad Children Plan framework.
Q And sir, are you aware of any courses that are available to

foster parents or child care workers or anyone involved in the raising of children which would help them in assessing the risk of suicide and dealing with it?

A At this point I'd have to pass on to the recommendations of the Tomlinson report, because I know that certain programs were implemented within the department as a result of that, those recommendations, and I am now aware that this particular program was at least available in draft form and for presentation to foster parents in the fall of 1993.

Q You didn't have any concerns about the adequacy or inadequacy of the --

A Of this particular foster --

Q The program outlined in that Exhibit 76.

A This suicide awareness, I have --

Q I appreciate you didn't look at it.

A I have immense concerns. I -- no, I reviewed it in some detail for other reasons and I have immense concerns about it.

Q What are your concerns, sir?

A If I might again turn to some of my notes here. Three hours in suicide awareness, it doesn't give anyone a sense of feeling comfortable in knowing what they're doing, working with a young person at risk of suicide. It runs, I believe, contrary to the recommendations within the department itself, wherein at least in the Thompson report a two-day program was recommended for staff, and I'm not sure if it was also for contract employees. I can share with you that

foster parents in the State of California undertake a two-day program and that doesn't just direct itself to some knowledge, but addresses other issues as well in terms of the skill of working with a young person who they believe might be at risk of suicide.

I have to speak to this particular -- and I'm going to -- I have an inquiry for you and for His Honour here. This -- this is an area in which I am very active, and in fact some of the pieces in this manual are plagiarized from materials that we have created. So, I feel some potential conflict in reflecting on -- on all of it. If it's all right, I will do the best I can.

This is an effort that attempts to take a program that at least among most experts who teach about suicide, it's now agreed would take a minimum of one day and probably longer and attempts to do it in three hours. For example, it leaves a space of about 10 to 15 minutes for people who have never met each other to sit down with each other and talk about their experiences with suicide and how they felt about them, with no preparation. And this simply doesn't work and -- and I can share with you from having taught -- having been involved in a program that's taught about 100,000 people and that recognizes the importance of people talking about their experiences with suicide, that this can be an immensely traumatic and dangerous venture as set out in the teaching program, that it would be quite unusual to do this without significant preparation and training on the

part of the trainers, and certainly it never would be allowed to happen in diads for a period of only 10 to 15 minutes. If I might digress, I've seen whole teaching programs come to a stop for up to a whole day when issues like this are introduced. That's the simple -- the first piece.

A second piece, "The Mnemonic Sad Children Plan", I think it's important to recognize, as you pointed out, that this is an art and not a science, and that all these are, are cues to -- to a parent or to a -- to a caregiver. There is no sense at all that one can add up any report or instrument or check list and say here's the risk and it's high, and here's the risk and it's low. It's also important to recognize that at least using Sad Children Plan, that many of the features are not temporary features. They're long term. So that, when one does Sad Children Plan, do you -- do you say how many of these were operative within the last three months, how many of them have been operative for the last two years, and how does that change the risk? Are we looking for things that are new in this context or are we saying, gee, if you look at this, [redacted] was at risk almost all his life, if you use Sad Children Plan as the Mnemonic.

And finally, there's the question what does one do when you get a score that -- whatever the score is that might create some concern, and the -- the indicator about how you use this instrument is simply that if there are any one of these three, one should immediately contact a case manager,

and if one looks at the three of them -- the three if I can reflect on them, one of them is a plan and this young man specifically denied a plan when asked. A second one is are there any gestures and there were none. And the third one is, is there the cluster of indicators indicated by Sad Children Plan. And I've pointed out -- as I've pointed out, [redacted] had almost all of this cluster of indicators. So, you're in a situation either where if you look at the instruction about how to use this program, you would never phone the case manager to report a suicide risk, or every time you applied it, you would be phoning the case manager on every occasion to say this young man has the cluster of indicators that you've told us if we see them we should phone you.

My conclusion is that it's an effort that needs to be done, but that has lots of difficulties in it.

I would like to indicate, as well, however, that it's my understanding that this is the program for foster parents. This is -- this is not the program that at the present time at least caregivers within the department undertake. Their program is more extensive.

Q And I take it your review is based on the documentation. You haven't participated or observed one of these sessions being taught.

A No, I haven't observed one of the sessions being taught. I could -- my -- my -- it was based not only on the review of the materials, but I would suggest review of about, now, I

would think 130 other programs that are like this that I've had the opportunity to review.

Q Sir, I am going to give you an opportunity in a few moments to ask you what recommendations you would have based upon your file review. Before I do that though, if I could ask you to, if it's possible, to summarize and conclude your review as you've done on Page 10 of your report.

A A review of suicide risk estimation?

Q Suicide -- pardon me, your conclusion based on your review of the file with respect to first of all multiple placements --

A Oh, okay.

Q -- and secondly, with respect to risk assessment.

A Let me address risk assessment first. Although the only piece of training program that I had access to I believe was clearly inadequate and I don't know how well prepared the Quest staff were, I think it's important to emphasize that we don't have a check list that would have predicted [redacted] death, and using the check list that we have available, it would have identified him as being at risk of suicide for almost his entire life.

My concern is that in reviewing the response to this young man's death in the case file reviews and the reports that were written, it seemed to me that there was a clear belief that somehow somebody missed something, and that -- and that something must have happened at Quest that if the staff had only known more or been more properly trained or

followed procedures more effectively, that it would have made a difference. And my own assessment of the activities undertaken by the Quest staff and by the Child Welfare Services staff in the time between the 14th and the 17th of June is that I think that the quality of care that they provided was very good to excellent in anyone's estimation of what was going on in terms of suicide. Now very good, I couldn't say excellent. Very good in terms of how they handled the issue of the suicide risk in its estimation and communicated appropriately about it. But that would be my -- my summary of the issue of risk estimation.

To go back to the issue about multiple placements, I again emphasize that I don't believe it was the quantity of the placements that was important. The quality of the placements that were offered were, except for the emergency situations, I think well researched, well chosen by the department and that because of the difficulties that [redacted] brought to the placements, despite the fact that the Department learned of these difficulties and, for example in the Van Gall placement, were able to offer tremendous support to this adoptive family, and that in other placements the Department were willing and able and did in fact provide significant support through the school and through consultative and other treatment services, that they were -- that they did the best that an agency could do on behalf of the young man. I don't believe that the placements themselves in terms of their quantity were what

-- were the reason why [redacted] ran dry. I believe that finally because of what was going on inside of him he simply gave up and gave in, because it appeared to him that the situation was -- and now we move into the profile of the suicidal person, that he was alone, that no one particularly cared about him, that he was powerless and that he was hopeless to do anything about what was going to happen to him in the next day, which was that he was going to be moved on to another foster home.

Q Sir, we -- we had an interesting discussion during the break about what you with 20/20 hindsight and based only on a review of the file, what you would consider to be helpful recommendations to prevent similar deaths, and one of those, I asked you whether or not there would be an merit into some sort of flagging system that would see Child Welfare files flagged at five placements or 10 placements or 15 placements or what have you, and that would mean some further action should be taken. What were your thoughts on that, sir?

A My thoughts are that it would -- there would be a lot of red flags on their files, not because of the number of placements, but because there are a number of other criteria that I think would be more important than simply flagging a number of placements. As I indicated in discussing placements, it's not just the number of placements but their quality that needs to have some assessment. And the quality is in fact an interaction between what the placement offered and what impact it had on the young person. There are

placements that don't work for various reasons. In this young man, some of the placements, I believe many of the placements, didn't work because of his unwillingness or inability to allow the process of carrying on and moving on to be effective.

My own belief is that a flagging system that would simply work on the quantity of placements would only be one in a large number of factors that I'd want to consider, and in fact in summarizing I think it would probably be of little value as a suicide predictive risk factor.

Q And so what -- what recommendations would you -- if you were in a position to do so, what would you make that might prevent similar deaths in the future?

A Well, and I say this not lightly, because I have considered it for -- for a while, but one wonders whether one should ever say things like this in our modern culture, but I think -- I do believe it needs to be said. I think that this young man, if he had been removed from his natural family soon after his birth, would have been able to be involved in a caring and meaningful system that would have found an effective placement for him. I believe the fact that his mother, with all of her difficulties, was allowed for three years to carry on hurting this young man's emotional development is something that needs to be more clearly addressed. And this is not to suggest in fact that the Child Welfare Services did not, because even in the first several years of his life, numerous Government support and

other agencies were involved not only with the mother, but with the child. I think at some point there needs to be a recognition that there are simply some environments that are too damaging to children, and that someone needs to make a decision to remove them from them. That would be a first I guess idealized recommendation that I'd want to --

A second one would be that -- that we do do something to make sure that the staff who are involved with young people recognize issues of suicidality. In one sense, one of the things we know about people who kill themselves, whether they're teenagers or adults, although there are not a lot of things we can be sure of, there does seem to be a clear belief that if a young person is separated from important and significant emotional figures in his life before the age of 10, that that seems to be an identifying factor for suicide in later life, separation, not number of placements, but simply the issue of being separated from them. And for that reason it would almost be my sense that it would -- Child Welfare Services would have to say we are aware that every young person in our care is more at risk of self-destructive behaviour than people who are raised in whatever the variants of natural families are today.

Q Any other recommendations, Doctor?

A That we make sure that the staff who are working with them are competent, because in my work we have learned over and over again that competency in the area of intervening with young people at risk of suicide is sorely lacking in all

professional groups in our society.

Q Is there anything else you'd like to add, sir?

A No.

MR. MERRYWEATHER: Thank you very much for coming this morning, Dr. Tanney. My friend Mr. Ford and His Honour will likely have some questions for you.

THE COURT: Mr. Ford?

MR. FORD EXAMINES THE WITNESS:

Q Dr. Tanney, to deal with some of your last comments first, it sounded like what you were suggesting as a first recommendation was to the effect that in certain cases the Department would do well to intervene earlier than they actually do.

A Yes.

Q That is in [redacted] case I get the sense that you're suggesting the Department should have gone with some form of permanent application at a much earlier stage in his development.

A It's easy to say that in hindsight. We do have this commitment in our society towards the -- the value of the natural family, no matter what, and I believe sometimes that simply needs a full assessment and I guess objective assessment.

Q Okay. You also made some comments earlier in your evidence, and I'm jumping around a bit, that you felt that in some senses encouraging contact with biological family for a child in care can be more destructive than actually cutting him off and getting him through a grieving process about that and getting him on with his life. Is that a fair

comment?

A I believe that's true for some young people where the damage has been significant already.

Q And did you think [redacted] fell into that category, that it would have been better to cut him off from any attempts to locate natural family at an earlier date?

A Well, I think that -- I think that when we saw what happened to [redacted] --

Q Mmm hmm.

A -- whenever people made efforts to do that with him and on his behalf, that the results were destructive. It was time to sort of say we need to stop and look at whether this -- fully implementing this policy for this young man is a useful and constructive thing for him.

Q Okay. My understanding of some evidence that was given in your absence of course, was that the Quest Program in part encouraged attempts to reconnect with extended family for children in care. Were you aware of that?

A I'm -- I couldn't reflect on whether Quest made that a part of their policy. I was only aware because I saw it was the Department policy.

Q Okay.

A And I don't know then if it was a particular Quest policy or if it was simply following through on something that the Department had already been fully embarked on.

Q Okay. So, it really doesn't matter where the direction came from. You don't think that's a good idea in [redacted]

particular case.

A Well, I -- I think it's important to say I don't think it was -- I don't think it was a good idea.

Q Okay.

A I think it was important to say that the people who knew him --

Q Mmm hmm.

A -- in 1984 and in 1989, and in 1989, who were professionals who had a chance to meet him say it's time to stop doing this to this young man.

Q Okay. How would they go about doing that if he's expressing a desire to have continued contact with extended family? Would he just simply be told no, this isn't going to be -- going to happen, or --

A I -- I think it's fair to say that, at least as far as I was able to read, that there was a sense of [redacted] let's do this, or let's make efforts to contact your aunt, your grandparents --

Q Mmm hmm.

A -- and that was facilitated and in fact the policy says that especially with siblings, we will do everything to facilitate it.

Q Okay.

A There was a very clear sense that on -- on several occasions the Department actually chased his brother to find him and -- and let him know what was going on in terms of involvement.

Q Okay. What should the Department do if a child like [redacted] wants to have contact and the Department doesn't think it's a good idea? Should the Department be saying no to the -- to a child like [redacted]

A It's my understanding that the Department at that point acts as the parent.

Q So, the Department should make the decision in the best interests of the child?

A Yes.

Q Okay. Now, I get the impression from your evidence about your file review that you think a lot of the damage to [redacted] was done before he came into the care of the Department at all.

A I very much believe that.

Q Okay. And then later on in talking about placements, you said [redacted] would in essence break down placements by his behaviours.

A I think that there were four in which I believe his behaviour of testing to see if he was going to be accepted was -- was directly resultive in the family saying no, this is not a young person who we can accommodate within our family.

Q Okay. To me as a parent testing can be a child just refusing to do something that I want. Would that be what [redacted] was doing, or would his efforts to break down a placement be more extreme?

A I believe his efforts at breaking down placements were -- in

the context of normal parenting, would be regarded as extreme.

Q Okay.

A Lying, stealing, cruelty to animals, these are all, you know, for many of us as -- for the norm of parents, these would be behaviours that I think we would be turning and asking for professional help and support.

Q Okay. Would they be the kind of behaviours that in [redacted] would -- if he was attempting to break down a placement, would they just happen as isolated incidents or would there be sort of a continuous pressure from [redacted] exhibiting one or more of these behaviours?

A Well, again, this is in a sense a generalization, but one saw it reflected a number of times in the file, that there was and is usually a period of honeymooning in a new placement. He's glad to be there, they're glad to have him.

Q Mmm hmm.

A But it's almost as if as the placement becomes stronger and more secure and has more to offer to him, he becomes more frightened, and that his response to that worry -- the analogy that I often use is someone climbing up a ladder, and if you have fallen off the ladder before, one of the things you learn to do is not to climb up the ladder again, and anybody who wants you to climb up the ladder and say come and be with us and feel secure with us, you're going to resist it. And the more they invite you and encourage you and say they can handle it, the more you will test and try,

see how -- how meaningful this is.

Q Okay. So, his efforts would -- to break down a placement would escalate?

A Very much.

Q Did you see signs on the files that you had from the Department and from Quest that [redacted] behaviours were escalating in any way while he was at Quest? Did you see efforts there to break down that placement? For example, we've heard from Mr. Hale that there was incidents of property damage. We've heard that there were some incidents of alcohol consumption, some instances of A-walling behaviour while he was on leave to Red Deer, that kind of thing.

A They -- all -- all of those, I think even the -- the alcohol, was present when he was at Parkland, so that they weren't newly discovered behaviours.

Q Okay.

A As he became older and his potential for doing damage to others got greater, I think that's where he became involved with the young offender system.

Q Mmm hmm.

A But certainly his placement at Quest resulted in fact from his being at Strathmore and in the youth assessment centre and in fact being -- in fact being taken away from Parkland because they simply couldn't handle him any longer.

Q Yeah.

A Did he test at Quest? I think -- I felt that Quest had a

very clear sense that this young man was going to push their limits as far as he could.

Q Mmm hmm.

A And -- and he did. There's a number of expressions that they felt that over the course of the last several months [redacted] had been resisting their efforts even more strongly, and this is the difficulty as the helping agency and person they get into. When do you say that's all I can handle as a helping agency and person, and when do you persevere with a belief that says this is like riding a horse that needs to be broken?

Q Okay.

A And I don't mean that in a vicious or cruel sense at all, but that there is a period of wildness and trying out to see if people really do care, and that that can be escalating and intensive and damaging as it was in this young man.

Q Okay.

A My sense was, I think as I indicated earlier, that essentially what I think happened at the middle of June was that the Child Welfare Services and Quest had run dry and [redacted] at the same moment in an intersection also saw no opportunities for him, and it was that, maybe not in the week, but it happened at that moment and I think that's really why we saw suicidality appear so -- so suddenly in this young man.

Q Okay. When you say "suicidality", does that have a special meaning?

A I guess the sense is that 85 percent of the people in the world will think about killing themselves at some point in their lives, but most of us, it comes and goes very quickly, and that's where we use the word "suicidiation" (PHONETIC). Was there a time in your life when you thought life wasn't worth living? I think [redacted] would have answered yes to that question over and over and over again, but the sense that he was going to do something about it didn't come through. My own belief in response to the risk estimation is that [redacted] was a chronic and ongoing risk, but that to predict when he would act would have been essentially a chance manoeuvre.

Q I'm sorry, I missed that.

A We would have been guessing.

Q Okay. So, the introduction of -- effectively, if he's chronic, it would need the introduction of some new behaviours before you -- you would be, you know, as a lay person for example, alerted that there might be some change in his risk. Is that a fair statement?

A Yeah, and I think that Ms. Nikiforuk noted that, said, you know, if he starts to write about suicide --

Q Mmm hmm.

A -- should we take that as an indication and be more responsive? That was an appropriate point to be taken.

Q Okay.

A Chronic risk is punctuated by periods when the risk can increase. But you can have in a sense an acute risk overlying an ongoing chronic risk.

Q Okay. Is it fair to say that [redacted] risk became acute so suddenly that it's not remarkable that it was not picked up on?

A Well, I don't -- I don't believe it's remarkable at all that his risk wasn't picked up on. I also believe in fact that his -- his period of what we call, what people have recently begun to call the suicide zone --

Q Mmm hmm.

A -- if there's a chronic risk that an accentuation of it can push people into a zone where they -- the resolution will either be that they go back to being chronically suicidal or they act.

Q Mmm hmm.

A And I think -- I believe [redacted] was precipitated into what we have come to call the suicide zone in the last two weeks of his life. We learned much later of course from one of his peers that he had actually mentioned suicide. But in terms of a -- no, I agree with you, it would not be remarkable at all for this not to be noticed.

Q Okay. Are there differences in the way males and females present as suicide risks? Like are boys more likely to suddenly act in a final way than girls?

A Boys -- exactly. Boys are much more likely to be quiet and to do it unfortunately at their first effort. [redacted] picture, I have to share with you, is not an unusual, in fact it probably fits the profile of suicide in a young man, except for the method that he chose, and in fact he chose

the second most common method, not the first.

Q What's the first?

A Firearms.

Q About how much greater is the risk that a boy will act and successfully kill himself than a girl?

A One works simply on numbers, and the likelihood is that a young man is five times, perhaps 5 1/2 times as likely to kill himself as a young woman.

Q Okay. And how likely is a young man -- how much more likely is a young man to just act once as opposed to having what you might call calls-for-help kind of attempts?

A Again, this is the -- the story that we have is that young women will in attempts to sort of connect and have someone do something will make an overt statement that they are suicidal --

Q Mmm hmm.

A -- that they will do something behaviourally to hurt themselves of low lethality, that people will say, what's the matter? Why were you trying to hurt yourself? And they would then have a chance to connect and to communicate. Young men in almost all American/British cultures don't have that behaviour pattern. They keep to themselves, and it's almost as if it -- if there is a suicide impulse, it appears suddenly and can explode very quickly.

Q Okay. Are there any significant differences in the rate of suicides of children in care versus the rate of suicides of children in the general population?

A I wouldn't be able to comment on that in terms of -- of rates. I can reflect back on my earlier discussion that the situations that put children in care, being separated from a natural parent earlier on in life certainly lead in both adolescence and adult life to an increased amount of suicide and suicidal behaviour.

Q Okay. So, essentially you are dealing with a very damaged population that's more prone to that kind of behaviour --

A I would -- I would --

Q -- when you're dealing with children in care?

A I would agree entirely.

Q Okay. So, sir, if I understand what you said to Mr. Merryweather correctly, in a general -- in a specific sense in [redacted] case it might have been useful if the Department had attempted to intervene at a younger age?

A In a -- in a --

Q In a particular sense in this case.

A Yeah, in a particular sense.

Q In the general sense I understand what you're saying regarding training of people working for the Department is that you feel foster care workers, foster parents, should be provided with more training regarding this particular issue, suicide awareness and suicide prevention?

A If we accept your earlier premise that this population are more at risk.

Q Okay.

A I think this should be a priority among the training

activities that we offer these families and parents.

Q Okay. And I understood that comment to be directed at the foster care area primarily?

A Yes. The -- and that was because I had no access to the programming and the training experiences that full-time members of the Child Welfare staff had available to them.

Q Okay. And in the general sense, I don't think this was one of the specific recommendations you made to Mr. Merryweather, though I could be mistaken, if the Department dealing with an adolescent like [redacted] is able to maintain some form of primary therapist, primary caregiver throughout that child's involvement with the system, that would be a good thing?

A Specifically for [redacted] I think it would have been a good thing. I believe that in many situations it isn't necessary because the placements don't break down and that's already available within the system.

Q Mmm hmm.

A But I -- I do believe that the Department's approach of having case managers is a -- is an effective system, because the case manager's role is in fact to provide that coordination and ongoing stability. I believe that in [redacted] situation what was needed was more than the managerial aspects of the case manager. What was needed as well - and I think this would not happen in many placements - what was needed as well because of the damage [redacted] had experienced earlier in his life was a consistent treatment resource who

in fact could function almost in parallel with the case manager, and I think it's important to recognize that the Department made efforts to do that in its placement at Parkland, because they did propose that the case manager, social worker and a psychologist would meet with [redacted] and I believe that they -- they recognized that both aspects were necessary.

Q Okay. From the file review did the information suggest that the actual case manager did attempt to maintain contact and involvement with [redacted] while he was at Quest Ranch?

A I -- I have no questions at all -- yes, I -- yes, they made significant efforts to maintain contact and to be an ongoing and continuing resource and support for.

Q Okay. Again an impression that you think that there was a breakdown perhaps in the area of the psychological resource continuing involvement once [redacted] was at Quest?

A I think that the breakdown in the psychological continuity of resources came much earlier than when [redacted] went to Quest.

Q You're referring to --

A And it continued at Quest.

Q Okay. So, you're referring first when Dr. Kincaid's involvement ended, and then later to Dr. -- or Mr. Quig's involvement?

A Yes.

Q Okay.

MR. FORD: Can I have just a second to speak to my client, Your Honour?

THE COURT: Yes, go ahead.

MR. FORD: Okay.

THE COURT: And Madam Clerk, if I might see Exhibit Number, I believe it is 76.

(DISCUSSION OFF RECORD)

Q MR. FORD: Dr. Tanney, have I raised anything in my questions that you feel I didn't give you an adequate chance to comment on or expand on? If so, please feel free.

A Perhaps just as an extension of the last comment, because I was afraid we were going to pass over it, but I believe that -- that the -- I believe that this was a philosophical problem, not a efficiency or a negligent issue on the part of anyone who was involved with this young man. I truly believed as I read the file over and over that this was a framework for providing care that was followed very, very well, but that in this young man something not alternate, but in addition was needed, and that the system for whatever reason was unable to respond to it, and perhaps that's the piece that you have cued me to, and that the explanation for Dr. Kincaid's discharge after she makes the offer to engage in long term, ongoing therapy with this young man is that he -- she is discharged ostensibly for -- because they couldn't afford to pay her any longer. And I think that that would be something that would need serious consideration because I believe that it was that breakdown and in fact the nature, the way that that relationship broke down was disastrous for this young man, in that the -- Dr. Kincaid -- it was

indicated to Dr. Kincaid I think in January that they would be terminating, and there were still sessions being yes, no, we won't let you see him again, we will let you see him again that went on well into May. So, if we're talking about a young man who has difficulties with being abandoned and left, here is the person who had been available to him as a supportive therapist who was pulled away from him, ostensibly for reasons of cost.

Q Okay.

A And that when it's -- becomes apparent that [redacted] disagrees with this, that his social worker disagrees with this, that Dr. Kincaid disagrees with this, that they go and speak to the Child Advocate, and the Child Advocate, although I did not see the full text of the letter, in the case file review there's a notation that the Child Advocate simply felt they couldn't act because [redacted] couldn't give clear instructions that he wanted to continue to see Dr. Kincaid.

Q Okay.

A And I think that that -- if there's one other place that I would have wanted to be able to focus for a moment, that would have been it, that if it -- that it was a philosophical decision, but that if it was in addition an economic decision that this happened, I believe that then someone needs to recognize that there is a cost for human life.

Q Okay. So from what you've just said, I gather both that the worker and the therapist and the child at the time of Dr.

Kincaid's termination, if you will, were all agreed that it would be a good thing to have her continue?

A Yes, enough that the -- the two professional workers encouraged [redacted] to go to the Children's Advocate.

Q And he got no assistance there?

A I --

Q I --

A All I know is in the case file note it says that the Children's Advocate chose not to go forward with anything else because [redacted] --

Q Okay.

A -- didn't give clear enough instruction.

Q What's your understanding of the role of the Children's Advocate, not in this particular case but in general?

A I assume that it's an ombudsman role, that -- that if there were departmental policies, that in particular instances these could be overruled or asked for in special circumstances.

Q Okay. Essentially to help the child deal with the Department?

A I think a lot of people were helping this child deal with the Department. I think that his case manager and his -- Mr. Quig --

Q Mmm hmm.

A -- both took that on as their major role within the social behavioural philosophy, that their job was to help [redacted] get into the system that was trying to help him as much as

possible.

Q Okay. Anything further, Doctor?

A No, thank you.

MR. FORD: Your Honour, that's all the questions I have.

THE COURT: Thank you. Mr. Merryweather, anything arising?

MR. MERRYWEATHER: Nothing arising, Your Honour.

THE COURT: I have a few questions I would like to ask then.

Mr. Merryweather, perhaps you can help me in identifying the exhibit that I'm looking for, and it relates to the results of Dr. O'Malley (PHONETIC) review. There were two doctors' reports that were prepared when --

MR. MERRYWEATHER: Dr. O'Malley and Dr. Fisher's reports?

THE COURT: Yes.

MR. MERRYWEATHER: Numbers 45 and 46.

THE COURT: May I see those please, Madam Clerk?

(DISCUSSION OFF RECORD)

THE COURT: Thank you.

Again, Mr. Merryweather, the reference I am looking for, and I assumed was in these two reports, related to an assessment of the -- a suicide assessment of him, and perhaps I am looking at the wrong reports for that. They'd been referred at one point in time for further review of that.

MR. MERRYWEATHER: Your Honour, there is a report from June

6th, 1991 by Dr. Quig, or Mr. Quig, excuse me --

THE COURT: Perhaps --

MR. MERRYWEATHER: -- regarding seeing [redacted] on June 3rd after an incident where he tied his sweater around his neck. Is that what you're thinking of?

THE COURT: Yes, perhaps that is the one that I am thinking of.

MR. MERRYWEATHER: That's Number 42.

THE COURT: Thank you. That is not the report I am looking for either.

MR. MERRYWEATHER: Sir, I believe the -- if it's Dr. Fisher, I believe Exhibit 46 is the only document we have with -- with his signature on.

THE COURT: No, I just don't recall the author of it. I recall that there was a review of a suicide incident and a report that followed from it. And I am looking for that report. It has been suggested that's Mr. Quig's report, but I don't see the reference that I thought I had seen.

MR. FORD: I don't know if it is any help, Your Honour. Essentially my understanding of the events is Mr. Quig did an initial report which you've got. Then the boy went to see Dr. O'Malley and that interview terminated very quickly because he did not wish to speak to Dr. O'Malley, and then he was referred to Dr. Fisher. But all of them stem from the initial incident report by Mr. Quig regarding the tying of the article of clothing around the neck.

THE COURT: Yes. The only reason I have concern about that, again from reviewing the documents, is Dr. O'Malley seems to be more concerned ultimately about the sexual aspect of the activity he had seen.

THE COURT QUESTIONS THE WITNESS:

Q You have had perhaps a more recent review of these documents than I have.

A I think that --

Q Do you recall which incident or report --

A I think that as it's been expressed and when this young man reached Dr. O'Malley in November, it was almost six months after the -- the episode that Mr. Quig had written the report on, on the 3rd of June, and I think the -- that the events that had followed on after that dealt largely with [redacted] use of sexual acting out to disturb other residents. And so when he went to see Dr. O'Malley, that became the focus of Dr. O'Malley's consultation at that time.

I, too, was surprised that in both of the consultations there was no direct addressing of [redacted] potential suicide risk, that of Dr. O'Malley or Dr. Fisher.

Q And Mr. Quig's concerns seem to have changed from a concern about any suicide attempt to some other activity.

A Some other activity.

THE COURT: Okay. Madam Clerk, thank you.

A It was -- in another application or extension of care, in September of that year, that offered an opportunity to indicate that suicide risk was one of the concerns of the

Department, they indicated that it was not a concern. It did appear that it -- that this single incident seemed to have been handled effectively and not to have been a difficulty and they moved on to some of his other problems.

Q Do you have any sense of why this occurred in terms of the evaluation assessment of him and the aspect of suicide by people who have been trained or have gone through a training program?

A I believe I would reflect directly that it's not just foster parents who don't receive training with respect to suicide. It's my awareness from a number of surveys that have been done throughout North America now that the professional caregivers, and I can speak directly to social workers and nurses and psychologists, that 50 percent of those professionals receive no training or experience with respect to suicide risk and suicide risk assessment during their professional qualification.

Q Where is the breakdown if there has been training, that they have gone through the training and then failed to identify it in this case, [redacted] situation?

A I believe the breakdown comes, especially with children because it's an issue that we want not to think about, and that if they don't do it we don't ask, which is a remarkably common response of professionals of all disciplines with respect to suicide.

Q And how does one deal with that situation?

A One deals with it by undertaking professional education

activities at the qualification end at the continuing professional education level that enable the professionals and the caregivers feel more comfortable asking about suicide and dealing with the answers that they get, and I can assure that there are programs that effectively do this at this time.

Q You have reviewed the trainer's manual and this isn't the training manual, but the training of the trainers, I understand, and the Sad Children Plan. You have expressed some concerns about that. Dealing firstly though with the plan itself as suicide risk indicators, do the headings make sense?

A The headings make sense as a selection of the suicide risk indicators one would wish to consider.

Q You have concerns about some things that are missing in it?

A I have concerns about some that are missing, but more about the fact that the largest number of those factors have no time framework attached to them, that they would be operative through large periods of a person's life and would not allow one in an effective way to say what is the suicide risk now.

Q How should that plan be changed then to accommodate the concerns that you have?

A I believe that the staff at Quest did what I think needed to be done for clinical effectiveness. They recognized the risk when it was directly presented to them, they conferenced the situation and they went in and they went in

and directly did what one has to do, which is to talk to the young person that's risk in a caring and supportive way.

Q What about follow-up?

A I think that there -- that's why I would say very good and not excellent. I think that there was some indication that the follow-up that they decided on, and not from matters of making inappropriate or an unqualified assessment, but that there was some indication that they might have kept their ears open a bit more over the next few days.

Q Monitoring?

A Monitoring would have been appropriate. Mr. Quig put that in place in 1991 for 24 hours. This was discussed the next morning by the treatment team at Quest, and I have -- we don't have their notes, but I would imagine that there would have been some discussion that would go along the lines of we did an assessment. We will contact the Department as we need to. Now, what do we need to do? And I believe that there must have been some discussion at that point to say well, what is our plan? And monitoring was not apart of it.

Would monitoring have been appropriate? In the context in which I work, I would only have moved his level of supervision up on a scale of -- let's say if you were basically free in the system as a level of one, and five was being watched 24 hours a day constantly, I might have moved him up one level of supervision at that point.

I felt that the staff knew him and had worked with him

and had had some relationship with him, directly talked with him about this issue, and that is the best we know about how to do a suicide risk estimation at this point.

Q Now, we've sort of moved a little bit from the initial question. In terms of the Sad Children Plan, it has limitations. What changes do you see would be necessary to make that plan a better plan?

A I -- I -- we take a position, "we" meaning the academics that I work with, that there is no check list that will provide the answer that we're all looking for, and so my suggestion would be that whatever check list they choose to use, it be accompanied by much more activity about how to use that check list, which really means how to feel comfortable with yourself asking a young person if they're thinking of killing themselves, and then having within your own boundaries some sense of what you will do to continue to be a support to that young person at that time.

Q During the course of this fatality inquiry, Mr. Hale, representative of the Quest Program, has submitted on a number of occasions different policies or procedures that they have or were considering implementing. Some were just drafts, so they've been submitted as exhibits. Have you had an opportunity to review those?

A No, Your Honour.

Q I would be interested in having an opinion on that, and I suggest that perhaps we should have an adjournment - I will ask some more questions here - but just to allow you to

review them because I would like to have your opinion on whether or not it advances the Quest Training Program or policy and procedures specific to their program, but also in terms of any recommendations for other programs or in that sense. So, I will suggest we have an adjournment.

THE COURT: And Madam Clerk, I don't have a watch. What time do we have?

COURT CLERK: Twenty after twelve.

THE COURT: Twenty after twelve. Well, we are coming very close to the natural adjournment. I will ask a few more questions in other areas in the meantime.

Q You have seen Exhibit Number 76, the -- this is with respect to foster care. With respect to other caregivers within the Department, are you aware of the program -- programs that they have and the programs they undergo in terms of suicide awareness?

A I'm not aware of the programs presently used.

Q I had understood you may have had some involvement in the early stages of the Department's responses to the Tomlinson report and that sort of thing. Am I incorrect on that?

A No, you are correct, that I was involved as an advisor to Dr. Tomlinson, who was one of my colleagues.

Q And that would be at the stage of the writing of the report?

A Yes.

Q Were you involved at all in the Department's responses to the Tomlinson report recommendations in terms of preparing training for caregivers, social workers within the

Department?

A In an in -- if I might just explain for a moment, Dr. Tomlinson made a clear recommendation that the Department should use a program that colleagues of mine and I had been developing at that time. The Department chose not to use that program because they felt that it wasn't extensive enough or involved enough for their staff.

Q And how extensive is your program?

A Our program was a two-day program, and they said that they wanted to have at least three days to deal with the issue of suicide.

Q I believe we have heard evidence it's now a one-week program.

THE COURT: Am I incorrect on that, Mr. Merryweather? Do you recall?

A One day.

MR. FORD: (INDISCERNIBLE).

MR. MERRYWEATHER: I -- to be quite honest I can't recall.

THE COURT: One day?

MR. FORD: Four days.

THE COURT: Four days.

Q But you are not familiar with the program that's in place right now?

A No. My understanding of the program that was presently used a year ago was that it was one day. Though I would -- I would welcome the opportunity to review a four-day program.

Q I am going to ask the next question and perhaps I am going

to suggest we put it over to the afternoon for the answer because it is going to be -- it may be extensive. We have heard today of some future changes that the Department of Social Services is expected to undergo. In fact, it is described as being that the Department may well disappear in two or three years, that the direction is towards regional committees, and we are obviously aware of the emphasis in the Government policy towards contracting out even more and more of the services that are available. I would like to have you consider what recommendations this Court might make concerning this situation of suicide awareness and training in that context. We have had in the past fatality inquiry reports resulting in recommendations, and in addition the Tomlinson report. Department of Social Services, I understand, has conducted its own other reviews and the Tomlinson report being one of them. And those recommendations have been acted on or not acted on in various ways, and I understand tomorrow I will learn of that response. Are there additional concerns that we should be aware of in the context of the future of the Department, and recommendations that I might make directed toward that future as opposed to perhaps what will become a thing of the past if the Department of Social Services is no longer the vehicle by which the Province of Alberta governs its Child Welfare and child care concerns.

THE COURT: So, I suggest at this stage we adjourn to two o'clock, and that would be the question I would like

to perhaps begin with. But also I would ask Madam Clerk if with Mr. Merryweather you could pull the reports or the exhibits that Quest has -- the Quest staff or counsel have presented and provide them to the doctor.

If it is not possible for you to comment on at all, given the time of the adjournment, certainly we can look to adjourning it further.

MR. MERRYWEATHER: Your Honour, I -- my understanding was that the last to go around, Exhibit 69, were some draft standards Mr. Hale put in. I was wondering if you had in mind any other documents that he put in. I know in the beginning that we went through three or four exhibits that they had, would be documentation they had in place at the time of [redacted] suicide.

THE COURT: Yes. There were also some additional drafts, earlier drafts. 69 I think was the most recent one that was presented on the last date, but as I recall it, there were others presented, perhaps in the context of a review, and I'll look through my notes to see if I can zero in on those numbers if they don't come quickly to mind.

MR. MERRYWEATHER: It may have been --

THE COURT: Madam Clerk, do you have a list of all the exhibits?

COURT CLERK: Yes, I do.

THE COURT: That might help in identifying them. Madam Clerk, if you could make a copy available to me, and in the meantime perhaps use that list with Mr. Merryweather

and he could review it. If I identify some, I will get a hold of the clerk's office. So, if you could photocopy them and make them available to me right away and discuss it now. And I will leave you with this.

We will adjourn the inquiry then until two o'clock. Mr. Merryweather, any difficulty with that hour?

MR. MERRYWEATHER: No, that's fine, Your Honour.

THE COURT: Mr. Ford?

MR. FORD: No problem, Sir.

THE COURT: Very well. We will adjourn until two o'clock then. Thank you.

PROCEEDINGS ADJOURNED UNTIL 2:00 P.M.

8th May, 1995

2:00 P.M. SESSION

D. Been, Ms. Court Recorder

COURT CLERK: Continuation of Fatality Inquiry of [redacted]

[redacted]

BRYAN LAWRENCE TANNEY, previously sworn, questioned by the Court:

THE COURT: Dr. Tanney, you acknowledge you are still under oath?

A Yes.

THE COURT: Thank you.

MR. MERRYWEATHER: Your Honour, during the break I referred Dr. Tanney to five exhibits, 13, 21 and 22, which were the materials that were available to Quest at the time of [redacted] death and 67 and 69, which were I think the two most recent exhibits that Mr. Hale entered as being changes or proposed changes to their handbook and their policy.

THE COURT: Thank you.

Q Dr. Tanney, I had left this morning with the suggestion we should deal with what the future might hold and any recommendations, but if you wish, we can deal with those reports first.

A Whichever.

Q You have something in your hand --

A I have something for both, so whichever you prefer.

Q Why don't we deal with the narrower issue first, and then go

on to the broader one. And so the question would be, having -- you have had an opportunity to review the documents that the Quest Ranch people have entered as exhibits?

A Yes, I have.

Q And do you have any comments concerning them?

A Yes, I do. They are -- in the largest part probably represent the standard of care that one would see in most institutions and agencies at the present time that have not had or taken or been mandated to look more closely at this issue, which is to say that at least in terms of standard of care, I believe across Canada, they would be relevant in accord with sort of standard practice. At the same time, they are clearly inadequate, which is a judgment that has been rendered upon the quality of care that's been provided at least in written form by many other agencies in this country. I could address each of them individually, each of the exhibits, very briefly.

Q Go ahead.

A The first one, in fact, I can speak to, it's a -- it's a summary of the program that we had developed and teach.

Q Number 13, is it?

A Number 13.

Q Mmm hmm.

A And it is a summary of the risk assessment framework. The program that we present is designed to be taught as a learning experience for people who are helpers. They come and they participate in a two-day program that immerses them

in issues like this. Now, we have a very clear belief that it is of very little value to take the written materials from this program away from it and to go and hand it out to people, that what you learn is you learn by doing when you are a professional at this level of competence. I don't believe it would have been of terribly much value to them, nor would it perhaps have been widely understood. The people who do present this program, this two-day program to caregivers in the community, undertake a five-day certification program, in order that they feel comfortable presenting the material. So, I would be of much concern if some member of Quest had attended the program and then took these materials and tried to teach it back to the other staff members themselves.

Number 21 I believe is a -- taken -- is a chapter out of a textbook taken out of context written by a colleague of mine who wrote about -- not about suicide, but this chapter was written in the context of a -- of a book on much more serious adult behavioural disorders. It's an excellent chapter. It says, and one sees this repeated in the Quest materials later, if one is going to make a suicide risk assessment, one has to have all of the variables firmly committed to memory and available to recall at a moment's notice. This in a sense validates the idea of having a mnemonic like Sad Children's Plan, but it leaves open which are the variables that one should firmly commit to memory.

This chapter, I believe is at a remarkably sophisticated

level and I think would challenge the reading and intellectual capacities of well trained professionals to be able to follow and understand some of what it was saying. Its content is excellent, but the ability to apprehend it because of the level at which it is written I think would be somewhat difficult.

The third one is the -- I believe is a piece taken from an available manual that's used around Alberta. It outlines at risk children and the procedures that one might undertake to -- to be involved with them, and at the end there's an added appendix.

Q This is Exhibit 22 you are talking about?

A Exhibit 22.

Q And I believe this is a Child Welfare document from a manual of some sort.

A I -- I'm --

Q It has at the bottom CW-508A. At any rate, I'm sorry, you were saying it's --

A It's suggested to make a risk assessment one has to make some estimate of the combination and intensity of some 11 factors, five of which are ongoing chronic factors, two of which are non-specific and three of which are so obvious as -- that if one were wondering if someone were suicidal, they are obvious enough that the person has said they're going to kill themselves, that they're preoccupied with death, and that they have been making the final arrangements for their death.

So, there seems to be a difficulty in discrimination here using this framework between no risk, ongoing risk and -- and risk that would be I hope obvious to even the most tyro lay person. If someone says they're going to kill themselves and is proceeding to give away everything they own, I would hope that would be recognizable as a person who had some seriousness to their suicide risk.

There is another piece to this though that I was pleased to see in that it says after you get some measure of whatever you think the risk is, that it then gives some instruction about what one should do, and it is guidelines. I would suggest it's not a protocol or a policy document. And it suggests two things, that supervision and support are necessary, but then it moves, I believe, quite -- to the next most, and the next and most common thing that one sees in documents of this kind. It simply says obtain mental -- obtain medical, psychiatric, psychological assistance, and there's no other discussion about what should be done with a young person at risk at that time.

The appendix similarly reflects the same thing. The indication is that if you do make an assessment of suicide risk, go and find a professional resource to help you with it. As you may be aware, Your Honour, in Alberta today that's much more easily said than done and I think we saw it unfortunately reflected in Mr. [redacted] circumstance where the initial concern about his self-destructive behaviour was the third of June, and by the time he saw the first non-

psychiatric, non-psychological resource was the 15th of November, by the time he gets to a psychiatrist, and it's already into the next year, some seven months later.

The last two, Exhibits 67 and 69, are provided by -- by Quest, I believe they -- they suffer from the -- the problem that most of these programs do that attempt to put it all in -- in four or five pages. There is no sense of a framework by which a beginner or a relatively unsophisticated person wanting to address what I think they would be anxious about and concerned about, the fact that the person who they were working with was at risk of suicide. There's no sense of giving them a sense of what order to do it in, of how to priorize different factors that they might come upon and have to consider. It just seemed to be a listing of you could do this or you could do this or you could do this, or you could think of something else. It is very much, by the way again, a reflection of someone who has taken a basic program and simply tried to write down the important points on a separate sheet of paper and make them available.

I was concerned in the context of how the discussion was presented here. I appreciate, as I'm sure we all do, from having heard -- you've heard from people at Quest, that in some sense they use what Dr. Kincaid proposed [redacted] needed, a -- in a sense tough love approach to things, certainly not in a sort of classical way that's meant, but a fairly reality based approach. And I was somewhat concerned to see that when they were writing down their suggestions about how

their staff might approach the issue of suicide they used words like "confront the child". They used words like "make him understand". One had a sense that there was not an appreciation that the critical issue in the area of suicide at risk assessment is to listen to the person who is talking and that simply by listening one can give them the feeling that they're no longer alone, which is one of the major reasons why young people kill themselves, is because they feel alone.

Again, in the risk assessment framework presented in Number 67, it's remarkably simplistic and I would suggest inadequate, and in 69 we see a small elaboration of the same framework. They capture the major features, which again they abstracted from a training program that they were involved in, but the abstraction has missed the essence of the training program that was attempted.

69, Exhibit 69, I felt was clearly written after the [redacted] event, and was an attempt to allay some of the concerns that had been raised by the -- is it O'Hara, the -- the -- O'Hara, the terms of reference for the Child Welfare Services inquiry into Quest that was undertaken in the fall of 1993. I felt that this was written directly in response to that.

There are some good pieces to it in terms of asking that after one notices suicide risk one ensures that there's written communication between members of the treatment team. The assessment framework that's suggested, again I would --

I would have to comment is -- is simply inadequate and represents a lack of input or knowledge from the awareness -- from the professionals and from the -- the knowledge base that we have about this issue.

They do make some effort at this point to I believe address the issue of monitoring that we mentioned this morning. There is a sheet made up about how the staff could document the fact that they have been monitoring. It's what I would regard, having seen a number of these documents before, as an unacceptable first draft that would need not only input from both within their agency and their staff, but I would hope input from some professional with experience in the area of suicide risk assessment. Thank you.

Q Before we leave the documentation, I appreciate that your view is that it is not simply something that one can read from a paper prepared or a policy guideline, but also recognizing the reality that we are not likely to have everybody involved in a training program as you have described it where people participate in a two-day session immediately. So, there must be some room for a policy guideline or a manual or some written documentation to assist people who have to be aware of the risk, and then also have to assess. How might that be prepared?

A I believe that at the present time in Calgary and certainly in Alberta, the Government has funded an agency, the Government of Alberta has funded an agency over the last

dozen years called the Suicide Information and Education Centre, and that agency has undertaken to collect all of the written materials about suicide that have been produced in the English language in the last 40 years. They have available to them resources, written and personal, that would be more than able to supplement a document like this that attempted to lay out some basic policies and procedures. I believe that there are at least four or five places in Western Canada that have remarkably well done protocols, policies and guidelines at the level of community agency being able to provide adequate if not exemplary services to children at risk.

Q The title of the organization is Suicide Information and --

A Education Centre.

Q -- Education Centre. And it has been around for --

A 1982.

Q We have heard from a representative of Quest in which with some anguish it was suggested that the lack of resources made available to an organization like themselves in creating documentation, policy and that sort of thing was really recognized by them as not being available. Obviously in your opinion there is something available that people at Quest were not aware of and have not been made aware of by others. From your description of this centre --

A I have --

Q -- there is a great deal that could be provided to them in assisting them in preparing standard policy guidelines and

policies. Social Services people are aware of this centre, I trust?

A Social Services people are aware of it, but I -- I have to share with you it's like many information centres, the motivation and willingness to use it doesn't arise until a tragic event. It's been -- I've been involved with this agency for 12 years and very regularly we received after-the-fact phone calls saying how could we have done it differently? And one of the things that we teach and (INDISCERNIBLE) people with regularly is that -- is that we and this agency are quite prepared to do preparatory and developmental work.

Q Do you see any reason why for instance Social Services would not tell Quest, "You've got an inadequate policy. Go to the Centre. We can't help you, but go to the centre and they will help you prepare your policy"?

A I --

Q There is nothing institutional as far as --

A No, the Suicide Information Education Centre is a public agency funded by the Government of Alberta, whose mandate is specifically known to all Government agencies in the province. I must admit I was remarkably surprised to see in the Child Welfare document about agencies and people that one could call that in fact the Suicide Information Education Centre was not mentioned. But it may in fact reflect a lack of awareness of this resource.

Q Even within Social Services?

A Even within.

Q Is the Centre involved in any kind of, I don't want to use the word "advertising", but promotion of their own facilities and the services that they offer to agencies?

A They -- they have the usual pamphlets and they have made it a policy of the agency to appear at the conferences of most major professional helping organizations around the province over the past decade. I wouldn't assure you that they appear at each year at each one, but they have made several appearances at almost all of the major helping organizations.

Q You have expressed some limitations found in the Exhibit Number 22, which is what appears to be a Child Welfare policy document. Is it apparent from this that it has been prepared without input by the Centre, or there has been input but it hasn't been well received? What is it that is being evidenced there?

A I think -- I think the input has -- has been there. The -- the listing of the 11 factors that -- that are indicated are, I would suggest, available in any one of 10 pamphlets that one could pick up at the present time. My own feeling in looking at it was that this is the sort of material that we distribute by the thousands through the information centre to laymen each year. It was not at the level that I would have expected from people who are being asked to take responsibility for making critical decisions. Similarly, a simple suggestion that one should provide supervision and

support and then obtain medical, psychiatric, psychological assistance seemed to be a bare-bones policy.

Q And you had indicated that there was no advice present there as to what could be done in the -- at the immediate moment of dealing with the child. It was directed towards obtain services, without advice as to what could be done.

A Obtain -- provide supervision and support was the essential direction to the caregiver on site. I would indicate, Your Honour, that there is -- one of the programs that has been developed that's available throughout the province through the information centre is in fact a program, a three-hour program, called Awareness, that spends one of its pieces documenting a list of 11 things that one can specifically do on site at the moment to be of support to the young person who is at risk. That would be one example that they might turn to.

Q You are not familiar with the program that Social Services has in place to expose social workers who are looking for accreditation to the issue of suicide? You haven't reviewed that program?

A I didn't think I was aware of it until we broke for lunch and I made an inquiry of a colleague of mine about the three-day program that we heard about, and in fact, it's my understanding now that this three-day program is in large part the one that was generated in response to Dr. Tomlinson's report. I couldn't report as to how much it's been modified or changed or updated over the following

decade. I could also indicate that as far as I have been able to establish in the very brief amount of time, that some of the materials used in that program are being used out of context.

Q You have raised the issue of updating material as new information and advice might come up. What would you recommend for keeping up with that sort of thing? Is the Centre the sort of central repository for that information?

A The Centre has a -- the Centre is a branch that -- that simply collects the information and will make it available to anyone who wants to come and use it to draw conclusions from it. The Centre has an adjunctive group of people who actually design and develop and implement public and professional training programs in the area of suicide. So, at the present time I think they have five different programs that they would make available and each of these programs is -- has an advisory body of interested volunteer professionals usually, who go to great lengths to keep the programs very much up to date with the material that they can get from the Information Centre.

Q They are involved in the designing of programs. Presumably they would be also in a position to assess programs that are being organized and designed by others to determine whether or not they are adequate to the task?

A Yes, their advisory professional body undertakes that on a regular basis. I can indicate that they've done it for the Province of Saskatchewan in the last six months.

Q Do you know whether or not they have been involved in any kind of a review of the Alberta program?

A I could -- the Government of Alberta Child Welfare Services chose not to use the programs that were being developed by the Suicide Information and Education Centre in 1980 -- after the Tomlinson report, and instead indicated that they would develop their own programs.

Q And there is no cross-referencing or review by the different agencies of the programs to develop their own, and didn't look to the centre for any assistance?

A Some of the -- some of the materials that are being used in the Child Welfare program, the three-day program at the present time, I understand are materials taken out of context from the programs developed at the Suicide Information and Education Centre. Having not seen the program, I couldn't affirm that, but it's -- it's what I've been able to establish in some brief conversations.

Q Is the Centre -- now moving on to the other problem or question I had put to you before we broke, and moving from this issue, is the Centre up to what might be the demands made of it by a variety of agencies, as opposed to being available for one major agency like the Department of Social Assistance for whatever assistance they might be able to offer, although they haven't, they chose not to use it, but is the Centre in a position to accommodate the needs of a variety of agencies that are contracted with the Government and do not have a body that reviews their programs and --

A The Centre is a -- the Centre essentially functions as a library that provides the materials for others to review. It does have available on a contract basis resources who would be willing to evaluate specific programs, but it cannot undertake that as a public function at the present time.

Q So, the need to have some review and some material available for all of these various agencies, small or large, becomes greater under the context of what might be the future (INDISCERNIBLE) department?

A Very much so. Very much so.

Q If there is no Department of Social Services, and I don't want to -- I think I am maybe exaggerating what I have heard, but assuming that there isn't the same sort of body involved but there are multiple bodies involved, how could that best be achieved that there be some quality control in this area, that there be some policy in place and materials made available?

A Well, one of the suggestions that has been made is that the -- the Government might not continue to provide the services directly, but it could be in large part responsible for ensuring that clinical and legal standards are an expectation of agencies that they -- that they undertake contracts with, and that those clinical and legal standards would be translated directly into the policies and procedures of the contract agencies, such that rather than simply saying here is the terms of reference of your

contract, that it would be accompanied by a very clear list of "and here are the written standards that you will be expected to meet," sometimes in fact reaching the -- the level that the standards would be standardized as an expectation across the province. One of the concerns always in sort of setting a set of objectives as an over-arching Government agency or contract agencies is that that is all they become is objectives, that one then is -- has to undertake the process of doing program evaluations to see if individual programs have met those objectives. And the suggestion has rather been made that there are frameworks that the Government could set forward at this time to any agency that wished to come forward and undertake the contract to replace services presently provided by Government agencies, and that that could be very well laid out with up to a dozen different categories in which there would be clear performance standards set forth. This framework is available and in fact is presently being discussed by Child Welfare Services.

I would appreciate the opportunity to address a specific issues. That is a process question, but there are some specific issues vis-a-vis suicide that I believe needs significantly to be addressed in any devolution of Government agency services.

Q Perhaps now is the time to go into that then.

A We saw in the case of Mr. [redacted] that the issue of continuity of care was important, that he was moved and

moved and moved and there was some concern, I believe, at some point that moving created problems. I think it was -- I think that the -- the trail of documentation on Mr. [redacted] in the volumes of the case file is extremely well done, but at the same time it was -- it's because it was one agency that was involved. I would have major concerns about the ability of competing contract agencies to share information cross agencies in cross placements in the same manner.

I also would be concerned that many contract agencies will provide a single model of care and provide only one facet of the services that are required by children in need of care and protection. The issue then comes up in terms of continuity of care not of continuity, but of coordination, and if these are competing contract agencies, it's sometimes hard to envision clear coordination between them. Perhaps the most straightforward example would be to use the Quest situation. When -- when Quest -- if Quest discovered that a young person was at risk of suicide, and that was not within their -- and the level of care required was beyond their -- the level that they had undertaken to provide or in fact felt they could provide, it would be remarkably important that they could access almost immediately a more intensive level of care, and that would require very clear coordination between different contract agencies. A coordination that I -- I must share with you in my experience in California is they move into the same area has

been fraught with immense difficulties. So, we have some people who have been doing this already. Saskatchewan has experienced, I would share as well, some of the same difficulties about continuity and coordination. Why I feel comfortable using these words, because they are becoming well known in the literature of people looking at this situation at this time.

It's important that if a -- if the Government devolves their system of care to contract agencies, will the -- will a young person in a given community be given a choice between different models of care, or will it be simply because you will live in Community 'A', this is our contract agency, if you live in Community 'B' you might get a different contract agency with a remarkably different philosophy, care and treatment. Issues of philosophy, care and treatment I think are quite important, as I have attempted to dwell on this morning with respect to Mr. [redacted] outcome.

There is a remarkable concern expressed in other jurisdictions about the devolution being largely cost driven. One of the results has been moving to the lowest -- moving to inexpensive caregivers and sacrificing professional expertise along the way. It makes it very difficult to imagine that a capitated, for example, contract agency would be able to seek external consultation effectively, and it's unlikely that as a single contract agency that they would be able to provide the full spectrum of resources that, for

example, Child Welfare now has available to it. I reflected this morning that I was -- I was really quite impressed by the domain of services that [redacted] had been provided during the course of his life.

With respect to training, this again comes back to I believe something that a provincial standards agency could mandate, that in the area of suicide it would be expected that there would be -- that people working within -- with young persons at risk would have clear and enunciated training programs mandated that they would have to attend, and that the agencies in which they worked would have written, and perhaps standardized according to a provincial framework, standards and -- and guidelines. I hesitate to -- to go so far as to suggest that protocols would be appropriate, because protocols are -- need to be changed on a regular basis and protocols only work effectively if one has ongoing evaluation and feedback about how well a protocol is working. A guideline being less rigorous is -- has the opportunity for some more flexibility in interpretation.

A colleague of mine in our discussions about our consultation in California had shared with me a large concern that he had about contract agencies, that many of these contract agencies were hiring professionals and then asking the professionals in the course of their work with the contract agency to undertake activities which were contrary to the professional standards and guidelines and

codes of the professional organizations. We have suggested in other places that it would be appropriate for a contract agency to make an undertaking to the contractor, the Government, that any professionals who they hired would be expected to meet the professional standards of -- and codes of ethics of their own organizations.

It -- it brings up an issue that in fact was specific to Quest, that was an agency that had largely non-mental health or recognized caregiving professionals working with it. There's a very real concern in some jurisdictions that professionals will not work with agencies -- with agencies that have a staff that has no professional component or no professional organized consultation available to it. I believe that this is not simply a -- an old boys club. I believe it's a very real concern that a non-professional group of caregivers have no standards or guidelines or expectations of performance of them, and that a professional who works with them places himself significantly at risk in offering consultation to that -- to that group, because there is no assuredness that his ideas and suggestions and consultation will be able to be assessed appropriately. And as I indicate there are some -- in some jurisdictions professionals are refusing now to work with contract agencies that have hired non-professionals and who have no professional support network available to those non-professional caregivers.

There are some very specific things about working with

suicidal children that I think are appropriate. One of them -- I appreciate this moves out of the issue of policies but into other areas, and I think the Department presently offers it. And some of the things -- not some. I believe most of the policies of the Department are developed from experience and are very well taken policies. I would like to see them as the framework for policies and procedures that contract agencies were to use.

For example, the idea that the -- that the Child Welfare offers an opportunity for foster parents to have time out (INDISCERNIBLE) is a remarkable social advantage that we offer in this province. I'm very concerned that a contract agency simply would not be able to afford that, and that we would see children being regarded as failed placements simply because they had burned out the placement resources that were available to them. Thank you.

Q Another issue again raised in the context of need for reviewing policies, is this something that is ongoing? Is it a yearly affair? Is it -- I mean, is this an area that requires adjustment -- a quick adjustment, in other words a recommendation that there be policies and procedures prepared in certain ways and would require some evaluation process?

A Mmm hmm.

Q Now, what kind of time frame do you see that as in specifically this area?

A Because I work in a care environment now, I believe that the

decision to work on two and four-year accreditations has developed at least in the hospital environment over almost a century of looking at hospital standards and practices, and it's my belief in this area that -- that a period of initial accreditation is appropriate, but after that, at least in terms of large agencies, one regularly sees three to six-year terms of accreditation without a need to -- at least on a must-do, you must review them on this basis. I would share with you that many of the agencies I have had occasion to work with who provide public care services try to go over most of their policies and procedures at least every two years.

In the area of suicide, at least in terms of risk assessment, I think that that would be a luxury and perhaps not a need.

Q I raise that in that I note that Exhibit 22 is dated 1989, I assume. I'm not sure if that works on the January the 9th or the 1st of September, '89, but that would be approximately four years, and your recommendation is policy and procedure in a larger agency such as the Department of Social Services should be more frequent than that.

A I would. Perhaps the issue here about policies and procedures is -- is one I'm -- I'm sure you appreciate from your work here and all of my colleagues do, as well. We're working with human beings, where it is remarkably difficult to write down every last possibility, and that one can only do the best you can and keep up as well as you can, but I

believe that to demand a policy manual that covered every contingency for every young person at risk, we would spend all of our time writing and updating the policy manuals. I think there is a sense of reality that has to be entered into here with a small contract agency.

Perhaps the other thing that -- I'm sorry, I passed it by when I stopped, but it struck me that it was worth mentioning. At the top of the Quest draft policy, I think it's -- I think it's 69, there they have done what I think many, many agencies in the United States have done, and I am concerned that we will see agencies doing here, in that if the Government devolves it social services functions on a contract basis, that you will find many agencies simply refusing to take on the care of young people at risk, because they are immensely time consuming, immensely resource consuming and that it's easier just to say we will not take suicidal persons. One sees this already and has over the past decade, as in evolving care form, and one sees it in fact proposed here by Quest. I have a great concern that we'll see a stratified of the good children and -- and the difficult ones will be left perhaps with a Government agency that has been stripped of its mandate and effectiveness and resources, simply because no contract agency would be willing to take them on.

Q The rationale given concerning the Quest's concern about suicide and not wishing to take on a suicidal client is that being in a ranch setting relatively isolated, there are many

opportunities for causing harm to oneself, and therefore that was their reason for not taking it on. It seems to me if one is intent on causing harm to oneself, one doesn't have to be in an isolated area. It can be done in the middle of any city or in the middle of a crowd for that matter. Do you have anything to say about the Quest's view of their exposure to suicide problems and their ability to cope?

A If that's the argument that they've used, I'm quite unimpressed by it. I think that when they -- when they -- when their documentation, as I indicated, uses words like "make the child do this, confront the child," and we hear about them -- I had an instance in my -- in my own notes documented when the -- two of the incident reports that Quest filed where I think the staff member very realistically said, "I lost it with this young man today." I thought that this was something that one would never see a professional agency document, but I thought to myself as I read it, this is a reflection of people who are very much caring about young people and who are being very real in the approach that they're taking with them. Perhaps that appreciation of reality goes a little bit too far sometimes, and if they see that because they have perhaps firearms available to them, that that's a major issue in rural Alberta today. That's the only issue that I would see as being a direct connection. I agree with you entirely that there are a myriad of ways to ends one's life and that it --

it can be done anywhere.

My concern was rather that, when I saw it at the top of the draft policy document that it reflected a policy statement that one sees increasingly among private contract agencies today, because of the time and the consumption of resources that these young people take.

Q Just a moment while I review my notes to see if there is something else I wish to raise with you. Mr. Ford had asked you whether or not in your opinion much of the damage had been done to [redacted] prior to Social Services becoming involved and you have spoken about your concern in that regard and expressed the opinion that an earlier intervention might have been of some assistance. Assuming, however, Social Services has not intervened earlier for whatever reasons, as a three-year-old what -- and those early years between three and I gather four or five or six, the time when school might be a crucial time for the child, what might have been done with respect to [redacted] at that time while he was within Social Services' care?

A I -- I felt at that time between the ages of three and six that Social Services removed him from the home, appropriately sought the responsibility for him legally fairly quickly and so were able to sort of stop this young man from being bounced back and forth, that they had him in I think -- that he moved to one brief placement and then moved to almost a year in a group home environment, which I think is -- is quite stable, and from there moved in fact to

a two-year placement at the Deboss (PHONETIC) household. I think that in terms of what -- of wishing to assure continuity for a young person, that was pretty good, a group home placement followed by an opportunity to look at this young man and look at who would be willing to work with him and moving him into the Deboss household where there was a view to adopt consideration being undertaken.

Q Is it at that early stage that the need to have -- would his needs at that time be identified to Social Services, that ultimately that need being translated into the requirement of continuity and treatment and therapy?

A I think -- I think it's fair to say that in 1980 -- I have to turn to my notes here, but it was the Child -- Larry Brooks at the Child Development Centre and then a person by the name of Lavelle in October of '84 and Dr. Kincaid and her first involvement in September of '84. All were very clear in indicating that this was a disturbed young man who needed special resources. Ms. Lavelle was the one who suggested that in fact maybe a placement at a -- at a child treatment services facility would be more needed at that time. So, there was -- there was an awareness, not just the awareness of Ms. Brook at the Child Development Centre that some play therapy was needed because his development was delayed, but a recognition by two therapeutic resources who assessed him on behalf of the Department, that here was a young boy who was disturbed and that maybe a formal treatment placement and not just a foster home placement would

have been appropriate at that time.

Q The failure to have done -- gone that route was a philosophical one?

A I think the -- that was a tough one because five years later they looked at the same situation again at a -- at a child treatment services placement and refused it at that time when it was offered by the placement committee, and then it was even --

Q Who refused it?

A It was -- my understanding was that it went before the placement committee with a recommendation of him being placed in a treatment facility. The placement committee didn't go along with the recommendation for a treatment facility, but offered a 45-day assessment in a -- in a young adult centre, which would have moved him out of the Child Welfare stream into the treatment stream, and that was refused at that time. There was no indication, by the way, of why it was refused, but there was another adoption -- not adoption, but there was another foster placement undertaken soon after that. So, I couldn't suggest that there might not have been good reasons to have refused the placement.

Q So, treatment was recommended to the placement committee. The committee accepted that treatment was perhaps something to be looked at, recommended an assessment and neither one of those recommendations were followed up on, and from your review of the file, is there an indication at what level or how that decision was made?

A I -- no, the placement committee offered the referral and I believe the case manager felt it wasn't appropriate and instead went for another foster placement at that time. I believe that was late '89, but I could consult my notes.

Q If you would, please.

A Excuse me, I didn't bring all of them back here. Excuse me.

(WITNESS LEAVES STAND AND RETURNS)

A I believe it would have been September '89. No, September of '90.

Q Thank you.

A But the initial one was in fact in 1984, in September and October of 1984 that -- that the initial recommendation about a special needs placement might have been appropriate.

THE COURT: Thank you, Dr. Tanney.

Mr. Merryweather?

MR. MERRYWEATHER: Nothing arising, Your Honour.

THE COURT: Mr. Ford?

MR. FORD: Just a couple, Doctor.

MR. FORD RE-EXAMINES THE WITNESS:

Q Doctor, do you have Exhibits 62 and 63 there? I'm not sure that you do or not. Could I ask you to look at those two and compare them with Exhibit 22, which you have already referred to?

A Yes. 63 and 22 look very similar.

Q Having looked at those two exhibits, 62 and 63, and compared them with 22, it looks to me like they are essentially the same policy updated in slight form and split into two

sections. Does that seem like a fair characterization?

A Yes.

Q Okay.

A And both of them suffer from the same lack of appreciation---

Q Okay.

A -- of the issue of suicide risk assessment.

MR. FORD: Your Honour, I just wanted to bring that to your intention because I thought the impression might have been left that this 1989 draft had never been re-incorporated, if you will, into various successor manuals.

THE COURT: Yes, thank you.

Q MR. FORD: Doctor, has there been a decline in the availability of psychiatric resources for children in the last few years?

A It's my understanding that within the Province of Alberta on a capitated basis there has been a decline in resources.

Q Okay. Is that worse in shall we say rural areas, or isolated areas?

A I think it's accepted that it's much worse in Southern Alberta than in Northern Alberta.

Q When you say "Northern", are you referring to like the Edmonton region?

A Edmonton and north, Edmonton region and north.

Q Okay. And it is worse in the southern part of the province?

A Right.

Q Okay.

A Yes.
Q Why is that, any idea?
A Because the Federal Government is responsible for funding Native Children Services and they have been willing to provide extensive funding for Native Children Services, some of which have been able to provide a general infrastructure for children support services.
Q Okay.
A And in Southern Alberta that hasn't been available.
Q Okay. Just generally in the area of training, something you said in questioning by His Honour led me to wonder, the University of Calgary has a Faculty of Social Work, correct?
A Yes.
Q Do you lecture in that faculty at all or have any familiarity with its course -- its program structure?
A Yes, I do. I don't lecture, but I have a lot of familiarity with their course program structure with respect to issues about suicide.
Q Okay. Do they adopt a social behaviour model and instruction of their students in that faculty?
A Yes, I think that would fairly be said, although my colleagues would contend with me. Over the last 20 years I think there would be a general agreement that they have not moved to what has been called the, quote, "individual case work approach," which is the alternative approach to social work teaching.
Q Is that type of -- I don't want to call it a bias, but is

that form of instruction fairly common throughout faculties of social work, schools of social work in other colleges and universities in the country?

A Very much so, that over the last three decades social work has turned away from the individual case work approach and I believe adopted a social behavioural approach with very strong theoretical underpinnings.

Q Mmm hmm.

A And in some sense has assumed that if they had need for an individual case work approach, that they would be able to turn to other mental health professionals like psychologists and psychiatrists for support.

Q Okay. So, the same kind of philosophy exists in the system of education for most workers. Is that a fair statement?

A In the area of social work and as a general trend in terms of the provision of mental health services I would agree --

Q Okay.

A -- that there has been a sense that social work would have the responsibility for the environment around and other mental health disciplines would focus more on the what I call within the person context. This is certainly not to suggest, as you are aware, that individual therapists and caregivers of whatever discipline can adopt their own helping style.

Q Okay. Now, to come back to the issue of training and suicide awareness, suicide prevention and schools of social work, you indicate you are very familiar with those aspects

as far as it relates to the University of Calgary Faculty of Social Work. Is that right?

A Mmm hmm.

Q What kind of training do they provide?

A Well, I -- a colleague and I co-teach a graduate level course offered every two years on suicidal behaviours. It's offered cross-disciplines to manage just this problem of not having an isolated approach, that all of the attendees from five different faculties work with one another on different projects.

Q What faculties would be included?

A Psychology, educational psychology, medicine, nursing and social work at the last giving of the program.

Q Now, that's a graduate course?

A Yeah, that is a graduate -- at the undergraduate level, it's my understanding that all of the students at the University of Calgary undertake a basic suicide preparedness course, that initially in fact they did on a volunteer basis, and that later the Faculty agreed to incorporate as a course cred. on their behalf.

Q So, it's a full-term course then?

A No, it's a -- it's a course very much along the lines of what we hear Child Welfare Child Protection offers. It's a two-day what we call suicide first-aid. It certainly -- I do not believe it in any way qualifies caregivers to do anything beyond providing first-aid.

Q Okay.

A It doesn't empower them as therapists at all.
Q Okay. So, more equipped with a basic risk assessment --
A Yes.
Q -- ability. Is that a way to say it?
A Yes. And the risk assessment tool that in fact is taught is -- is subsumed in Exhibit Number 13.
Q Okay.
A That's essentially the program that all social work graduates in Alberta I believe at the community college and the University of Calgary level are now exposed to.
Q Okay. When you say community college, then you'd be including Mount Royal College, that sort of thing?
A Mount Royal, yes.
Q Mount Royal has a social work diploma program, I believe.
A Yes.
Q Are there other community colleges that have similar programs in the province?
A I'm sorry, I couldn't reflect on that. I know that Mount Royal does because I have done some teaching with them around the issues of suicide.
MR. FORD: Okay. Thanks, Doctor. That's all that came up.
THE COURT: Mr. Merryweather?
MR. MERRYWEATHER: Nothing arising, Your Honour.
THE COURT: I have one issue that has been raised.
THE COURT QUESTIONS THE WITNESS:
Q In the context of the services available, one reads now of

professionals leaving Alberta for a variety of reasons, some stated dealing with the political approach to medical services available in Alberta. Are you aware of any movement of professionals from the province in this area that -- well, I will leave it at that.

A At the present time it is my belief that this area is so under-serviced that we have -- we have so few people doing it at a professional medical level, that they are afraid to leave, because they have a commitment to the persons who they're caring for and recognize that in some instances the entire care system that their underpinning would collapse if they were no longer available. I can -- I guess I can say that with some assuredness from a conversation I had this weekend with several colleagues, who simply said they would be gone except for the fact that they have a commitment to caring for the people and the systems and -- and their professional colleagues.

I think it's important to recognize that, just to reflect on this issue of the dire need for services, I had occasion personally to see a young woman last Thursday in my role as an emergency psychiatrist, and a woman who -- of 15 who -- who is not in care, who had undertaken three suicidal behaviours in the past year, who had had some therapeutic involvement with the Child Welfare Child Protection System, and essentially is a, if I might use the word, a highly -- a person highly amenable to therapy and to working through these issues remarkably quickly and was quite prepared to do

it, and the first person I have been able to get to see her is somewhere between six weeks and three months.

If that reflects the -- the ability of our system to respond to the Quests and the Parklands, I think it's an accurate reflection of where our system is at the present time.

THE COURT: Thank you. Anything further you would like to add?

MR. FORD: No.

A Thank you very much.

MR. MERRYWEATHER: Thanks, Your Honour.

THE COURT: Thank you. You may stand down.

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PROCEEDINGS ADJOURNED UNTIL 9:30 A.M., 9TH MAY, 1995

Certificate of Transcript

I, the undersigned, certify that the foregoing pages are a true and faithful transcript of the contents of the record of Provincial Court held at Calgary, Alberta, taken from Tape Nos. I724 and I734.

Date: May 18, 1995

Carolyn Farnum
Transcriber

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