CANADA
Province of Alberta

Report to the Minister of Justice and Attorney General
Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Court House

in the Town (City, Town or Village) of Stony Plain (Name of City, Town, Village), in the Province of Alberta,

on the 8th day of May, 2007 year, (and by adjournment

on the 9th to 11th days of May, 2007 year),

before Hugh W.A. Fuller, a Provincial Court Judge,

into the death of L.S. (Name in Full) 17 (Age)

of Spruce Grove, Alberta (Residence) and the following findings were made:

Date and Time of Death: September 28, 2005 at 11:59 P.M.

Place: Highway 16A

Medical Cause of Death:
("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – The Fatality Inquiries Act, Section 1(d)).

Blunt force injuries (struck by motor vehicle)

Manner of Death:
("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – The Fatality Inquiries Act, Section 1(h)).

Undeterminable

Circumstances under which Death occurred:

Chronology of Significant Events

Ages Birth to 1 Year (1987 / 1988)

L.S. was born on November 17, 1987 at Edmonton, Alberta. His mother was high on solvents throughout the pregnancy and when he was born this resulted in an organic brain disorder which became a relevant factor in his demise. As a direct result of his mother's solvent addiction and his father's alcohol addiction, Alberta Children's Services received numerous calls from the community expressing concerns as to the quality of the care the infant would be receiving. L.S. remained in the family home until January 28, 1988 when he was apprehended and placed with extended family and on April 18, 1988 he was placed in a foster home.

Ages 1 to 2 Years (1988)

Children's Services efforts to engage the parents in a rehabilitation program were unsuccessful and on October 21, 1988 a Temporary Guardianship Order was granted and L.S. resided at several different foster homes. The chronology of significant events (Case Review) notes that L.S. was hyperactive, was throwing temper tantrums and did not respond to affection or direction.

Ages 2 to 3 Years (1990)

Dr. B. Haave, a psychologist, completed a psychological assessment and the results indicated that he required a specialized foster home as well as specialized programming to enable him to realize his potential. This assessment, made when L.S. was only two to three years old, provided a template for what would be required throughout his lifetime.

The basic requirements were an enriched environment which would provide:

1. special attention to his communication difficulties;
2. consistency and structure;
3. stability and love; and
4. security.

As a result of this assessment and other relevant considerations a Permanent Guardianship Order was granted on November 23, 1990.

L.S. was to remain in the care of Children's Services for the remainder of his life and no useful purpose can be served by reviewing in detail the efforts of the Director throughout this time period. There are however some matters which should be commented upon which will provide an overview of the issues faced by both L.S. and the Director. The Inquiry has received full disclosure and cooperation from the Director and a very detailed history of all actions taken by them relative to L.S. All relevant witnesses from Children's Services as well as the medical professionals and other agencies which provided services also gave evidence and produced all relevant documentation. I found all of these witnesses to be candid, credible and compassionate.

Essentially every trial and tribulation faced by L.S. while in the care of the Director was documented in detail and presented at the hearing. The efforts of the Director and the various workers involved throughout the file are to be commended. The Inquiry would like to particularly recognize the efforts and the compassion of Ellen Schaefer who had been L.S.'s caseworker since 1994 when he was only seven years old. During this 11-year period she was more than a

caseworker to L.S. as she assumed the role of a surrogate mother. Her compassion for L.S. which was always tempered with professionalism deserves both recognition and commendation.

Placement History

January 28, 1988 to April 18, 1988 - Extended Family
April 18, 1988 to June 30, 1995 - Foster Care
June 30, 1995 to October 28, 1995 - Residential Treatment (Catholic Social Services Group Home)
October 28, 1995 to January 4, 1996 - Residential Treatment (Children's Treatment Program)
January 4, 1996 to August 1, 1997 - Foster Care
August 1, 1997 to June 12, 2000 - Residential Treatment (Bosco Homes)
June 12, 2000 to Present - Residential Treatment (McMan Group Home)

L.S.'s psychological issues, initially diagnosed by Dr. Haave, were to remain a dominant factor throughout his lifetime and would ultimately contribute to his demise. His issues were significant and the Director monitored them diligently and acted upon professional advice in every instance. His issues and concerns changed as he progressed from childhood towards adulthood and I will address this in greater detail as relates to the last few months of his life. However it is appropriate to review some of the professional advice / assessment obtained while L.S. was in the care of the Director as well as some significant occurrences. The following is a very brief overview of the chronology of significant events presented at the hearing.

Ages 2 – 3 (1990)
Dr. B. Haave, Psychologist: completed assessment.

Ages 3 – 4 (1991)
Speech Pathologist Assessment: severe articulation diagnosed.

Ages 4 – 5 (1992)
Attended specialized program at Camilla School; moved to new foster home because of abuse which was confirmed and prior foster home was closed.

Ages 5 – 6
Assessed by Dr. K. O'Malley (Glenrose) who found (1) Organic Brain Disorder related to prenatal exposure to solvent abuse; (2) Attention Deficit Hyperactivity Disorder (ADHD). Medications were prescribed.

Ages 6 – 7 (1994)
Dr. O'Malley consulted as L.S.'s behaviour was deteriorating. Confirmed diagnosis of L.S.'s abnormal neurological condition and that there would be progressive degeneration of the brain; some hint of alleged sexual abuse which was addressed and resolved within the foster home.

Ages 7 – 8 (1995)
Behavioural issues and resulting psychological assessments; Residential Treatment setting required (Catholic Social Services); new school setting / therapy / monitored medication.

Ages 8 – 9 (1996)
Relocated to Treatment Foster Home.

Ages 9 – 10 (1997)
Ongoing behavioural issues. Dr. Haave reassessed L.S. and results were consistent with initial assessment; relocated to Bosco Homes; assessed by Dr. D. Massey who determined (amongst other things):

1. ADHD and brain dysfunction / but of average intelligence;
2. lacked internal impulse control;
3. any substance abuse would damage his brain a lot more, very quickly; and
4. severe behaviour disorder.

Ages 10 – 11 (1998)
Dr. M. Blackman; medication for depression; speech therapy; volunteer family and supervision.

Ages 11 – 12 (1999)
Trial of former foster child re alleged sexual abuse of L.S. (ages 4 – 5) not proceeded with as L.S. in no condition to testify. Charges were dropped. Mother passes away. Individual Service Plan home proposal was approved by the Edmonton Placement Committee. The facility was a Group Home located at Spruce Grove and was provided by McMan Youth, Family & Community Services Association (hereinafter "McMan").

Ages 12 – 13 (2000)
The creation of the individualized service plan group home which was established for aboriginal youth allowed staff to interact with the residents. This proved to be a very successful program which created a home environment and an opportunity to achieve independence and allowed L.S. to organize and chair his own case conferences. L.S.'s attitude and behaviour showed marked improvement when he relocated there on June 12, 2000.

Following his relocation L.S. learned of his eligibility for a trust fund from the Band at age 18. These funds were to become a focal point for L.S.'s anxiety as he progressed through the transitional period towards adulthood.

Ages 13 - 14 (2001)
L.S. is doing well in school and in numerous community activities. He is cheerful and confident as he is now able to voice and address his personal needs. He is interested in meeting his father and siblings and other relatives from the Band and attend a Round Dance. Dr. M. Parsons would now be L.S.'s psychiatrist.

Ages 14 – 15 (2002)
L.S. talked of frustration; no place to go and there were times he wanted to kill himself. He struggled with issues; Warren Phillip Ganshorn, staff member, had a good working relationship with L.S., providing both counseling and friendship. He was also the worker who provided transportation on the evening of his demise. Dr. Parsons consulted and reviewed medication. L.S. felt suicidal on 8-10 occasions during the year; this occurred when he was having issues with school, peers or his family. The staff had a protocol to follow with suicidal residents which was strictly adhered to. Face-to-face visits with the caseworker were maintained and L.S. was at this point an extremely well mannered young man – he was a joy to be around and a deep feeling young man.

At this point in L.S.'s life the Court believes that there were two developments which became factors in L.S.'s demise:

1. He learned that the current value of the trust fund was $130,000; and
2. He declined further visits with his brother because he was drinking or using marijuana.

Notwithstanding the efforts of his caseworker Ellen Schaefer, L.S., because of his mental challenges, desperately required the love and companionship which could only be provided by his family. He understood the importance of avoiding the use or abuse of alcohol or drugs as he had been a victim since birth. There was also great concern for handling the funds he would

receive at age 18 and he later suffered dreams about his father hunting him down.

The choice L.S. had to make was either:

1. Remain at the Group Home with his surrogate family and hopefully reach a level of maturity which would allow him to function in society without a meaningful relationship with his family; or

2. Disregard his awareness and abhorrence of alcohol and drugs which he knew had damaged his life and was now proceeding to destroy his father and siblings.

It was a classic conflict of standing firm or adopting the old adage “if you can’t beat them, you may as well join them”.

Despite L.S.’s awareness of the consequences, the efforts of his caseworker and several staff members and the professional assessments and counselling he received, L.S. began to follow the path of least resistance. This decision was not readily apparent and L.S. struggled with his options and from this period of time until his demise his internal conflict steadily increased.

Ages 15 – 16 (2003)
L.S. suffered blackouts and migraine headaches. Dr. Parsons was consulted and medications changed; a comfortable relationship existed as he had been a patient since age seven. L.S. graduated from junior high; received lots of presents; former teachers and staff wished him well. There were some behavioural issues. He denied using a “bong” to smoke marijuana but staff suspected his denial. He had shown considerable growth, maturity and stability. He expressed disappointment in his brother and father due to substance abuse and lack of contact.

Ages 16 – 17 (2004)
L.S. began to test the limits and push inappropriately for independence. He was buying drugs and using same but his school reports were positive and showed class contributions and outstanding leadership qualities. He suffered an anxiety attack; had concerns with father and anticipated receipt of Band trust funds. His behaviour began deteriorating; he had delusions and hallucinations. Dr. Parsons prescribed medication (Seroquel) used to treat schizophrenia. L.S. expressed suicidal feelings, got intoxicated and staff referred him to the adolescent drug program at AADAC. He avoided confrontations with staff re use of drugs and behaviour. His caseworker was vigilant and concerned. He made efforts to maintain cultural connections and possible elders to work with L.S. and researched family connections. L.S. met his father and his emotions fluctuated from hate to anger to gladness. His internal conflict continued as he had also recently met an older sister.

Ages 17 – 18 (2005)
L.S. started the year by awoling and getting drunk. He was nervous about independence. His caseworker diligently pursued all issues and reviewed individual service plan. A social functioning assessment was completed along with appropriate applications and contact with Indian and Northern Affairs.

The Inquiry was satisfied all efforts were made to identify and address any concerns L.S. would have in achieving independence but his drug use continued to increase.

Dr. Parsons prescribed Welbutrin as he saw the depression worsening and L.S. isolating himself. The relationship and communication with Ellen Schaefer remained strong but L.S.’s attitude continued to deteriorate as shown in the comment made in his transition plan, “I say f--- the future and my life”. The transition plan which was prepared by Ms. Schaefer in consultation with L.S.,

was with the exception of a crude comment he made on a "bad day", was well received and very achievable. L.S. was fully aware that his caseworker intended to remain in an active, informal role once he became independent. Extended family was not considered as a support because of the extensive violence and substance abuse.

In the period immediately preceding L.S.'s demise on September 27th, 2005 the court heard evidence and viewed documentation which confirmed L.S.'s behaviour was causing concerns.

In the months preceding his demise L.S. had numerous critical incidents of running away, drug and alcohol abuse and missed medications. It was a concern for his caseworker and the staff at the group home which carefully monitored each and every development. Incident reports were prepared in accordance with the required protocol and staff also completed the group care daily progress report. He had seen his psychiatrist, Dr. Parsons, in March and the latter had prescribed an anti-depressant Welbutrin, which medication was monitored by the staff. His appointment with Dr. Parsons in June was routine and there was no change in medication or counseling contemplated. All medication is monitored on a daily basis in a medication record chart.

The Group Home Service Review Summary was completed August 12, 2005. The meeting was held to discuss L.S.'s progress at the group home and to review his quarterly service plan. L.S. took an active and positive approach at the meeting which was also attended by:

i. Ellen Schaefer – Caseworker, Alberta Children's Services
ii. Marnie McMullen - Program Manager, McMan Group Homes
iii. Corey Entrop - Program Supervisor, McMan – Group Home, Spruce Grove
iv. Anik Bellavance - Youth worker, McMan – Group Home – Spruce Grove

The meeting focused on a variety of matters and the only matter that caused L.S. some concern was that he was scared to leave the group home and become independent. It was decided that L.S. would not focus on independence at this time and the expectations of L.S. would stay as they were before beginning to work towards independence. This appeared to appease any of L.S.'s concerns and the issue was to be revisited in October of 2005.

September 5, 2005
- incident report: suspicion of drug/alcohol abuse (was grounded for the rest of the day)

September 8, 2005
- incident report: drug/alcohol abuse. Will continue to monitor L.S., encourage to make good choices and was grounded for the evening. Returning to AADAC discussed but he refused that option.

Although L.S.'s behaviour in the few days preceding his demise was relatively unremarkable an emergency meeting was being contemplated to make certain L.S.'s behaviour would be monitored and steps taken to ensure compliance. There was nothing to suggest that any action / intervention was required at this point in time.

On September 28, 2005 Ellen Schaefer drove L.S. so he could attend the round dance. At L.S.'s request they dropped by the residence of his sister C.S. on the Reserve and it was agreed he would attend the dance with his family. Later in the day L.S. asked Ms. Schaefer if he could stay with his family rather than return with her to the group home. It was a routine request which had been granted on earlier occasions and Ms. Schaefer notified the group home of the change in plans and also arranged to have his medication delivered. Her last observations of L.S. was that he had no signs of impairment and was very upbeat and there was no indication of depression or suicide. He was enjoying his time with the family and there was no hint of any problems at this

point in time.

At approximatrely 11:18 P.M. Mr. Ganshorn, the night worker at the group home, was contacted by L.S. who advised that he wanted to be picked up from his sister's residence and returned to the group home. In confirming the travel arrangements his co-worker Anik Bellavance spoke with L.S. on her cell phone and his slow speech and angry tone caused her some concern. She conveyed this to Ganshorn when she arrived at the group home at 11:31 P.M. At 11:35 P.M. Ganshorn departed in his employee's vehicle which was a standard 4-dour family sedan [Dodge Neon].

Ganshorn, like all staff members at McMan, had received Suicide Intervention Training, which course is re-done every three years. He was also very well acquainted with L.S. (see ages 14 – 15 (2002)) as he provided L.S. with both counseling and friendship. On arriving at the residence of C.S., Ganshorn announced himself to pick up L.S. who promptly stumbled from the residence and proceeded to lie down on the road. These theatrics were in keeping with L.S.'s behavioural patterns and when requested to get up and get in the car he immediately proceeded to do so. He entered the vehicle (right front passenger seat) without assistance and put on his seat belt. As they proceed toward the group home, L.S. was ranting and indicated that when he got home he would end his life and show his family. He indicated he was on "meth". (Toxicologist report detects only alcohol, cocaine and marijuana) and efforts by Ganshorn to understand what L.S. was ranting about were unsuccessful. There was no indication as to what actions L.S. was contemplating but Ganshorn considered taking him to the nearest RCMP detachment to get assistance if he became uncooperative. The conversation went quiet as they traveled west of the turnoff on Highway 16A at approximately 100 kph. Without any warning L.S. opened his door and attempted to exit the vehicle. Ganshorn grabbed L.S. over his chest area and held him in the vehicle while pulling over to the shoulder of the road. [It is to be noted that L.S. was 6'1" and weighed 210 pounds.] A struggle and discussion ensued and in anticipation of L.S.'s positive response to being released and being given some space Ganshorn loosened his hold. L.S.'s response was immediate and he bolted from the vehicle and as he ran towards westbound traffic he proceeded to remove his clothes. Coincidental with his departure from the vehicle Ganshorn called 911 for assistances and pursued L.S. down the highway and after observing several near misses witnessed the impact with a vehicle operated by Keith Brzak. Ganshorn checked for vital signs and then removed his shirt to cover L.S.'s naked body and awaited the arrival of the Police and Ambulance Services. Ganshorn then reported the incident to his co-worker Anik Bellavance at the group home who then notified the representatives of Child and Family Services as well as McMan Group Home.

Recommendations for the prevention of similar deaths:

This inquiry focused its attention on the role played by the Director of Child Welfare in the life and death of L.S. who became a ward of the Province of Alberta at the age of three months. In taking a child into custody there is an inherent obligation that Society will use all reasonable resources to provide services to allow the child to reach adulthood with a reasonable prospect of achieving a useful and rewarding life. As was mentioned earlier the Director has provided full disclosure of L.S.'s files and I received the evidence of the following persons who had a key role in his life, namely:

1. Ellen Schaefer - Caseworker – Alberta Children's Services
2. Edward Ian Shaw - Social Worker - Manager, Alberta Children's Services
3. Danica Dale Frazer - Executive Director, McMan Group Homes
4. Marnie Elise McMullen - Program Manager, McMan Group Homes

5. Warren Phillip Ganshorn - Night Worker, McMan – Group Home, Spruce Grove
6. Dr. Mitchell Byron Parsons - Psychiatrist
7. Corey Lynn Entrop - Program Supervisor, McMan – Group Home, Spruce Grove
8. Anik Mary Bellavance - Youth Worker, McMan – Group Home, Spruce Grove

I also received the evidence of:

9. Dr. Bernard Bannach - Assistant Chief Medical Examiner.
10. Dr. Graham Jones - Toxicologist, Medical Examiner's Office.

Drs. Bannach and Jones confirmed L.S. was legally impaired (defined as .08 [80 mg/100 ml] in the *Criminal Code*) as his reading was 1.2 [120 mg/100 ml] and there was also evidence of marijuana and cocaine usage in addition to the medication prescribed by Dr. Parsons.

11. Cst. Brent Bliss - RCMP, Investigating Officer
12. Cst. Philip Dahdona – RCMP, Investigating Officer
13. Keith Allan Brzak - motor vehicle driver

These individuals confirmed Ganshorn's description of the accident and the driver noted that L.S. appeared to attempt evasive action immediately prior to the impact occurring.

14. C.S. - Sister of L.S.
15. D.M. - Common-law husband of C.S.
16. P.M. – First cousin of D.M.

These individuals were all in attendance at the residence prior to L.S.'s departure with Ganshorn to the group home. The consumption of alcohol, marijuana and cocaine was confirmed and they had no concern for L.S.'s well-being nor was there any hint of what was to occur on the trip home.

L.S.'s initial diagnosis of organic brain syndrome, compulsive behaviour, and the ingestion of alcohol and drugs was a volatile cocktail which manifested themselves in behaviour which was both uncharacteristic and uncontrollable. His actions cannot be categorized as either suicide or an accident and the Inquiry concluded that the manner of death was undeterminable.

This inquiry considered all relevant evidence and documentation relative to the well being of L.S. It included:

i. profile of L.S. and family;
ii. guidelines for transporting youth and particularly if behaviour may be affected by mental health issues or alcohol and drugs;
iii. effectiveness of assessment and decision-making processes re youth's placement and educational needs, alcohol and drug use, cultural and family connections;
iv. assessment of planning and communication concerning youth's plan for independence; and
v. policies and protocol.

The difficulties which L.S. faced from birth required the Director to provide adequate and ongoing treatment and services to help him cope with problems he did not create. The provision of these necessities can never be a static task and we must constantly assess and improve where possible the services which are being provided. That is one of the reasons for fatality inquiries where children in care are involved.

All witnesses provided their evidence in a candid and cooperative fashion as they were

personally searching for an explanation or any suggestion which might assist them in avoiding a similar tragedy. There were no observations made by the witnesses nor was there any evidence presented to the inquiry to suggest that more extensive training or any changes in procedural protocol on transportation or recording behavioural issues than that already in place might have prevented the tragedy. I agree with the findings and recommendations contained in the Case Review conducted by the ministry of Children's Services after L.S.'s death.

His death was an unforeseeable tragedy and neither the Director or any persons acting on his behalf can be faulted for their professionalism, concern or compassion which they so willingly gave. Having reached this conclusion that all matters were handled appropriately, the Court has some observations / recommendations which may be of assistance in the future.

Training and Suicide Prevention

Hindsight does not in this case provide any assistance as to what type of assessment or treatment could have avoided this tragedy. The complexities of the human mind in most instances makes it difficult to recognize what a person's intentions are and it becomes an impossibility when alcohol and drugs are involved.

It is therefore respectfully recommended that the program of suicide prevention and training as well as compulsory upgrading be maintained. Steps should be taken to ensure that any advances in the recognition and prevention of suicide or relevant case studies form a part of the initial and any refresher courses.

The Ministry of Children's Services should also recognize the efforts and achievements of their caseworker, Ellen Schaefer. Her dedication and compassion transcends her professionalism and her efforts should be a template of behaviour for all caseworkers.

Support / Services / Resources / Non-Compliant Children

The "hands on" approach taken by L.S.'s caseworker, Ellen Schaefer, guaranteed that every available resource was utilized. They covered every aspect of his life from health, education, physical and cultural activities to a relationship which bordered on motherhood. L.S.'s success in his short lifetime and the happiness he enjoyed resulted from his personal endeavours and that of his caseworker. She was innovative and resourceful and no parent could do more especially when one considers the availability of resources and programs such as the group home. Although there was no lack of resources or funding it was noted that all resources are not always readily available.

L.S.'s mental condition was such that psycho-therapy (talk therapy) was not something that appealed to him. Compelling him to participate in such programs would not have been beneficial and in cases of substance abuse, talk therapy (which is essentially parental guidance) is probably not effective even if the youth is willing to participate.

There was however one form of therapy which appealled to L.S. and it had been made available to him when residing at the Bosco Home. He responded positively to Pet Therapy and he probably would have pursued, persevered and endured any form of therapy provided that a dog would have been in attendance. He was very much alone, without a real family, and a dog probably would have given him something to love and a loyal friend to return the love he was so desperate to share. Efforts to locate a pet therapist were unsuccessful. It was also noted that expressive artwork or more 'hands on' activities would also be helpful in cases of this nature. Unfortunately these resources are not readily available in the Edmonton area where we seem to focus on talk therapy, which is really parental advice, and which is now being provided by an

unrelated party, i.e. AADAC. The concept is commendable but it only works if we have a willing and mentally able participant.

Compelling treatment is possible under a Secure Services Order which only arises in cases of extreme behaviour where there is a risk of significant damage to oneself or to another. L.S.'s circumstances, notwithstanding the workers' plans for an emergency review meeting, fell far short of anyone even considering a Secure Services Order.

The professionalism and sincerity of all persons involved is recognized but the lack of a meaningful therapeutic program to fill this youth's needs may have contributed to his demise. I commend the efforts which were made by Children's Services and at the group home but we must find resources which bridge the gap between talk therapy / supervision scenarios and where a Secure Services Order would be appropriate.

It is therefore respectfully recommended that the Ministry of Children's Services expand and improve the availability of mental health services and drug treatment programs throughout the Province. In particular those persons who are involved on a regular basis with wards of the province must be provided with information as to both the purpose and availability of such therapeutic and treatment programs. Efforts must also be made to create new innovative programs for both addiction and mental health issues as 'talk therapy" does not appear to be very effective.

It is also recommended that a task force be established to address the issue of non-compliant youth which is the predicament which arose as L.S. approached maturity. To fulfill his obligations as a legal guardian the Director and parents must have the reasonable authority to move beyond verbal encouragement to deal with addiction / suicide issues without waiting for situations which would mandate a Secure Services Order.

The implementation of the *Protection of Children Abusing Drugs Act* (PCHAD) has made a beginning but the courts are limited in their ability to grant follow up Orders. I appreciate the *Canadian Charter of Rights and Freedoms* considerations but also recognize an obligation to impose treatment for a minor if it is justified.

Achieving abstinence although preferable is not realistic and we must focus on education and harm reduction. The current PCHAD legislation allows only a five day window of opportunity to assess and treat youth who clearly have serious addictions issues. I respectfully suggest this very limited window of opportunity only serves to confirm the addiction and that treatment is required. Having reached that conclusion the youth is then returned to society where he is now in better health to pursue his addiction. When their addiction warrants treatment, continued confinement is both appropriate and justifiable. The PCHAD Order should remain in place provided the Court holds timely reviews and continued treatment is recommended by qualified addictions professional. Addictions counsellors must be given a reasonable opportunity to assess and provide treatment which should include compulsory confinement if necessary.

Difficult choices are required in dealing with addictions issues. There is an obligation to see that children are given the encouragement and appropriate treatment to deal with their addiction issues so they can achieve self-sufficiency by the time they reach adulthood.

DATED June 26, 2007

at Stony Plain, Alberta.

Hugh W.A. Fuller
A Judge of the Provincial Court of Alberta