ALBERTA

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Calgary Courts Centre

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

on the tenth day of June, 2019 (year), (and by adjournment

on the eleventh day of June, 2019 (year)),

before The Honourable H. M. Van Harten, a Provincial Court Judge,

into the death of SR (Name in Full) 17 (Age)

of 5511 Maddock Drive N.E., Calgary, Alberta (Residence) and the following findings were made:

Date and Time of Death: September 2, 2016 time uncertain

Place: Calgary, Alberta

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)).

Hanging

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)).

Suicidal

Circumstances under which Death occurred:

See attached pages.

Recommendations for the prevention of similar deaths:

See attached pages.

Circumstances under which the Death occurred:

1. Parties participating in the Inquiry:

   a. Inquiry Counsel, Alberta Justice and Solicitor General, Legal Services Division: Cynthia Hykaway;
   b. Counsel for Alberta Children's Services: Jo-An Christiansen, and
   c. Counsel for Stoney Nakoda Child and Family Services: Terri Mair.

   Although members of the family were notified throughout of progress of preparations for this Inquiry, including SR's father and grandmother, no one from or on behalf of the family appeared or participated in the Inquiry.

2. Witnesses called:

   a. Chris Schoepp, CFS Caseworker;
   b. Shelley Calf, CFS Caseworker;
   c. Paul Amanoh, CFS Caseworker and supervisor;
   d. Belinda St. Amand, Acting Senior Manager of ACS's Program and Practice Review Unit;
   e. Melissa Ferreira, Manager of Child Intervention Program Coordination, and
   f. Marnie Pearce, Director of Prevention, Early Intervention and Youth.

3. Exhibits received:

   a. Medical Examiner's Records;
   b. Calgary Police Service Records;
   c. CFS Records;
   d. Alberta Health Services Records;
   e. Previous Fatality Inquiry Reports about similar deaths;
   f. Office of the Child Youth Advocates Reports, and
   g. Handbook titled "Suicide Intervention Skills" (2015) used in delegation training of caseworkers.

4. On September 2, 2016, SR was found hanging in the basement of her grandmother's home. She had hung herself with an electrical cord which was tied a metal pipe. Her father discovered her body at 2320 hrs and called police. He had recently moved into the home where SR had been living on and off for some time.

5. SR was born July 22, 1999, the youngest of three siblings. The three were apprehended from their parents in early 2000 before SR was one year old. They were made the subject of a Temporary Guardianship Order in 2000 while CFS worked with her mother, father and his new partner (SR's "stepmother"). These efforts focused on the parents' persistent abuse of alcohol. SR and her siblings were placed in a foster home where they remained for approximately a decade. CFS was continuously involved with SR until the time of her death.

6. SR's mother lost contact with SR for approximately 9 years. Her father and step-mother had positive visits with SR but were never in a position whereby SR and her siblings could be placed with them. The children were made subjects of a Permanent Guardianship Order in 2004 when SR was five years old.

7. SR's childhood can best be described as chaotic. Her foster parents were concerned that she might have Fetal Alcohol Spectrum Disorder due to pre-natal exposure to alcohol although she was never formally assessed. SR fell behind academically, for example reading at a grade 2 level when she was in grade 5. She had difficulty controlling her emotions and often acted impulsively.

8. SR's mother began visiting her when SR was nine years old. Her mother appeared to have stabilized and CFS considered returning SR to her care. Unfortunately, her mother began drinking again and this consideration was abandoned. When SR was twelve years old, she and her siblings left the foster home. SR moved in with her mother but after about a year, she moved in with her grandmother who was also looking after other grandchildren. She frequently left her grandmother's to stay with her mother and other relatives.

9. SR, now thirteen years old, experienced the death by suicide of her stepmother. Shortly after, SR was found intoxicated outside in the cold. This event appears to mark the beginning of SR's own abuse of alcohol combined with being frequently AWOL from an indigenous youth group home where she had been placed.

10. At fourteen years old, SR was AWOL for about four months before being found at her grandmother's home. She was eventually placed with her father for about one year. She was frequently left alone, missed school and continued drinking alcohol. She frequently stayed with her mother, other relatives and friends. She became involved with the Youth Criminal Justice system. The Youth Court imposed conditions on SR, including abstaining from the use of intoxicants which she struggled to comply with.

11. When she was fifteen, SR was hospitalized with self-inflicted cuts on her wrist and intoxicated. She was placed at Secure Treatment but discharged after a week. She returned to the group home. The counsellor there, like the Youth Court, recommended that SR be assessed and undergo therapy. Due to her AWOLing behaviour, SR never made it to any appointments that had been set up for her.

12. At sixteen, SR was still using alcohol. She was charged with assault. The Youth Court ordered psychological and psychiatric assessments as part of the sentencing process but SR failed to attend the appointments. Without the benefit of assessments, the Court place SR on probation. She moved into a Supported Independent Living ("SIL"), group home and was assigned a new caseworker specializing in preparing youth for independent living.

13. The Stoney Nakoda CFS caseworker was Chris Schoepp, the first witness called at this Inquiry. He had SR's case from February to June 2016. Because of SR's history, including a second hospitalization after overdosing on cold medication shortly after being placed at SIL, Schoepp added SR to his "high-risk" caseload. He explained that high-risk cases require regular face-to-face meetings with the client. With SR, he relied on the suicide intervention training he received during his becoming a delegated caseworker to make a safety plan with SR. Part of the planning included working with SR and finding a placement where she was likely to stay and cooperate with him.

14. Unfortunately, SR's AWOLing behaviour continued. Her bed at the SIL group home was closed. She inevitably would show up at her grandmother's home. Schoepp had several face-to-face meetings with SR at least one of which included her grandmother. They made a safety plan and SR contracted with him that she would not harm herself. He drove her to the court-ordered assessment appointment but SR left before meeting the clinician. Schoepp found a therapist willing to meet SR at her grandmother's house but SR was never there when the therapist attended at agreed upon times.

15. On March 23, 2016, SR was hospitalized on a Form 1 under the *Mental Health Act*. She was transferred to the Foothills Hospital's adolescent psychiatric unit. She discussed her history with staff including her abuse of alcohol. She recalled the cold-medication over-dose a suicide attempt. On March 29, 2016 SR went AWOL from the unit. On April 28, after being missing for three weeks and without the phone provided to her by CFS, police found and returned her to the hospital.

16. Schoepp continued to meet with and make plans for SR. On May 16, 2016, SR was discharged from hospital with staff recommendations that she receive

therapy, especially for addictions. The recommendations were the very things that Schoepp had sought for SR since becoming her caseworker. SR was returned to her grandmother's home pending the finding of a new SIL placement. SR was excited about her father's intention to move into the home. However, SR continued to be AWOL and never made the therapy appointments Schoepp had arranged.

17. In June 2016, Schoepp was promoted to casework supervisor and transferred SR's file to Shelley Calf. At this Inquiry, he had no suggestions as to how SR's death could have been prevented. She was the first client to die in his 6 years as a caseworker. He was satisfied that his suicide intervention training was adequate and he used it in this case. He noted that his 28-file caseload included 30% high-risk cases. CFS has a goal of reducing a worker's number of files when it includes high-risk cases but this has proved difficult because recruiting and retaining workers is challenging. Finally, Schoepp did not consider a further secure treatment placement for SR because based on what she was telling him, she did not meet the criteria for admission. Even if SR had been placed, she would have been immediately discharged.

18. Shelly Calf, the second witness at this Inquiry, took over SR's file. She was chosen in part because she knew SR's father through some common family relations. On August 18, 2016 she met with SR, her father and her grandmother. They discussed schooling and future plans as part of a concurrent case plan. SR was a vocal, cooperative and happy participant. Calf described her demeanor and appearance as good. SR's grandmother discussed her need to receive funds for having SR back in her home and Calf agreed to deliver those at a future meeting.

19. The second meeting occurred August 30, 2016. Calf delivered the requested funds and reported SR's demeanor and appearance to be as it was on August 18, 2016. SR had also reconnected with her probation officer after Calf had made some initiating phone calls.

20. Calf then went on a Labour Day vacation and learned of SR's death on September 6, 2016. She testified that because she had not seen any signs of suicidal ideation (pursuant to her suicide intervention training) in SR during their two face-to-face meetings and that family members had expressed no concerns, SR's death was "very surprising" to her.

21. Notably, Calf testified that she had met with Schoepp and their supervisor Paul Amanoh to discuss the file transfer. However, when she met SR, she did not know about SR's hospitalizations. She did not know about SR's potential risk for suicide as noted by Schoepp during his management of the file. She had

no knowledge about Schoepp's frustrated efforts at getting SR into therapy. Her evidence is both disturbing and concerning to this Inquiry and will found the one recommendation I will make.

22. Paul Amanoh was the third witness at this Inquiry. He supervised the transition of SR's file from the previous caseworker to Schoepp and from Schoepp to Calf. While he was aware of Schoepp's concerns about his caseload, he could not lighten that load because of other commitments in the Stoney Nakoda CFS office. He too has had the suicide intervention training and, therefore, while the file was being transferred to Calf, he had a face-to-face meeting with SR on August 4, 2016.

23. Amanoh was sure that during the transfer meeting between Schoepp and Calf, SR's recent history would have been discussed. But he could not now say whether he participated in the meeting. He could not explain how Calf would not have known about SR's recent history. That history could have been found on the CFS Intervention Services Information System ("ISIS"). In any event, he could not offer how things could have been differently in SR's case. He did agree with Schoepp's concern about heavy high-risk caseworker loads but also with the difficulty of recruiting and retaining caseworkers.

24. Belinda St. Amand, the fourth witness, described CFS's internal death review process implemented whenever a child in care dies. The "designated review" provision was legislated after SR's death and came into force in 2018. It came from the recommendation made by the Office of the Child and Youth Advocate's Investigative Review of SR's death.

25. Alberta Children Services (“ACS”) Program and Practice Review unit compiles all information regarding a child who dies while in care. It develops a chronology and asks, hindsight bias aside, whether there are any gaps in CFS's delivery of services. A speedier, revised review process has been put in place in the wake of SR's death.

26. Melissa Ferreira is the Manager of the Child Intervention Program Coordination ("CIPC"). With a staff of three people, CIPC tracks the recommendations of inquiries like this, the Office of the Child and Youth Advocate (“OCYA”) and the Auditor-General. CIPC responded to the OCYA's review of SR's death in February 2019 by publishing "17-year-old Susan: An Investigative Review." It emphasizes that CFS's approach to intervention in cases like SR's should change from "something is wrong with you" to "what happened to you?".

27. Marni Pearce, the final witness, is the Director of Prevention, Early Intervention and Youth. SR's death and others like it spurred to publish "Building Strength,

Inspiring Hope: A Provincial Action Plan for Youth Suicide Prevention 2019-2024" in March 2019. With the artistic assistance of young persons, the Plan describes the problem of youth suicide and promotes information sources, alternative care approaches and specific recommendations aimed to lower the incidence of youth suicide generally including for youth in care.

Recommendation for the Prevention of Similar Deaths

28. As shown by "17-year-old-Susan: An Investigative Review" and "Building Strength, Inspiring Hope: A Provincial Action Plan for Youth Suicide Prevention 2019-2024", much has already been done in response to SR's death. These initiatives are also responsive to the recommendations made by Assistant Chief Judge Lillian McLellan in her December 19, 2018 report into the Fatality Inquiry into the death of T.C., a young indigenous woman who lived in circumstances similar to those of SR.

29. I make the following recommendation. It is based on the evidence of Calf. When she assumed conduct of SR's case, she had no knowledge of the concerns on which Schoepp had been so active. Their supervisor Amanoh could not remember whether he participated in the file transfer meeting.

Whenever a child's casework file is transferred from one caseworker to another, the transfer meeting should be noted or, preferably, be recorded. The new caseworker will then be aware of the file history and able to provide appropriate services to a client.

This recommendation mirrors the first made by Judge McLellan in the T.C. Inquiry. The issue there involved the transfer of a file to a "courtesy" caseworker in another jurisdiction. She emphasized the need to immediately make a child's history available to a new caseworker. My recommendation aims to make sure that this happens in any file transfer whether within or outside of CFS jurisdiction.

DATED October 29, 2019,

at Calgary, Alberta.

Original signed

The Honourable H. M. Van Harten
A Judge of the Provincial Court of Alberta