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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the The Provincial Court of Alberta

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

on the 13th to 15th day of October, 2021 (year), (and by adjournment

on the _____ day of _____, _____ (year)),

before T. W. Achtymichuk, a Provincial Court Judge,

into the death of Nevaeh Charette (Name in Full) 14 (Age)

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

Date and Time of Death: 3:05 pm on December 5, 2017

Place: Train tracks near 48 avenue and 54 street in Holden, 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 – *Fatality Inquiries Act*, Section 1(d)).

Massive disruption of body due to impact with train

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

Suicide

Circumstances under which Death occurred:

At about 3:00 pm on December 5, 2017, RCMP received a 911 call about someone sitting on the train tracks in the Village of Holden. It was on the outskirts of Holden, just past where the tracks crossed secondary highway 855. There was no RCMP detachment in Holden. The RCMP called Canadian National Railway (CN). Before CN could warn the approaching freight train, the train crew saw Nevaeh Charette on the tracks. Nevaeh had a history of mental health issues and suicidal ideation. Despite the train horn and bell, Nevaeh remained seated on the tracks with her arms and legs crossed. The train could not stop in time. Tragically, it struck and killed Nevaeh at about 3:05 pm.

The Issues for this Inquiry

The Fatality Review Board recommended that a public fatality inquiry be held to examine whether similar deaths could be prevented. That could involve issues about how the RCMP and CN respond to reports like Nevaeh being on the tracks. That also could involve issues about Nevaeh's access to, and treatment for, her mental health difficulties through Alberta Health Services (AHS) and Alberta Children's Services (CS).

In this report, my findings are to include the circumstances under which Nevaeh died, the cause of death, and the manner of her death. My report may contain recommendations to prevent similar deaths. But my report cannot contain findings of legal responsibility (*Fatality Inquiries Act (FIA),* s.53).

A conference was held before the Inquiry. The primary issues were identified as:

1. The circumstances of the collision:

a. Communication process between RCMP and CN regarding the need to stop trains;
b. Stopping time/distance of trains;
c. Innovations to detect obstructions on the tracks;
d. Train structure or design for mitigating collisions;

2. The availability of AHS mental health services:

a. Review of medical attendances close to Nevaeh's death and issues relating to diagnosing suicidality;
b. Review of availability of services in small communities through AHS for youth experiencing mental health difficulties;

3. The availability of CS mental health services:

a. Review of CS interaction with Nevaeh and her family in the months before her death;
b. Review of availability of services in small communities through CS for youth experiencing mental health difficulties, and their families.

Exhibit 1 contained 372 pages of records in 47 tabs. Exhibit 2 contained 160 pages of supplemental records in 9 tabs. I will refer to documents by their Exhibit and page number.

I now turn to the first main issue.

1. The circumstances of the collision.

1a. Communication process between RCMP and CN regarding the need to stop trains

The report of Nevaeh on the tracks first went to the 911 call centre. That centre decides what agencies to contact, whether police, emergency medical services or others. This call was routed to the RCMP Operational Communications Centre (OCC). The OCC receives communications meant for the RCMP, and triages them.

The OCC got the necessary information from the 911 caller. The OCC gave this a priority status #2. That means police need to be dispatched as soon as possible (meaning less than 30 seconds), because there is an urgent need for police presence. Priority status #1 means police need to stop all tasks immediately and be dispatched with no delay. These are the two highest priorities for dispatches. Here, police were dispatched right away. The difference between it being priority status #1 or #2 did not affect the timing of that.

The OCC immediately reported it to the Vegreville RCMP. That detachment covers Holden, which is about a 30 minute drive away. That call lasted about 30 seconds (Exh 2, p 92). The OCC did that before contacting CN. That was mainly because police can generally get to a scene faster than others, there may have been an officer close to the scene on other duties, and once there, police are better able to respond to emergencies.

The OCC then called CN. The CN Emergency Communications Centre (ECC) handles emergency calls for the entire CN network. The CN Traffic Control Centre (TCC) monitors the locations of trains. The TCC is responsible for their movements and directing them to stop.

CN's phone tree to direct calls was: Option 1 for all railway emergencies; Option 2 for railway crossings, such as damage; Option 3 for CN Police Service; and Option 4 for general inquiries five days per week. Option 1 connects the caller directly to TCC. The other options go through the ECC.

The RCMP likely chose Option 3 for CN police, which put it in contact with CN's communications centre, rather than the TCC. Once the information and location were given to CN, the RCMP were put on hold so that the ECC could contact the TCC to direct the train to stop. Within seconds of the RCMP being put on hold, CN's ECC was told that Nevaeh had already been struck.

The Inquiry evidence is that the RCMP choosing Option 1 in a situation like this and being put in direct contact with CN's traffic control, could allow the TCC to act quicker and stop trains in a wider area until the exact location is identified. That could save precious time in such emergencies. However, I am satisfied on the evidence that, unfortunately, this would not have saved enough time to prevent Nevaeh's death. That is because by the time the needed information had been given to CN, Nevaeh had already been struck.

It is recommended that the RCMP change its procedures so that they connect directly with CN's Traffic Control Centre in these situations. At the end of this Inquiry, counsel for the RCMP advised that the RCMP was already making that change to its procedures.

Other than the RCMP connecting directly with CN's TCC in these situations, I do not see how the communications between the RCMP and CN could have been faster. The evidence shows that the RCMP responded quickly and appropriately in who they contacted, when and for how long (Exh 2, p 92). By the time CN got the information it needed to take action, the collision had already happened. In the end, the short few minutes between Nevaeh being reported on the tracks and the collision, were not enough to prevent her death.

1b. Stopping time/distance of trains

Surinder Grewal is a CN Network Operations Manager. He testified that this was an average sized freight train. It had two locomotives and 121 loads. It weighed 17,358 tons and was 7,281 feet long. It was going 47 miles per hour, although the maximum speed allowed at this location was 60 mph.

Mr. Grewal says that the crew had not received a report of Nevaeh on the tracks before the collision. He says that a crew can see something on the tracks about ¼ mile ahead, although that distance can be reduced by many things. Based on the information he reviewed, including the locomotive video, Mr. Grewal says that the crew started blowing the train horn about ¼ mile away. The bell on the locomotive came on automatically. He says that it took 2,700 feet, or about ½ mile, to stop this train with emergency braking. If it had been going the maximum speed of 60 mph, it would have taken about ¾ to 1 mile to stop it.

Based on Mr. Grewal's evidence, by the time a train crew in these circumstances can see someone on the tracks ahead, there is not enough time to stop the train before reaching them. The crew was not warned that Nevaeh was on the tracks. Nevaeh did not get off the tracks in response to the sounds of the train, horn or bell, nor the nearby crossing lights and gates (Exh 1, p 34).

There was nothing in the Inquiry evidence to suggest that the conditions of the track or train contributed to the collision. The statements taken from the train crew at the scene suggest that the train was closer than ¼ mile away when they first realized that Nevaeh was on the tracks (Exh 1, pp 24-30). However, as I said, the evidence is that even if they had seen Nevaeh from as far away as ¼ mile, there would not have been nearly enough distance to stop this train.

In these circumstances, one possible way for a train crew to stop a train in time is by technology that lets them see farther ahead.

1c. Innovations to detect obstructions on the tracks

Mr. Grewal testified that there is no technology available now to give train crews an enhanced view of the track ahead.

CN is putting more video cameras at train crossings. But those only record accidents and the like. They do not transmit video to train crews to show what is ahead of the train, nor do they sound alarms.

He says that the railway industry is reviewing the possibility of using drones for this purpose. But this is only at the initial stage of reviewing the technology. Using it is still a long way off. He is not aware of that technology being used anywhere in the world. He also says that one of the challenges is that trains often operate in remote locations where there is no connectivity needed for some technologies.

At a general level, technology allowing train crews to see far enough ahead to stop in time to avoid colliding with a person who intentionally does not get off the tracks in response to warnings from the train, may be the only way to prevent death in these circumstances.

However, there was not enough evidence at this Inquiry about emerging technologies for specific recommendations to be made.

But based on the Inquiry evidence, pursuing such technologies is important. Suicide deaths are a persisting problem involving the railway industry in Canada. One study concluded that 38% of deaths involving trains in Canada between 1999 and 2008 were suicides. The number of deaths and injuries to trespassers involving trains is worsening (Exh 2, pp 102-119).

Even when a train crew is alerted to a trespasser on the tracks, that is no assurance that death can be avoided. Reports of trespassers are given a priority status #2 by default, unless particular information justifies a priority status #1. That is because trespassing can include many things, including being around the tracks but not on them. Priority status #2 means urgent, involving potential loss of life. Instructions to train crews for the default priority status #2 are to proceed with caution and be prepared to stop. But given the distance needed to stop trains like this, there is no assurance it can be done in time after the crew sees the person.

Apart from using technologies that allow crews to see farther ahead, there are other strategies for reducing the risk of suicides involving trains. A 2018 report published by Transport Canada recognizes that the railway industry, all levels of government and communities, need to develop a national strategy for suicide prevention relating to trains, but viewed in the broader context of suicide prevention generally (*Enhancing Rail Safety in Canada: Working Together for Safer Communities – The 2018 Railway Safety Act Review*, Exh 2, pp 102-115). However, that is beyond the scope of the issues and evidence at this Inquiry.

1d. Train structure or design for mitigating collisions

There was some evidence at the Inquiry about the braking systems and emergency braking procedures for this train. The evidence merely highlighted the limitations there are to stopping a train like this in an emergency, and the distance needed to do that safely. There was no Inquiry evidence to show how changes to the train structure or design could prevent future deaths in situations like this one.

I now turn to the second main issue.

2. The availability of AHS mental health services.

2a. Review of medical attendances close to Nevaeh's death and issues relating to diagnosing suicidality

AHS records show that Nevaeh first started reporting mental health difficulties in May 2014, when she was 11 years old. They started as mild mood and behavioural issues at home and school, but involved some superficial self-harm by cutting. Treatment, mostly with psychological therapy, continued until the late fall, when the family moved from Camrose to Holden (Exh 2, pp 38-76).

A year later, she engaged with AHS again in December 2015. She reported feeling depressed, with suicidal ideation. She was provisionally diagnosed with moderate Oppositional Defiant Disorder (ODD) with anxiety traits, but not major depression. The risk assessment for suicide did not warrant a caution on her file. She attended psychological counselling at the beginning of 2016 (Exh 2, pp 15-26, 63-64).

In February 2016, Nevaeh had a fight with her mother, and left to go for a walk. She was walking down a highway at night in dark clothing when a truck drove by and hit the back of her head with the side mirror. She suffered a traumatic brain injury and severe spinal cord injury. She was in hospital for about 3 ½ months (Exh 1, pp 45-47; Exh 2, pp 11-14, 58-61).

In July 2016, the Glenrose Rehabilitation Hospital referred Nevaeh to the Vegreville Mental Health Clinic for mental health therapy and support. At her first appointment on August 11, 2016, Nevaeh mentioned ongoing passive suicidal thoughts, including throwing herself in front of a moving train. However, Nevaeh said that she was not willing to carry out any plans for suicide. Based on her presentation over two appointments, the therapist could not find sufficient information to support a caution indicator on her file for suicide. Nevaeh's mother said on a later phone call that Nevaeh was doing much better since a medication change. Nevaeh's mother cancelled an appointment in September. On a phone call to Nevaeh's mother on October 21, 2016, she said they no longer needed the therapist's services, and decided to go with someone else (Exh 2, pp 5-10, 46-51).

Medical records show that Nevaeh saw her doctor on August 24, and October 7 and 23, 2017. Ongoing issues with temper, mood and emotional control were noted. But all three notes say Nevaeh was doing well, better than before, and on one visit was noted to be very happy.

About a month later, on November 17, 2017, Nevaeh's mother reported to RCMP that Nevaeh left the house after they had a fight, saying they would never see her again. Police found her laying in the snow at 8 pm near the CN train crossing in Holden. She was not dressed for winter. Nevaeh told police she wanted to be left there because she did not want to live.

Police took Nevaeh into their custody under the *Mental Health Act*. She was eventually taken to the Stollery Children's Hospital in Edmonton. She was kept overnight and thoroughly assessed by a psychiatric resident physician in consultation with another psychiatrist. Their conclusions included the following:

- Nevaeh had chronic suicidal ideation mostly from conflict with her mother and feeling isolated in Holden;
- Marijuana use in the home and her brain injury were contributing factors to her mood and impulsivity;
- Information in ER records that her February 2016 injury was a suicide attempt was not consistent with Nevaeh's and her mother's reports about that, nor with the medical records;
- Now that Nevaeh was out of the home, she was not acutely suicidal and denied suicidal ideation. She denied set plans for suicide, said she didn't want to kill herself, and was future oriented. Her actions are unplanned and impulsive, reacting to immediate situational stressors;
- Without an acute risk of suicide or current suicidal ideation, an admission to hospital was not indicated. The focus needed to be on long term solutions like psychotherapeutic supports focused on skill building, emotional regulation and coping tools; and
- Nevaeh would be discharged into the care of a family member in Edmonton for a few days for a cooling off period. There were a number of referrals to the Urgent Clinic for psychiatric assessment, Camrose Mental Health for therapeutic supports, and the Glenrose Hospital Brain Injury Rehabilitation Program for follow up. Information was given about the Mobile Response Team to provide urgent mental health support in crisis situations. There was extensive safety planning with Nevaeh's mother and the family member, including information about other support resources (Exh 1, pp 56-64).

The medical records indicate that the first phone call with Nevaeh's mother ended up with her yelling at the doctor and hanging up. She wanted Nevaeh kept in the hospital or permanently placed with Children's Services, in part because she had four other kids to look after. But she called back. It was a long call discussing psychoeducation, support and safety planning. At the end, the doctor was satisfied that Nevaeh's mother understood and agreed with Nevaeh's discharge with the resources given (Exh 1, pp 59, 76).

The psychiatrist Dr. Zbuk assessed Nevaeh at the Urgent Clinic in Edmonton on November 30, 2017. He noted a long history of mood dysregulation and impulsivity, likely made worse by her brain injury. He detected some cognitive deficits from that, but she presented as very bright. She did not meet the criteria for Depressive Disorder, Bipolar Disorder, a Primary Psychotic Disorder or a Major Anxiety Disorder. In his opinion, she was not suicidal. There was no self-harming ideation, and she was future oriented. He changed her medication to something that Nevaeh's mother said had worked better in the past (Exh 1, p 371).

Nevaeh committed suicide 5 days later.

Nevaeh's family questions why she wasn't kept in the hospital. However, the decision to not keep her in hospital was based on the medical judgment and opinion of two psychiatric doctors at the Stollery Hospital based on a very thorough assessment. It was followed by that of another psychiatrist 12 days later at the Urgent Clinic, essentially reaching the same conclusions.

Nevaeh's family may not agree with those opinions. But the Inquiry evidence does not show any systemic problems or other failures in the decision to not hospitalize Nevaeh. The medical opinions were based on Nevaeh's history from her records, information provided by Nevaeh and her mother, Nevaeh's presentation on those days, and the exercise of medical expertise and judgment. There is no evidence that this medical expertise and judgment were exercised incorrectly.

Dr. Zbuk says that the biggest challenge is trying to sort out whether a person's behaviour results from an intention to actually commit suicide, or instead whether it results from a reaction to stress without an intention to complete the suicide. Even when a person denies the intention to actually commit suicide, treating professionals have tools they use to test whether the denial is true. He concluded, as had many before him, that Nevaeh's behaviours were reactions to stress without an intention to actually kill herself. Now with hindsight, Dr. Zbuk agrees that when he saw Nevaeh, she may well have already decided to take her own life. But medical opinions trying to predict future behaviour and risk, do not have the benefit of hindsight.

One of the reasons for not admitting Nevaeh into hospital was that her actions resulted from situational stressors at home. There were 17 days between the decision to not admit her into hospital, and when she committed suicide right after a fight with her mother at home (Exh 1, p 10). In all her circumstances, institutionalizing her in hospital or some other facility was not a long term or permanent solution. Based on the Inquiry evidence, the only long term solution was for her and her family to be supported in the community where she would live.

I now turn to that issue.

2b. <u>Review of availability of services in small communities through AHS for youth experiencing mental health difficulties</u>

The Inquiry evidence shows that one of the circumstances facing Nevaeh and her family was that accessing therapeutic supports for them was more difficult because they lived in a small, relatively isolated community.

There were several things that contributed to this challenge. Nevaeh's family had a long history of involvement with CS relating to family violence and substance abuse. Sometimes reports by a mental health therapist to CS compromised Nevaeh's relationship with the therapist (Exh 2, pp 46-53). Sometimes Nevaeh's mother would reach out to CS for support for Nevaeh. But other times she was reluctant to agree to supports, apparently because of concerns for CS involvement (Exh 1, pp 89-93, 100-102). Often, Nevaeh's mother was not available for transportation because of 4 other kids, and for other reasons. She said that sometimes Nevaeh had trouble establishing a relationship with a new support person.

After Nevaeh's brain injury, Family Support for Children with Disabilities (FSCD) helped cover the cost of mileage, meals, overnight accommodation and sibling care for Nevaeh's medical appointments. This appeared to help Nevaeh access support services (Exh 1, pp 98-99). This indicates that cost was also likely a challenge to Nevaeh accessing community mental health services.

Whatever caused the challenges to Nevaeh accessing community supports, especially in-person supports, presumably it would have been easier for her to overcome them if she lived in a large urban centre where she had easier access to transportation and more support service options.

Before Nevaeh's death, the following community mental health support services were available to her:

a. In-person mental health support in Tofield (25 minutes away), Vegreville (31 mins) or Camrose (44 mins), all through the Camrose Addictions and Mental Health Clinic (Camrose Clinic);

b. Tele-Health TV equipment in health centres for, among other things, a client to attend in-person for therapy services provided virtually. There are health centres in Camrose, Vegreville and Tofield. This was said to have been available for years, which suggests that this was available in 2017. However, if Nevaeh travelled to those places, she could have accessed in-person mental health services;

c. Mobile Response Team to provide urgent mental health support in crisis situations;

d. In-person support through AHS, primarily by attending health centres in Camrose, Vegreville or Tofield;

e. FSCD funding related to her brain injury, to help with travel and other costs for treatment; and

f. Counselling through the Family School Liaison Worker program. The Inquiry evidence does not suggest that AHS was connected with this program.

After Nevaeh's death, the following community mental health support services have been added, some due to COVID:

a. Virtual mental health therapy and other support services by Zoom and phone through the Camrose Clinic;

b. In-person mental health therapy in the Village of Ryley, 13 minutes away from Holden. This was added by the Camrose Clinic because a client needed help there, a meeting space was available, and funding was available for a mobile therapist to travel there on an as needed basis;

c. eMentalHealth, an online interactive platform for people 14 to 24 years old to access support services. Camrose was approved as one of the communities to launch this pilot program. The person must be referred by a mental health professional or school based worker;

d. Kids Help Phone, providing 24/7 professional counselling by phone and chat, and supports by text. The rollout of a digital hub to connect youth calling the Kids Help Line directly to other people to provide support services, has been delayed by COVID. The Inquiry evidence was that this was made available in either 2017 or 2018;

e. 211 Alberta phone number, a general inquiry number that puts callers in contact with many services, one of which is mental health and addictions. It connects the caller by chat, text or phone to a web based search platform, including a crisis line. This was available in Alberta in 2017, but not everywhere. It has now been expanded to all communities;

f. Youth Mental Health Service Hub. This targets youth aged 15 to 24. It's not clear if Nevaeh was too young to access this service. This is a one stop shop for addictions and mental health supports for youth through the Camrose Open Door Shelter for Youth. The walk-in shelter has existed for many years. The Service Hub in Camrose was started around the time of Nevaeh's death; and

g. Mental Health Capacity Building program. This AHS funded program serves 150,000 students in 300 schools across 193 Alberta communities. Schools apply to get funding from AHS to provide approved programming. This program mostly deals with suicide prevention and early intervention. But it also helps connect children with clinical mental health services. Although this program existed before Nevaeh's death, it appears that increased funding after 2017 has expanded the program, maybe significantly.

AHS does not partner with schools or Children's Services in hiring and funding mental health treatment and support staff. Schools may have school counsellors within their own school budgets. CS hires its own mental health professionals.

This gives the impression of a patchwork of mental health support for youth that is fragmented between government ministries. Presumably, schools are where youth have a primary connection within their community. That connection can be important to a youth accessing mental health supports. However, I do note that the Mental Health Capacity Building program appears to operate as a hub where youth can be connected with access to support services for prevention, early intervention and intervention such as clinical treatment. That can be a connection between schools and AHS.

In my view, these are the programs and services that would have been most applicable to the situation of Nevaeh and her family: the need for ongoing clinical care, mental health therapy or counselling, dealing with crisis from time to time, and accessing support services related to those things.

There was Inquiry evidence about the Family Resource Network (FRN), another new and important program under Children's Services. However, with respect to mental health issues, this program is more directed to prevention and early intervention. Nevaeh's situation was past that, into intervention, clinical care and crisis management. There may be aspects of FRN that could benefit a youth and their family already in the intervention phase. However, for the purposes of this Inquiry about Nevaeh's situation, I will focus on intervention mental health support services. I will refer again to FRN in the next sections dealing with CS.

The evidence is that there are some limitations to the use of remote and virtual technology as a way for people to get information about mental health community supports, and also access those supports:

- In-person therapy has advantages in exchanging information, treating effectively, and assessing a person, especially when the risk of suicide is higher;

- Not all youth and their families have regular access to mobile devices and remote technology;

- Finding a safe, protected and private space inside a family home for therapies might be a problem for some youth; and

- There are some geographic areas in Alberta where inadequate internet access is a barrier to receiving supports remotely.

Despite these limitations, the Inquiry evidence supports the conclusion that there are some important benefits to the use of remote and virtual technology as a way for people in smaller or more isolated centres to get information about mental health community supports, and also access those supports:

- The more options that are available for people to get information and access mental health support services, the more likely it is that there will be an option that meets the needs of any one particular person or family. The expansion of remote access can remove the barrier of travel for youth who cannot travel independently, and their families;

- The expansion of remote access has coincided with evolving notions of consent for providing mental health supports for youth. At the time of Nevaeh's death, a youth in a small community who depended on parents for transportation was vulnerable to a decision by the parents to not approve, or for whatever reason to not facilitate, mental health supports. It appears likely that this was among the challenges facing Nevaeh and her family. Now, mental health support services are increasingly being provided directly to youth through technology;

- The expansion of remote access has also coincided with the goal of warm hand-offs becoming more central to designing mental health supports. In Nevaeh's case, she and her family were often given information about supports, and were left to their own devices to make those contacts. Generally, a warm hand-off is a referral that actually takes place when it is made. It can mean, for example, conferencing into a call the person or organization to whom the referral is made, so the person needing support is already directly communicating with the referral.

  This recognizes that different people and families have different abilities and capacities to follow through on their own with referrals and recommendations. It also recognizes that because the connection is already made with a warm hand-off, the referral can take the initiative to follow up later with the person needing support. Without a warm hand-off, there is generally no way for the organization to contact the youth to help them, unless the youth makes the contact first. It appears likely that these were among the challenges facing Nevaeh and her family;

- The expansion of remote access has also coincided with the goal of providing wrap around support services. It appears that some newer programs are designed as a one stop place to connect with many different types of mental health supports. This recognizes that it is generally harder for people to navigate a system of fragmented services in different places. It appears likely that this was among the challenges facing Nevaeh and her family.

The use of technology for remote and virtual support services did not cause these developments. Presumably they would be happening in some form independently of technology. However, the evidence does give the impression that technology is facilitating these developments. To the extent that it is, this is a benefit from the expansion of remote access technology as a way for people to get information about mental health community supports, and also access those supports.

Based on the Inquiry evidence, there are still some challenges that arose in Nevaeh's situation that should be addressed:

a. The Inquiry evidence is that there are problems with follow up about recommendations and referrals that are made after a person is discharged from an assessment or treatment for mental health issues at a hospital or elsewhere. These problems are province wide. It appears likely that this was among the challenges facing Nevaeh and her family. Many recommendations and referrals were made after Nevaeh's discharge from the hospital on November 18, 2017. Shortly after her discharge, Nevaeh's mother was telling Children's Services that she was having trouble coping with trying to access resources and help for Nevaeh.

The evidence is that sometimes on discharge, the doctor or other treating professional will notify the community agency to which a patient has been referred. For example, the Camrose Clinic receives these types of notifications from doctors. But the Inquiry evidence is that these notifications are not a consistent or standardized practice, given that witnesses identified this as an ongoing problem.

The *Mental Health Act* now requires that when a patient is discharged from hospital, there must be a notification of that back to the doctor or nurse who normally treats that person in the community. However, as I understand it, that only applies after a patient has been admitted into hospital for treatment as an inpatient under that *Act*. That would not apply to Nevaeh's situation.

There was Inquiry evidence that there is a need for immediate and direct contact with a youth and their family following discharge from an assessment or treatment for mental health issues including suicide risk, to ensure follow up with recommendations and referrals. The evidence is that this could be done by a nurse, mental health worker, or a social worker.

Therefore, it is recommended that AHS standardize the practice of, and dedicate staff and other resources to, the follow up by direct contact with youth and their families about recommendations and referrals that are made after a person is discharged from an assessment or treatment at a hospital or elsewhere, for mental health issues like suicide risk.

b. The evidence indicates that the availability of health professionals to provide in-person mental health treatment and support services in small or isolated communities is not reliable. Remote and virtual technology is helping to address this, but sometimes that is not a good or long-term replacement for in-person support. When those clinical services are expanded into small communities, such as the mental health therapist who now travels to Ryley as needed, it seems to depend on the funding and facilities that happen to be available at the time.

Therefore, it is recommended that AHS consider options for increasing the reliability of health professionals being available to provide in-person mental health clinical and other support services in small or isolated communities when it is needed.

c. The evidence indicates that AHS is involved with a number of programs that use technology to give youth more direct access to mental health support services using warm hand-offs for referrals and more wrap around services. Early indications are that these programs are achieving some success. These are positive developments that may help prevent deaths like Nevaeh's. Some of these initiatives have benefitted from increased funding for, and an increased awareness of, mental health issues and youth suicide prevention in the context of the COVID pandemic.

Therefore, it is recommended that AHS continue to develop, implement and evaluate, both during and after the COVID pandemic, the existing new programs giving youth more direct access to mental health support services using warm hand-offs for referrals and more wrap around services.

d. The evidence is that there are some geographic areas in Alberta where inadequate internet access is a barrier to receiving mental health supports remotely. There was no Inquiry evidence about the availability of high speed internet access across Alberta. The federal and Alberta governments recently announced a jointly funded program to increase its availability in areas of the province where it is currently lacking. Increasing the availability of remote mental health supports in small or isolated communities is one of many reasons to increase the availability of high speed internet access in those areas.

Therefore, it is recommended that the Alberta government continue to develop and implement policies and programs to increase high speed internet access in small or isolated communities where it is lacking, to facilitate the availability of mental health supports for youth by remote technology.

I now turn to the third main issue.

3. The availability of CS mental health services.

3a. <u>Review of CS interaction with Nevaeh and her family in the months before her death</u>

As I said, Nevaeh's family had a long history of involvement with CS relating to family violence and substance abuse. Most of it was about the family generally, rather than Nevaeh specifically. There were intake screenings, assessments and Enhancement Agreements, but no child apprehensions.

However, CS knew about Nevaeh's mental health issues in the years before her death, and especially after her brain injury. For example, Nevaeh's mother agreed to a three month Enhancement Agreement with CS ending November 2016. That included plans and supports for Nevaeh, including counselling two times per week in Vegreville. At the end of the Agreement, CS determined that the family had stabilized and the Nevaeh was doing well.

In May 2017, a professional in the community contacted CS to report a suicide risk for Nevaeh and concerns about the supports she had. CS took the first step in the intervention process, by completing a screening. CS decided that Nevaeh had sufficient supports at that time. CS closed the file at the screening stage.

However, for the purposes of this Inquiry, in my view the most relevant interactions between Nevaeh's mother and CS occurred just before Nevaeh committed suicide.

In the days after Nevaeh's discharge from hospital, CS learned that Nevaeh's mother was telling RCMP that she could no longer care for Nevaeh, and wanted her daughter put in a specialized facility. On November 20, a school liaison worker reported to CS that Nevaeh mentioned that she had thought about taking medications or getting hit by a train as ways she could commit suicide. The school worker developed a safety plan with Nevaeh's mother to lock up the medications and keep an eye on Nevaeh's whereabouts. A hospital social worker told CS that the hospital was not willing to admit Nevaeh, even though her mother thought Nevaeh would just try committing suicide again if she came home.

On a November 21 phone call with CS, Nevaeh's mother said she felt that there had not been enough support. While Nevaeh had access to a mental health therapist in Tofield, there was not a strong connection between them. She said she wanted a support worker to help her through the next while. She thought there was a 5/10 risk of harm then, and that she was open to supports.

During that call, CS talked to Nevaeh's mother about a safety plan, including supervision and removing triggers and tools for self harm. They talked about a referral to the Milestones program for counselling, and emergency mental health services. They talked about contacting FSCD to revive funding supports for Nevaeh's treatment. They agreed to touch base in the next weeks for an update.

The next day, Nevaeh's mother phoned CS. She said she had contacted the Milestones counselling program. She had contacted FSCD and was told funding for treatment costs would be available. She had cleared with her probation officer that she could take Nevaeh for treatment despite travel restrictions in her probation order. Nevaeh would be enrolled in home schooling to remove some triggers for her, which could be revisited when things stabilized.

After that call, CS rated 9/10 on their Clarity scale for Nevaeh's mother understanding the situation: talking about what happened and putting plans in place to keep Nevaeh safe. CS rated 8/10 on their Safety scale for Nevaeh's safety: Her mother was taking clear measures to protect Nevaeh by calling police when necessary, taking steps to put the safety plan in place, and calling CS right away to report the steps she had taken. CS decided that there were no reasonable and probable grounds to believe that Nevaeh was in need of intervention by CS. Therefore, CS decided to close the file at this screening stage. In keeping with CS policy, that decision was made by the case worker, in consultation with a supervisor.

Nevaeh committed suicide 13 days later. She had a fight with her mother. She left the house saying "You'll never see me again." (Exh 1, p 19). Nevaeh's mother did not call the police.

There are several arms to Children's Services. One is child intervention under the Alberta *Child, Youth and Family Enhancement Act* (*CYFEA*). CS's dealings with Nevaeh's family were under the intervention arm of CS. Briefly, when a matter is reported to CS, the first step is screening. If the matter is not screened out and closed, the next stage is assessment. That is a more in-depth investigation to decide whether the test for intervention is met under the *CYFEA*.

If an assessment shows that there are reasonable and probable grounds to believe that a child is in need of intervention, there are several different steps that can be taken. One of the least intrusive is for CS to enter into an Enhancement Agreement with the guardians. That is to put plans in place so that the child's needs are met. On the other end of the spectrum, the most intrusive steps are to apply to court for an order to apprehend the child. That can include placing a child in a secure facility. The requirements of the *CYFEA* must be met to do that. Those involve court orders, time restrictions, and meeting a test that requires that less intrusive measures are not adequate to sufficiently reduce the danger.

Because CS was dealing with Nevaeh's family under its investigation arm, once they close a file, CS has no authority to take any further steps. The evidence is that they can't follow up with the family, and can't provide any more support services.

Another arm of CS deals with services for children and their families that are outside of the intervention arm. This is the child care arm of CS. This is for families that are not currently involved with the intervention arm of CS, but are nevertheless looking for child support services. That includes mental health services for children.

Nevaeh's family questions why CS didn't do more to help Nevaeh and her family, such as apprehending Nevaeh and placing her in a facility.

In hindsight, one can understand why Nevaeh's family questions CS's decision to close Nevaeh's file at the screening stage in late November. The Alberta Government's 2019 report "Building Strength, Inspiring Hope: A Provincial Action Plan for Youth Suicide Prevention 2019-2024" (Youth Suicide Action Plan) (Exh 1, pp 219-220) sets out risk factors for youth suicide. It appears that Nevaeh exhibited most of them: Mental health issues like depression, substance use, poor coping skills, impulsivity, a health trauma from her brain injury, social isolation, negative school experience, a lack of meaningful connection to her school, limited peer relationships, interpersonal conflicts, and what some thought was a prior suicide attempt resulting in her brain injury.

In addition, she had told a school counsellor, a mental health therapist, a hospital doctor and a psychiatrist, that one of the ways she thought about taking her life was by being hit by a train. CS knew this too. Nevaeh's mother told the hospital doctor and CS that she was not able to deal with Nevaeh, and wanted her put into a facility because she would keep trying to commit suicide.

On the other hand, when CS made the decision to close the file, it was just a few days after a doctor and a psychiatrist made the decision at the Stollery Hospital that Nevaeh's situation did not warrant her being kept in hospital due to suicide risk. Also, days after CS closed the file, another psychiatrist assessed Nevaeh and concluded that she was not suicidal. In these circumstances, it can be questioned whether a court would have found that the test for placing Nevaeh in a secure facility was met.

That is one of the difficulties in this Inquiry about making recommendations to prevent similar deaths. Here, different health care professionals and support workers, in different roles, with different types and levels of training, on different occasions over time, generally concluded that Nevaeh's risk of suicide was low, or at least manageable. It turns out that those conclusions were wrong. But in these circumstances, it is hard to pinpoint why they were wrong, other than the difficulties there are in trying to predict when a person is actually intending to follow through with plans to take their own life. That evidence does not provide a good guide for recommendations for the future.

However, the Inquiry evidence does support some recommendations, which are addressed in the next section.

3b. Review of availability of services in small communities through CS for youth experiencing mental health difficulties, and their families

Children's Services contributes, along with AHS, to the funding for the 211 Alberta phone number, referred to earlier. If a youth calls in distress, 211 deals with the crisis, which may include some referrals. If the youth says they've been involved with CS, 211 will call back up to four times for follow up to see of the referrals were successful.

I have previously mentioned the FRN, or Family Resource Network program of CS. It was started in April 2019. It is a program that youth or their families can choose to access, whether or not they are also involved with the intervention arm of CS.

About 70 networks are set up around the province. In each, there is a hub – a physical presence - which can provide services. For any it doesn't provide, the hub connects with spokes, or other agencies in the community to provide those other services. The hub is to provide a one stop shop for child services, including mental health services, to connect a child or their family with community supports. The intention is that children and families can access support services in the same way even if they change locations in the province.

FRN services are focused on three areas: 1) the development and well being of the child, 2) caregiver capacity, and 3) social connections and support. COVID has led to many of these services being provided virtually, which has expanded services into smaller and more remote communities.

With respect to mental health specifically, the FRN is focused on prevention and early intervention. It is not involved with providing therapeutic intervention for mental health, but can make referrals for those services.

The FRN provides some important benefits that could reduce the risk of deaths similar to Nevaeh's in the future:

- It appears to be able to provide more seamless access to mental health services for children and their families who are in and out of involvement with the intervention arm of CS. In Nevaeh's case, after referrals were given and the case closed, Nevaeh and her family were cut off from follow up or more help from who they were dealing with, which was the intervention arm of CS. The child care arm of CS provided services then too. But accessing and getting those was fragmented. It required system navigation that could challenge families like Nevaeh's. Not surprisingly, Nevaeh's family did not appreciate the distinction between the two arms of CS. It appears that all they knew was that help from CS had been cut off.

  How seamless the access is to services, depends in part on whether the CS front line staff in the intervention arm are well trained in getting people in contact with the FRN. It also depends on whether they are warm hand-offs;

- Although the FRN does not provide therapeutic mental health services, it can make referrals out for that. Just like the Mental Health Capacity Building program can provide an important connection between schools and AHS services, so too can the FRN provide an important connection between CS and AHS services.

  How effective the FRN is in doing that depends in part on whether FRN front line staff are well trained in getting people in contact with AHS services when it's needed. It also depends on whether they are warm hand-offs;

- The FRN can and does follow up directly with families who are in the program, to ensure follow through with referrals and FRN services.

  The evidence is not clear about whether the FRN program provides for that follow up when referrals are made to agencies outside the FRN, like referrals to AHS services. If not, it could reduce the risk of deaths similar to Nevaeh's if follow up by FRN was done for those outside referrals;

- The FRN can provide transportation and other supports for people to access FRN programming. The evidence is not clear about whether that extends to smaller isolated communities outside of bigger centres where the hubs are located.

The FRN services are focused on prevention and early intervention. Some of the programming includes things like monthly peer support group meetings for caregivers, educational programming and the like. Some of that could have benefitted Nevaeh and her family along the way.

However, as I said, Nevaeh and her family were past the prevention and early intervention stage. They were instead dealing with intervention and clinical services, and sometimes crisis management. It may be that the services through the FRN are not geared for that. But the FRN could be a point of contact for a family like Nevaeh's that could lead to referrals out to AHS and other places to get the services they need.

My understanding is that the 136 agencies in the 70 networks making up the FRN, including the hubs, are community agencies that are not staffed by CS employees. I understand CS's role to be helping to set up the networks, and providing funding and other supports to the ongoing services provided by those agencies.

That said, there appears to be a role for CS in ensuring that there is adequate training for people working in the FRN, so that it is meeting the needs CS intends it to meet. CS has provided funding for suicide prevention training for staff in the FRN network. In my view, it would reduce the risk of deaths similar to Nevaeh's if CS took steps to ensure that FRN staff were adequately trained in 1) providing a connection between CS on the one hand, and AHS and other agencies or services dealing with mental health intervention, clinical services and crisis management on the other hand, 2) making warm hand-offs for those referrals, and 3) ensuring follow up with the youth or family about those referrals.

With respect to the training of CS staff, there was evidence that staff in the intervention arm of CS take a training module on youth suicide prevention. It includes the risk factors for youth suicide, and protective factors. The module was refreshed in 2019 to give additional information focusing on indigenous issues. The module has been refreshed to update language. Apart from these changes, the evidence does not show that there has been any thorough substantive review of, nor any such changes to, the youth suicide prevention training for CS staff.

In my view, it could reduce the risk of deaths similar to Nevaeh's if CS reviewed its training on youth suicide prevention for that purpose. This recommendation is not being made because a lack of training of CS staff contributed to Nevaeh's death. The evidence does not show that, especially when so many others reached the same conclusions as CS staff did about Nevaeh's risk for suicide and her safety.

Instead, this recommendation is being made because there was Inquiry evidence that COVID has spawned a good deal of research on suicide and its prevention. That is in addition to the increasing awareness of, and focus on, youth suicide that was developing even before COVID. Suicide prevention training should be in keeping with current research and knowledge. The Inquiry evidence suggests that the training for CS staff in the intervention arm has not been thoroughly reviewed for that purpose recently.

Finally, the 2019 Youth Suicide Action Plan addresses objectives and actions in five areas. The first is in the area of mental health supports and services. A good deal of the Inquiry evidence focused on that area, as does this report, because that was most relevant to Nevaeh's death.

However, the Inquiry also heard evidence on the other four areas of the Youth Suicide Action Plan:

- Training: that evidence informed suicide prevention training be readily available across Alberta for youth, families, front line staff and other people who work with youth;
- Awareness and Education: that social stigma be reduced and mental health well-being be promoted so youth and families are more likely to seek help related to suicide;
- Research Data and Knowledge: that approaches to suicide prevention and mental health well-being be continually improved with research, information sharing, data collection and knowledge mobilization; and
- Reduce Access to Means of Suicide: that youth have less access to common means of suicide.

The evidence is that the benchmarks and timelines for these actions are generally on track, as set out in the Youth Suicide Action Plan.

Other than what has been said so far about training, the evidence in these areas is more tangential to Nevaeh's death. Therefore, I will not detail the evidence about these topics. However, in no way is that meant to minimize the importance of the work in these areas. Having a provincial youth suicide prevention plan is fundamentally important to addressing the issues and challenges surrounding youth mental health and suicide. At a general level, progress on all the actions in the provincial plan could contribute to preventing deaths similar to Nevaeh's. Apart from recommendations in this report about training, there was nothing in the Inquiry evidence to suggest that recommendations were warranted in these other areas.

Summary of Findings

1. Nevaeh Charette committed suicide by sitting on railway tracks until she was hit by a train.

2. The evidence does not show that anything could have been done differently by RCMP or CN to avoid Nevaeh's death in these circumstances. That is because there was so little time between the first report to RCMP of her being on the tracks, and when the train arrived.

3. The RCMP can reduce the time it takes to stop a train by contacting CN's Traffic Control Centre directly, rather than contacting CN police. That could reduce the risk of future deaths in these situations. But this would not have prevented Nevaeh's death, because the time was too short.

4. The evidence does not show that anything could have been done differently by the train crew to avoid Nevaeh's death in these circumstances. By the time the crew of a freight train like this can see a person on the tracks, the distance is too short to stop the train in time.

5. One way to reduce the risk of future deaths in these circumstances is to use technology that allows train crews to see farther ahead so they have time to stop. Such technologies are not currently available, nor are they close to being available. There was insufficient Inquiry evidence on this topic to make specific recommendations.

6. Nevaeh had mental health difficulties and suicide ideation for several years before her death. However, different health care professionals and support workers, in different roles, with different types and levels of training, on different occasions over time, generally concluded that Nevaeh's risk of suicide was low, or at least manageable. In Nevaeh's situation, the evidence did not show that this was due to systemic or institutional failures. Instead, it highlighted the difficulties there sometimes are in trying to predict when a person is actually intending to follow through with plans to take their own life.

7. One of the circumstances facing Nevaeh and her family was that accessing mental health therapeutic and other supports for them was more difficult because they lived in a small, relatively isolated community.

8. Since Nevaeh's death, several community mental health support services in Alberta have been added to what was available to Nevaeh and her family, some due to COVID. Many of those use remote and virtual technology, which has made those services more accessible to people in small or isolated communities.

9. Using technology for these remote or virtual services has several benefits: they increase the support options available, which is more likely to meet the needs of any one particular youth or family; they can remove the barrier of travel; they allow for evolving notions of consent when support services can be provided directly to youth; and they support warm hand-offs for referrals and more wrap around services, both of which promote follow through with referrals and treatment recommendations.

10. Despite these positive developments, Nevaeh's circumstances show that challenges remain. There is no standardized practice for immediate and direct contact with a youth or their family following discharge from an assessment or treatment for mental health issues including suicide risk, to ensure follow up with recommendations and referrals. The availability of mental health professionals in small or isolated communities is not reliable. Not all mental health services involve warm hand-offs and wrap around services. There are parts of the province that do not have high speed internet to access some of the remote or virtual mental health support services.

11. At the time of Nevaeh's death, Children's Services (CS) generally did not provide community mental health support services that involved warm hand-offs and wrap around services. Nevaeh's family had been involved with the intervention arm of CS for years. The role of that arm of CS is limited to its authority under the Alberta *Child, Youth and Family Enhancement Act.* Shortly before her death, CS had determined that Nevaeh was not in need of intervention under that *Act*. After some referrals were made and the file was closed, the intervention arm of CS had no more authority to provide more services or to follow up.

12. After Nevaeh's death, CS started the Family Resource Network (FRN). That program can provide community mental health support services that involve warm hand-offs and wrap around services. The FRN has some important benefits. For families that are in and out of involvement with the intervention arm of CS, it can bridge the gap to continue CS mental health supports and services for youth and their families after the intervention arm of CS has closed their file. Also, the FRN can provide an important connection between CS and therapeutic intervention services provided by Alberta Health Services (AHS).

13. Although the FRN is an important positive development, whether it would prevent deaths similar to Nevaeh's could depend in part on the training provided to CS and FRN front line staff. Training in the areas of making connections with AHS services when needed, using warm hand-offs, and following up with youth and their families about those referrals, are important factors in whether the program prevents similar deaths.

14. The 2019 Youth Suicide Prevention Plan is fundamentally important to addressing youth suicides, including those like Nevaeh's, in the context of a provincial youth suicide prevention strategy.

Recommendations for the prevention of similar deaths

For all of the reasons mentioned, it is recommended that:

1. The RCMP change its procedures so that they connect directly with CN's Traffic Control Centre in these situations. At the end of this Inquiry, counsel for the RCMP advised that the RCMP was already making that change to its procedures.

2. AHS standardize the practice of, and dedicate staff and other resources to, the follow up by direct contact with youth and their families about recommendations and referrals that are made after a person is discharged from an assessment or treatment at a hospital or elsewhere, for mental health issues like suicide risk.

3. AHS consider options for increasing the reliability of health professionals being available to provide in-person mental health clinical and other support services in small or isolated communities when it is needed.

4. AHS continue to develop, implement and evaluate, both during and after the COVID pandemic, the existing new programs giving youth more direct access to mental health support services using warm hand-offs for referrals and more wrap around services.

5. The Alberta government continue to develop and implement policies and programs to increase high speed internet access in small or isolated communities where it is lacking, to facilitate the availability of mental health supports for youth by remote technology.

6. CS ensure that CS front line staff in the intervention arm are well trained in getting youth and their families in need of mental health support services, in contact with the FRN using warm hand-offs.

7. CS ensure that FRN staff are adequately trained in 1) providing a connection between CS on the one hand, and AHS and other agencies or services dealing with mental health intervention, clinical services and crisis management on the other hand, 2) making warm hand-offs for those referrals, and 3) where warm hand-offs are not possible, ensuring follow up with the youth or family about those referrals.

8. CS complete a substantive review of the youth suicide prevention training for CS staff.

I wish to acknowledge the following witnesses who appeared at this Inquiry:

Tracy Duval, RCMP Operational Communication Centre
Amanda Della-Posta, Manager, CN Emergency Communications Centre
Surinder Grewal, Manager, CN Senior Engine Services Officer, Network Operations Western Region

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Melissa Zimmer, Alberta Children's Services
Tristan Robinson, Alberta Children's Services
Coreen Everington, Alberta Health, Addiction and Mental Health
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Cristina Wendel, CN

I thank counsel for their conduct of this Inquiry, and for their invaluable assistance. I also thank the Charette family for their participation in the Inquiry.

It is so hard to imagine what Nevaeh was feeling before she died. It is such a tragedy that her young life ended this way.

DATED January 17, 2022,

at Vegreville, Alberta.

"T.W. Achtymichuk"

T. W. Achtymichuk
A Judge of the Provincial Court of Alberta