ALBERTA

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, Calgary Courts Centre, 601-5th Street S.W.

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

on the 8th day of June, 2017 (year), (and by adjournment

on the 13th day of September, 2017 (year), (and by adjournment

on the 14th day of September, 2017 (year), (and by adjournment

on the 15th day of September, 2017 (year)),

before The Honourable Judge G. Sean Dunnigan, a Provincial Court Judge,

into the death of Aminat Magomadova (D.O.B. 1992/07/20) (Name in Full) 14 (Age)

of 31 Fay Road S.E., Calgary, Alberta (Residence) and the following findings were made:

Date and Time of Death: 26th of February, 2007 at approximately 10:38 a.m.

Place: 31 Fay Road S.E., 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)).

Ligature Strangulation

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)).

Homicide - Aminat Magomadova was strangled by her mother, Aset Magomadova.

Circumstances under which Death occurred:

INTRODUCTION

[1] This Fatality Inquiry could not proceed until Aset Magomadova's criminal charges concluded. This did not occur until the Supreme Court of Canada dismissed the charges on June 11, 2015 following the death of Aset Magomadova in May 2015.

INTERESTED PARTIES

[2] Layla Magomadova, aunt of Aminat and sister to Aset, is a family member/next of kin and therefore an interested party under s. 49(2)(a) of the *Fatality Inquiries Act.* Layla Magomadova, however, did not wish to participate in the inquiry process and did not appear before the inquiry at any time.

[3] Government of Alberta, Children's Services applied for and was granted interested party status pursuant to s. 49(2)(d) of the *Fatality Inquiries Act* as Aminat Mogamodova was a subject of a family enhancement agreement at the time of her death. The Government of Alberta, Children's Services, was represented by counsel Julie Hart.

ISSUES

[4] Pursuant to s. 33(2)(a) of the *Fatality Inquiries Act*, the Fatality Review Board recommended a public inquiry to determine if the death could have been prevented.

[5] This inquiry focused on Children's Services involvement with Aminat and Aset Magomadova and considered the nature and extent of supports, if any, available to the mother and the daughter.

WITNESSES

1. Sheldon Maynes - case work supervisor with the Government of Alberta, Children's Services involved with the deceased in late January, early February 2007

2. Charlene Schmaltz - investigator/assessor for Social Services Response Team (SSRT) of Children's Services

3. Sally Monks - probation officer, City of Calgary Community and Neighborhood Services

4. Ruby Leong-Mueller – Team Leader, Social Service Response Team (SSRT)

5. Jocelyne Anderson – case worker, Children's Services Family Enhancement Unit

6. Marilyn Millions – retired elementary school teacher who assisted the Magomadovas with English as a Second Language (ESL) and other services

7. Fariborz Birjanvian – CEO, Calgary Catholic Immigration Society

8. Richard Lemieux – Manager of Operational Policy and Practice Supports for the Government of Alberta, Children's Protection Services

9. Deborah Baldwin – Associate Director, Calgary Region, Government of Alberta, Children's Services at the relevant time, was Team Leader for the Calgary Central Office

EXHIBITS

Binder Exhibit #1

A. Background

1. Order to a Judge for a Public Fatality inquiry dated January 21, 2009
2. Stay of Public Fatality inquiry dated January 22, 2009
3. R. v. Magomadova 2011 ABCA 147 (Alta C.A.)
4. R. v. Magomadova 2015 ABCA 26 (Alta C.A.)

B. Relevant Medical Examiner's Records

5. Certificate of Medical Examiner
6. Confidential Autopsy Report Form
7. Post Mortem Examination
8. Forensic Laboratory Report
9. PCR #7125106, PCR Continuation and Practicum Patient Care Record
10. Alberta Health Services/Calgary Health Region Records
    a. September 29, 2006
    b. May 17, 2006 - October 18, 2006

C. Relevant Calgary Police Service Records

Relevant Calgary Police Service Records regarding February 26, 2007

11. PIMS Report - #07065150
12. PIMS Report Update
13. Event Chronology
14. Transcript of 911 Call
15. Witness Statement (C.O. L. Furniss)
16. Witness Statement — Kristine Craig (EMS)
17. Witness Statement - Trevor Marquis (EMS)
18. Witness Statement — Aset Magomadova
19. Summary of Interview with Aset Magomadova
20. Transcript of interview with Risvan Magomadova
21. Transcript of interview with Marilyn Millions
22. Review of Telephone Interview with Marilyn Millions
23. Summary of Interview with Stephen Ford
24. Summary of Interview with Dave Stamp and Kathy Mitchell
25. Wood's Homes Youth Shelter Case File Synopsis
26. Transcript of interview with Jocelyne Anderson

Relevant Calgary Police Service Records pre-February 26, 2007

27. Police Report LG05374854 - November 1, 2005
28. Police Report LG07028004 - January 25, 2006
29. Police Report 0637301 - October 4, 2006
30. Police Report 06373304 - October 13, 2006
31. Police Report LG06361128 - October 13, 2006
32. Police Report LG07047046 - February 9, 2007
33. Police Report LG07045780 - February 9, 2007
34. Police Report LG07046939 - February 10, 2007

35. Police Report LG07047558 - February 11, 2007

36. Police Report LG07059909 - February 21, 2007
37. Police Report LG07064260 - February 25, 2007

Binder Exhibit #2

D. Relevant Government of Alberta, Children's Services Records

38. Case Review
39. Relevant portions of the Children's Services records with respect to Aminat Magomadova from May 12, 2004 to February 26, 2007
40. Summary of Relevant Policies in 2007 and 2017
41. Relevant sections of *Enhancement Act* Policy Manual during the period in which Children's Sen/ices was involved with Aminat Magomadova
42. Current relevant sections of *Enhancement Act* Policy Manual - Intervention
43. Youth Pre-Sentence Report – February 26, 2006
44. Relevant records regarding Aminat Magomadova

Exhibit #3

45. Case Review with Youth Pre-Sentence Report

Exhibit #4

44. CCIS Government Assisted Refugees Resettlement Process and Cultural Brokerage Program Flyers

Exhibit #5

45. Draft Special Case Review (AM) Regional Work Plan Report

Exhibit #6

46. Magomadova Special Case Review Work Plan for Recommendations by Children and Youth Services

Exhibit #7

47. Signs of Safety Assessment and Planning Framework Tool (MAP)

Exhibit #8

48. Sample Redacted Safety Plan executed for a different child

Exhibit #9

49. Current Enhancement Plan and Safety Plan Form

Recommendations for the prevention of similar deaths:

See attached Introduction and Overview, Summary of Witness Testimony, and Conclusions and Recommendations.

DATED May 9, 2019,

at Calgary, Alberta.

Original signed

Judge G. Sean Dunnigan
A Judge of the Provincial Court of Alberta

Introduction and Overview

[1] The Magomadova family came to Canada as refugees from war-torn Chechnya, jointly sponsored by the Calgary Catholic Immigration Services and a community church refugee committee from St. James Anglican Church.

[2] The father was killed in the Chechen war in 1994 after being imprisoned. The mother, Aset Magomadova, lost a portion of her foot in a bombing and was similarly imprisoned, for six months, without appropriate medical treatment for her injury.

[3] The children, daughter Aminat Magomadova, born in 1992, and her brother Risvan, born in 1994, were cared for by their maternal grandparents for six months when the mother Aset and her sister Layla were imprisoned by terrorists. It was the family's understanding that they had both been killed.

[4] Once released from prison, the family fled to Azerbaijan and hid in dugout cellars to avoid terrorists. The United Nations provided the Magomadovas with paperwork to apply for refugee status.

[5] Upon arrival in Canada, in 2003, the son was diagnosed with terminal Duchenne's Muscular Dystrophy. Both mother and sister attended to his personal needs, which was difficult for both. Daughter Aminat resented the attention mother Aset paid to her brother Risvan. Aminat had only one year of formal education in Chechnya and, while bright and able to read and write fluently in English, struggled academically as she was placed in classes beyond her competency levels.

[6] Aminat also had difficulty getting along with other children at school and, when bullied, retaliated with a knife. She was given to inappropriate behaviour and service providers described her as a child in constant crisis. Her misbehaviour

escalated upon entering junior high school, including fighting with other students, threatening and assaulting a teacher, damaging property at home, running away, using alcohol and drugs, stealing from the family, and becoming involved sexually with older men.

[7] Mother's limited facility in the English language, her clinging to older cultural ways and expectations of her children, all contributed to tension and distress in the household. Children's Services was obliged to intervene early on due to allegations that the mother was using corporal punishment on the children. The mother, Aset, was taught alternative approaches and Children's Services were satisfied that she very much loved her children and was trying her best to care for them.

[8] Ultimately, Aminat's escalating misbehaviour resulted in criminal charges and discussions with Children's Services and the family regarding possible applications to the court for secure service orders. On February 25th, tension in the household had reached a crisis point and physical altercations occurred between mother and daughter. Ultimately, Aminat was strangled by her mother, who used her Muslim head scarf.

[9] A Public Fatality Inquiry into the death of Aminat was ordered January 21, 2009 but stayed the next day due to Aset being charged with murder.

[10] There followed extensive criminal proceedings, including Appellate intervention and the ordering of a new trial. During the criminal proceedings, Aset was diagnosed with cancer and ultimately passed away before trial and appeals were complete. The Supreme Court of Canada dismissed the criminal charges against Aset Magomadova in 2015 by reason of her demise.

[11] This Public Fatality Inquiry recommenced in September of 2017.

[12] Further details of the events transpiring in the Magomadova household are well-documented in the Youth Pre-Sentence Report prepared in January and February 2007 by Aminat's probation officer Sally Monks, a witness in these proceedings. The Youth Pre-Sentence Report forms part of **Exhibit 3** in these proceedings.

Summary of the Testimony of Sheldon Maynes

[13] In January of 2007 Mr. Maynes was employed as a case work supervisor, having served ten years with Children's Services, primarily in investigative and assessment roles. In his capacity as case work supervisor, he oversaw a team of six or seven investigators, which are now called assessors.

[14] In January 2007, Children's Services through its Social Services Response Team (SSRT), received a call with a concern about the family. This team would then determine if there's a concern related to a child being at risk of abuse or neglect and decide what further steps would be taken.

[15] The SSRT is a central intake line which receives calls from the community regarding children and then does a screening report to be sent to a work site, of which there were eleven or twelve in the Calgary region at the time. SSRT, is located in a central office as opposed to geographical areas of the city.

[16] Each work site manages a certain area or district of the city. Mr. Maynes was in the Bowness office, which is not the Magomadova family area. Once the file is examined, a determination is made whether an investigation should be undertaken. In such instance, the investigator would meet face-to-face with the child, siblings and parents to determine what concerns existed and what supports they may need or already have.

[17] A determination is then made whether to close the file or refer them to supports in the community through the school board or health agencies. If it is determined that Children's Services must get involved to minimize risks or provide supports to a family, a file is opened and legal authorities are notified. It is then possible to enter into a Family Enhancement Agreement to set out a plan on how services will be provided to the family to reduce risk to the child, or matters can proceed to court for court orders. At the most intrusive end, a child may be removed from the home through court order or by agreement.

[18] Once a file is opened, a case worker is assigned the geographic area of the family and they work with a team leader as well as other assessors.

[19] In the Magomadova case, the contact was treated as a "bumped emergency." It came into Bowness but the Magomadova home was not in that area. A transfer process typically is used to move the file into the geographic area of the family.

[20] For reasons unknown to Mr. Maynes, the file in this matter was referred to the Bowness office, not the geographical area of the Magomadova home. This is not the first time the Magomadova family had come to the attention of Children's Services. There were a couple of screenings in prior years, mostly involving Aminat's brother complaining about physical discipline in the home. Both children were apprehended at one time and then a supervision order was put in place. As the family followed the terms of the order, the file was closed in 2004.

[21] In September and October 2006 Children's Services received three different calls, one of which proceeded to investigation. Allegations of physical violence in the home were not substantiated, but concerns about Aminat's mental health existed and Children's Services noted that numerous community and professional supports were involved with the family to assist the mother.

[22] As there was no protection concern for Aminat at the time, Children's Services did not have a role and the file was closed. Once a file is closed, there is no follow-up, whether to ensure that community supports were being followed up on by the mother, or otherwise.

[23] Complaints on October 17, 2006 were raised regarding Aminat making threats to harm or kill one of her teachers at school. This was not regarded as a Children's Services role and the matter was handled through criminal charges and the Calgary Police Service. The decision to close the file was made by the Team Leader who at the time was Deb Baldwin.

[24] A second call in October 2006 regarding Aminat running away from school, resulting in a school lockdown, resulted in a similar conclusion that no application for secure services was necessary.

[25] On January 25, 2007, Aminat alleged her mother, asset Magomadova, struck her with her cane from her wheelchair as they were crossing the road after discussing court charges against Aminat for the threats and assault against the teacher.

[26] Police interviewed Aminat as well as her mother, Aset, but could not substantiate the assault. A mark on Aminat's head was inconsistent with the allegation she advanced against her mother. Aminat was nevertheless taken to a shelter by either CPS or her aunt.

[27] On January 26, SSRT received further information which caused them to open a file and assign it in the regular courts. Normally this would result in a follow-up and face to face meetings with the child and the family but it was deemed non-emergent.

[28] The SSRT team learned that Aminat had not stayed at the shelter the previous night and had taken off with a group of kids. She was reluctant and resistant to return home and the SSRT team regarded this as an emergency matter.

[29] Once again, for reasons unknown to Mr. Maynes, the emergency file did not go to the community where the family resided but came to the Bowness site instead.

[30] An assessor attended at the school to interview personnel after reviewing the history of the file and to interview Aminat and come up with a plan depending on the level of risk.

[31] Aminat was exhausted from the night before and simply denied being involved in sexual activity or drugs, despite Children's Services having information to the contrary.

[32] Aminat talked about a level of conflict in the home and constant arguing and fighting between herself and her mother. She indicated that she did not want to return home.

[33] It was agreed that Aminat would go to the shelter that night. Discussions were had with the mother, Aset, the aunt, Aset's sister Layla, and support worker, Marilyn Millions on January 31. Because of the level of conflict in the home, a Family Enhancement Agreement with the mother was prepared recognizing that the child was at risk and in need of intervention services. A three- month Family Enhancement Agreement was signed setting out specific goals:

1. reduction of parent/youth conflict in the home;
2. assistance for the mother to intervene effectively with Aminat's acting out behaviour, without using corporal/physical punishment;

3. strengthen parenting and coping skills through the provision of in-home support services; and

4. connect Aminat with appropriate community resources.

[34] It became evident that the family was not connecting with services that they required and that had been suggested in September or October. Three to four months went by and they hadn't received any of the recommended services from agencies.

[35] Mr. Maynes does not know the reason why this happened, whether it was by reason of language or other gaps in the process.

[36] It was sensed that the family required support by virtue of the cultural gulf between their language and experience and the society in which they now lived. PTSD from the war in Chechnya was a concern. Ten years ago, however, Child and Family Services did not have cultural brokers who could bridge the cultural gulf. Today the family can be referred directly to a cultural broker to discuss their needs.

[37] The Magomadova family were scored as high risk in terms of safety and family risk. The Family Enhancement Agreement was intended to reduce the risk. In Mr. Mayne's view, by the end of January, it was the investigator's role to get the file ready for transfer and to ensure the Family Enhancement Plan was written up and entered in the system for transfer to an ongoing case worker.

[38] At the time this was being transferred to a case worker, the file became emergent. On January 25th there were accusations about physical discipline in the household. On January 26, Aminat had fled from the shelter and was refusing to go home. On February 6, there were phone calls received from the school that

Aminat had made threats that she would return with a knife and stab her teacher. Aminat's behaviour was escalating.

[39] On February 6, the file was being transferred from the original site in Bowness to the community in which the Magomadovas lived. Unfortunately, there was a clerical error and the incorrect file was sent. This delayed implementation and transfer to the case worker.

[40] On February 9, reports of Aminat destroying property inside her home were received. That very day Child and Family Services identified that an incorrect file had been sent, as a consequence of which the case worker had yet to be assigned to provide the appropriate supports. Mr. Maynes concluded that this matter was urgent and that a case worker needed to be assigned. Typically such a process took several weeks.

[41] The death of Aminat intervened before either the case worker or the supports were in place.

[42] Today, new procedures are in place. When a bumped emergency occurs in a region, the matter is addressed immediately that day and the file proceeds directly to the site where it is supposed to be addressed. Bumped emergencies can now be directed to the appropriate site the very next day for follow up. This was achieved through an improvement in the filing and procedural systems involving family files.

[43] Mr. Maynes testified that, in hindsight, while Aminat did not meet the criteria permitting her to be held in secure services and while the *Act* specifies that the least intrusive services be engaged in supporting a family, it would have been better to ensure that the appropriate connections were made with Mental Health or other programs as had been identified in October.

[44] They had no grounds to remove the child from the home and accordingly matters were to proceed by way of a Family Enhancement Agreement or a Supervision Order. The level of risk sufficient to require removal from the home had not been reached. Further, the family was prepared to proceed by way of the Family Enhancement Agreement, negating the grounds to proceed with the Supervision Order.

[45] Concerns were expressed about the use of corporal punishment in the home and it was intended through the supports under the Family Enhancement Agreement to address those issues. It is intended to have an in-home support worker who could assist mother Asset in connecting with outside agencies to deal with her out of control child and to teach her coping skills to deal with the situation other than by corporal punishment.

[46] Although there was an interruption of involvement due to an administrative glitch in file transfers, it is Mr. Maynes' assessment that, short of apprehending Aminat and placing her in secure custody, for which the criteria were not as yet met, the circumstances that led to her death were not predictable. It is Mr. Maynes' assessment that only complete separation of the mother and child could have prevented the tragedy.

Summary of the Testimony of Charlene Schmoltz

[47] In February 2007, Ms. Schmoltz was an investigator with the Social Services Response Team (SSRT), a screening and after-hours office.

[48] At that time, Ms. Schmoltz handled intake and answering of phones as part of Child Protection. The tasks were to find immediate or short-term solutions to emergent files, rather than carrying a caseload, as might a case worker. Calls were

received from a variety of sources including neighbours, hospitals, police, parents and schools.

[49] With ongoing files, contacts were either handwritten or typed and faxed to the case worker's office in the morning. Originals were sent by inter-office mail.

[50] Ms. Schmoltz's sole involvement on the Aminat Magomadova case was a contact note on February 25, 2007. Calgary Police contacted Ms. Schmoltz advising that Aminat had been picked up and returned to her mother's house but was planning to run away from home again. She was verbally aggressive and rude with her mother. The police wanted to know what else they could do for the girl or her family.

[51] Secure options such as PChIp and Woods Homes were discussed, as Aminat did not meet the criteria for a Form 10 Mental Health Apprehension.

[52] Other options such as Avenue 15 or EXIT which are common places where teens are sheltered, are not locked settings and the children are able to run away if they so choose. Aminat's mother was concerned that they would be ineffective.

[53] The mother was also concerned that Aminat had been hanging around with older boys who might be grooming her for prostitution. The PChIp Program, now called PSECA, addresses concerns about minor children at risk for being lured into prostitution. It was concluded that Aminat did not meet the criteria for secure custody or PChIp, as there was insufficient evidence regarding those risks.

[54] Although verbally aggressive and rude, Aminat was not indicating that she would harm herself or anyone else at the immediate time. She was accordingly also ineligible for a Form 10 apprehension.

[55] Ms. Schmoltz was aware that there was an open file with a Family Enhancement Plan which specified some supports while Children's Services

worked with the family, but it was contemplated the children would remain in the home. She was also aware of the contacts in September and October of 2006 under the old computer system entries, but did not read them at the time. Ms. Schmoltz was similarly unaware that the police had been called to the Magomadova home on February 9 and February 10 as a result of conflict between Aminat and her mother. She was also unaware that Aminat had not been home since February 9, 2007.

[56] Ms. Schmoltz would not speculate whether, with that information, she would have changed her assessment of the situation. Aminat's cultural background and Muslim religious affiliation, although also unknown to Ms. Schmoltz at the time, would not have changed her assessment.

[57] Similarly, absent any evidence that the child was engaged in sexual activity for money, the assessment would not have been changed regarding meeting the criteria for a secure placement. As the information that Aminat was trading sexual favours was third hand, and the *Act* specifies that the least intrusive measures should be implemented, Ms. Schmoltz concluded that this militated against secure custody.

[58] The option of having a one-on-one worker come to the home was discussed with the mother who decided that she preferred to use only family to help her. Aset Magomadova declined a one-on-one in-home worker. Such a worker could be, trained in child care and child management, and could have been in place within thirty minutes.

[59] This would have been useful in order to permit the parent to sleep and the worker to monitor and prevent the child running.

[60] Ms. Schmoltz said it was not possible to over-ride the mother's refusal of the one-on-one worker. It is not a support that can be forced on the family. Aset Magomadova wanted her sister, Layla, a family member, to help with the situation.

[61] In hindsight, Ms. Schmoltz questions whether Aset Magomadova was able to understand the options available to her as a result of the language barrier and her having come from a very different cultural setting. In order to flag the file for a subsequent worker, Ms. Schmoltz stamped it "emergency." This alerts the worker that there are difficulties in the family situation which must be addressed. Typically these notes would be faxed the following morning with the original going by inter-office mail.

[62] Ms. Schmoltz did not have any further involvement with Aminat Magomadova or her family that evening. She heard about Aminat's death on her next shift. Distraught in the witness box, Ms. Schmoltz testified that she has thought about what may have been done differently over and over since the death of Aminat. She had relied on the information of the police officer and the calm conversation between the officer and the mother. She had also relied upon the ability of the sister to be in the home to keep things calm.

[63] Under the new computer system, contact notes could have been reviewed more readily. At the time leading up to Aminat's death, it was not possible to look at the computer to have access to contact notes. In hindsight, Ms. Schmoltz testified that the situation after the Family Enhancement Agreement was signed began escalating. Police had been involved, Aminat had fled her home and access to contact notes from earlier in February would have been helpful.

[64] In addition, the introduction of cultural brokers who can speak the language and address the cultural gulf of families, in Ms. Schmoltz's assessment, are very helpful. This was a resource that was not available at that time.

Summary of the Testimony of Sally Monks

[65] In February 2007, Ms. Monks was the Probation Officer for Aminat Magomadova. Ms. Monks wrote a Pre-Sentence Report on Aminat but the child was waiting to report to her at that time.

[66] Aminat had pled guilty to an assault charge and was awaiting sentencing. In anticipation of the court appearance, Ms.Monks recommended the preparation of a Section 34 Psychological Assessment but Aminat did not show up for the second appointment with the counselor at the Forensic Adolescent Program. No assessment was completed.

[67] In order to prepare the Pre-Sentence Report, Ms. Monks interviewed Aset, the mother, through a family interpreter. She also interviewed a volunteer assistant and Aminat at her home. Ms. Monks was attempting to determine what supports had been put in place after numerous calls to a variety of services including the Catholic Immigrant Aid Society, The Bridges Program and the Victims of Torture Program. Ms. Monks also spoke with Child and Family Services and personnel where Aminat was attending school.

[68] Ms. Monks found Aminat to be friendly, outgoing, and very cooperative in assisting with the preparation of the report. With respect to the assault, Aminat indicated that she had acted impulsively, had been extremely angry and was very remorseful.

[69] In February 2007 there was a lot of tension in the family and a lot of stress. The son had muscular dystrophy and Aminat had begun acting out. Mother Aset had not received counselling for her trauma and resorted to throwing a shoe for discipline. It was Ms. Monks' further impression that Aset was stressed, unhappy

and really worried about Aminat getting in trouble and becoming involved with the wrong people.

[70] The Probation Officer relied upon the interpreter and volunteer, Marilyn Millions, as Aset did not understand English. Ms. Monks agrees that there were cultural issues and barriers at play in the family dynamics. Youth and parents who are immigrants or refugees have a particular need for immigrant support systems particularly if they are dealing with prior trauma from their original countries.

[71] It was also Ms. Monks' further recollection that Aset Magomadova had stopped participating in the Bridges Program and the Victims of Torture Support Service but was still receiving support and services from the St. James Anglican Church through Marilyn Millions.

[72] It was also Ms. Monks' assessment that Aset struggled with discipline in dealing with her children. In 2007, there were fewer programs to assist and guide families. Now there exists a Real Me Program through the Immigrant Aid Society, where a mentor is matched with a youth and they provide wrap-around service including sports, counselling and anything else required. In addition, there is the YARD Program (Youth at Risk for Development) which works with high-risk youth to steer them away from gangs.

[73] Ms. Monks was of the view that Aminat was high risk to become involved in drug society and sexually involved with older males. Ms. Monks completed a Pre-Sentence Report on Aminat for the purpose of a youth sentencing for assault on February 25, 2006. In the report, Ms. Monks reviewed in detail the concerns about Aminat's behaviour and the difficulties in the family home. Ms. Monks arrived at the following conclusion:

> "The writer is extremely concerned regarding the young person's circumstances. It appears that Aminat and her mother not only struggled with a new culture but understanding each other's viewpoints within this new way of life. Aminat has clearly not dealt with all the issues of post-traumatic stress that occurred in Chechnya. It is also the writer's opinion that Aminat is displaying rebellion against the old ways and feeling resentful towards her brother for taking away her mother's attention and support. Aminat too has faced many obstacles with school, her peers, and the community. The writer believes that it is crucial that Intervention Services offer support to Aminat and her family and that treatment be assessed through Probation Services in conjunction with Intervention Services. The writer believes the young person is at risk in the community and if untreated, will likely re-offend."

[74] Ms. Monks concluded her Pre-Sentence Report as follows:

> "In light of the information presented in the above report, the writer respectfully recommends the Forensic Adolescent Program should complete a Section 34. Due to the age of the young person, and her current lack of cooperation with professionals, the writer respectfully recommends the report be completed in custody."

[75] A Section 34 Order is a full mental health assessment to obtain recommendations for treatment in consultation with Probation.

[76] Ms. Monk was concerned that Aminat was staying in shelters and professionals in those locations were advising her that she was at risk with the youth in the facilities and was becoming involved with older men sexually. Ms. Monks also recommended to the family volunteer, Marilyn Millions, that

application be made to the court for a PChAD, compelling Aminat into custody for drug treatment and her protection.

[77] Ultimately, on February 26, 2007, the next court appearance date, neither Aminat nor her mother Asset Magomadova appeared in court. Child and Family Services similarly did not appear and Judge Cook- Stanhope ordered that the parties appear at the next scheduled date. That date was pre-empted by the murder of Aminat by her mother, with the Calgary Police Service finding Aminat's body on February 26, 2007, the day of the scheduled court appearance.

[78] Ms. Monks was upset to learn of Aminat's death. In hindsight, it was Ms. Monks' conclusion that it would be helpful to have assessments for immigrants that come into the country if they'd been through trauma so that they could get PTSD help right away.

Summary of the Testimony of Ruby Leong-Mueller

[79] In February, 2007 Ms. Leong-Mueller was a Team Leader of the Crisis Unit providing 24-hour support. Its acronym is SSRT, the Social Service Response Team. As Team Leader, Ms. Leong-Mueller was responsible for a number of staff and reported to manager Amanda Latiff.

[80] When SSRT receives a call, a file is opened. If it is an emergency situation, the file will be marked as such and faxed over to a case worker for emergency response. A discussion will be had with the front line worker to determine whether or not after-hours employees needed to respond to the situation.

[81] All communications with the case worker are documented in a contact note and sent to the appropriate area of the city.

[82] Charlene Smoltz was one of the workers reporting to Ms. Leong-Mueller. Recommendations for secure services in 2007 would be made by a manager in consultation with the crisis worker and team leader. As only a manager can recommend secure services, there is an expectation that they will be consulted on those decisions.

[83] Ms. Leong-Mueller had no involvement with the file prior to Aminat's death on February 26, 2007. A worker advised her there was a death in the Magomadova home and that there were concerns regarding Aminat's younger brother.

[84] It was Ms. Leong-Mueller's understanding that Charlene Smoltz took an SSRT call on the 25th of February, 2007, but she was neither involved with it nor consulted about it. Ms. Leong-Mueller was further not consulted when a review by Children's Services into the circumstances of Aminat's death was conducted later that year.

[85] Today, crisis workers handle case work differently and the focus is on situational or crisis intervention versus ongoing case work and assessment. Furthermore, the Team Leader ensures that there is coverage if someone is away, particularly with a matter that is to be assigned. Ms. Leong-Mueller was not aware that in February, 2007 Ms. Anderson's case worker was away on vacation for a portion of the month. She similarly had no information on Ms. Anderson consulting with people regarding intervention options available in the absence of the Team Leader for her unit.

[86] Since 2007 there is an updated information system which is very different and allows individuals to enter information directly on the system so current notes and any specific information relevant to the family or child is posted and workers have access to that. The system is used province-wide and every unit has access.

[87] Earlier testimony from Ms. Smoltz in this inquiry indicated that she did not have relevant information available to her when she received the call to the SSRT unit on February 25, 2007. The fact that Aminat had been AWOL since February 9 of that year and that she was due in court the following day, February 26, 2007, were not known to her. Nevertheless, Ms. Smoltz completed a contact note on February 25th, 2007 and stamped it "emergency."

[88] Ms. Leong-Mueller advises that practices have changed, but she is not aware of any recommendations following the case review and has nothing to add with respect to her limited involvement with this case file before Aminat's death. She does not feel she can comment on whatever steps might have been taken or changes made to procedures.

[89] It is however, Ms. Leong-Mueller's assessment that Family Services is much more in tune with the cultural awareness necessity in dealing with families and the trauma that some families experience immigrating to Canada. The service is aware that specific cultural supports can and need to be provided to those families who are struggling. In addition, Ms. Leong-Mueller's assessment that Child and Family Services is aware that it needs to be transparent about concerns regarding families and must work with them to engage their support networks.

Summary of the Testimony of Jocelyne Anderson

[90] Ms. Anderson was a Case Worker with Children's Services in Calgary in February 2007, serving South Calgary.

[91] As a Case Worker she was to meet with families and attempt to work with them and to come up with plans and strategies on solving whatever issues were facing them.

[92] If a file were to be assigned to the South Unit, the Team Leader would talk to Ms. Anderson as the Case Worker. When she began working in February 20th 2007, however, the Team Leader, Heather Percival, was on holidays.

[93] Ms. Anderson holds both a Bachelor of Arts and a Bachelor of Social Work degrees, received training with Children's Services and today performs the role of Assessor. In February of 2007, case workers would meet with the children first before coming up with a plan and then interviewing the family. The current system is, in her view, better. It is a more collaborative approach and the family gets to be part of a plan.

[94] Training, which she engaged in later in February and onward, included modules on Mental Health, Aboriginal Awareness and a variety of topics. Today the training is more involved and includes the use of cultural brokers to address language and cultural issues being experienced by the families.

[95] When Ms. Anderson started on February 20th 2007, she was attempting to contact Aminat with the view to finding a placement for her to go to a different home because of the conflict between her and her mother. To Ms. Anderson's recollection, she had been advised that there had been some violence in the home the previous weekend and Aminat perhaps damaged some of her mother's property.

[96] Ms. Anderson had difficulty locating, Aminat as she was not showing up at Avenue 15, the youth shelter she was supposed to be at.

[97] Discussions were being had regarding a PChAD Order having regard to her possible drug involvement or a PCHP Order due to her involvement in sexual exploitation. Ms. Anderson felt that there were insufficient criteria for a Secure Order.

[98] With respect to the PChad Order, Ms. Anderson was to meet the mother on February 26 at 2:00 pm at the court house for the purpose of applying for both PChad and PCHP Orders. The basis of the application was information received from community members including the school, the family and the shelter.

[99] Ms. Anderson confirmed that the file was a "bumped emergency," meaning it had come from a different area of the city. She was also aware the family had already been the subject of a Family Enhancement Agreement which precluded Children's Services taking custody of Aminat. Ms. Anderson does not recollect the statement in the Safety and Assessment Plan dated January 31, 2007 indicating: significant parent/youth conflicts which escalates to verbal and physical altercations between parent/youth.

[100] In terms of community supports available to the Magomadovas, it was Ms. Anderson's understanding that there was a family friend involved, Marilyn Millions, and that Aminat attended home school and had a Probation Officer as well as a counsellor. Ms. Anderson had just begun working with Children's Services and was attempting to locate Aminat.

[101] Ms. Anderson does not recollect having discussions with any SSRT staff or with the former case worker Paulette Arsenault when she took over the file. Ms. Anderson similarly does not recall having a discussion with Ms. Arsenault regarding her observation in a safety assessment and plan: community mental health/forensic adolescent is required for a youth to stabilize. This family requires in-home support.

[102] The same is true regarding Ms. Arsenault's notations indicating that the risk level for the safety of the child in the home was high. Ms. Anderson cannot recall if she was specifically aware that the family had a high risk level when she was assigned to the file. She was aware, however, that Aminat was not in the home and

had been staying at the shelter as part of the safety plan. The same is true regarding the notation of “conditionally safe” and whether that referred to the child being in a shelter as opposed to the home.

[103] Lastly, Ms. Anderson does not recall whether she saw the Safety and Assessment Plan dated September 22, 2006 completed by Fiona Wilson. Her main focus was on locating Aminat. She was ultimately successful in meeting with Aminat, despite reluctance on the part of the child. Aminat was largely unresponsive, simply indicating that her mother was crazy.

[104] No face-to-face meeting was had with the mother as Aset’s skills in English were very limited. Most contact occurred through the community member Marilyn Millions.

[105] Between February 20th and February 26, Ms. Anderson had discussions with Team Leader Middle Melanie Carefoot about PChad and PCHP Orders as well as a potential Secure Order but no updated safety assessment was done for the Magomadova family.

[106] Efforts were made to meet with family but Aminat up and left the meeting, leaving Ms. Anderson to have any consultations only with her mother. A Secure Order was not available as Aminat was neither suicidal nor intending to harm herself. There was limited information on her use of drugs as might permit a PChAD Order but she had talked about using Ecstasy.

[107] The intention was to make court application for both orders on the 26th of February 2007, as Aminat had run off to High River and was unable to get a ride back to town to reside in the shelter. She didn’t come back from High River and Ms. Anderson was attempting to locate her once again.

[108] Ms. Anderson does not recollect getting an alert from SSRT on February 25th late in the evening or the morning of February 26th regarding Aminat. The notes contain an entry on February 26 indicating "police returned Aminat last night to home."

[109] The notes indicate that the mother was going to court on February 26 to get a PChAD Order. Ms. Anderson somehow is not aware why the application was to be made on the 26th when the decision to pursue a PChAD Order was made on February 23rd. This was something to be handled by the mother.

[110] Today, Children's Services is more involved in supporting the parents in the court process. Further, alerts from SSRT today come as contact notes provided directly to the case worker, as well as by e-mail. In addition, the information is entered into the system and available to all. In February 2007, alerts would sit at the front administration for periods of a time.

[111] A placement was ultimately found for Aminat on February 26 in Edmonton. Had the applications for PChAD and PCHP proceeded, this secure facility for youths would have been available for Aminat.

[112] In Ms. Anderson's last contact with the family on February 26, Aminat had called and left voice mail messages and when she returned their call they answered and stated that Aminat does not want to go to court. Aminat could be heard screaming and crying in the background. Ms. Anderson called a second time, Aminat answered and advised they had taken all her property and her lipstick and would not allow her to use the phone.

[113] Aminat said she didn't want to stay at her mother's or her aunt's and that her aunt and her mom are yelling at her again over past events, calling her garbage and punching the table.

[114] The worker suggested Aminat stay in her room until court. Aminat repeated that she did not want to go to court and then asked what would happen if she did not. She was advised that she could be held for evaluation.

[115] Nevertheless, Ms. Anderson was not concerned for Aminat's safety. And then she learned about Aminat's death about two to three hours later.

[116] Following the case review which took place in August of 2007, Children's Services implemented a number of changes at the front end of cases so that consultations occur prior to anyone even receiving the file.

[117] Now there are people from the community in attendance and mental health and other professionals to advise and give resources. The case worker participates and then the information is brought to the family and a map is created. As Ms. Anderson had not been on the file long enough, no concrete plans to assist the child or the family had been put in place.

[118] The other significant change is the addition of cultural brokers who speak the same language, have the same historical background and connect with the families.

[119] Given the short time she was on the file, Ms. Anderson is not able to say in hindsight what might have been done to prevent the death of Aminat Magomadova. Ms. Anderson was trying to locate her and to come up with a plan and a lot was happening quickly.

[120] The only other suggestion Ms. Anderson proposed in hindsight was possibly arranging with Marilyn Millions that she contact the family immediately. In follow-up examination, Ms. Anderson described in greater detail the changes in approach since 2007. The process now is more transparent and the family mapping process is more collaborative. Documentation is better than it used to be

and the biggest difference is that all involved people are at the table, including workers, support and resource people and the family, as well as any children.

[121] The family map that is now developed lists the strengths, any harms or danger present, complicating factors such as culture: past history or exposure, safety goals and concrete safety steps to be taken in the event of difficulty.

[122] Furthermore, a worker cannot meet with a family alone. They must adopt a team approach.

[123] Lastly, the information system now in place allows workers to input special cautions so they show up as a flag on the file of the family or child.

Summary of the Testimony of Marilyn Millions

[124] Ms. Millions is a retired elementary teacher who first met the Magomadovas in September, 2003 when she served on the Refugee Committee at her church.

[125] Ms. Millions was asked to help Aset Magomadova with English as they couldn't as yet get her into a class. The Committee also supported refugees financially by sponsoring them for one year and helping them settle down, find housing, arrange doctors and assist them with gaining access to school. A math teacher was also tutoring Aminat in mathematics.

[126] Ms. Millions noted early on that Aminat had deep fears from her time in Chechnya, was afraid of the dark and had trouble relating to other children and people. She was enthusiastic and embraced her new life which included dolls and playgrounds and hiking, experiences she had never heretofore enjoyed.

[127] Aminat was 11 years old when she arrived, but had about a Grade 1 equivalent education.

[128] Ms. Millions felt that Aset Magomadova really cared about her kids. She had come from a horrible situation and had health issues. In addition, her son, Risvan was very handicapped. They found out that he had Duchenne Muscular Dystrophy and that it was terminal. She was told that he would probably live to eighteen years old, if he were lucky. Over time, Ms. Millions saw Risvan's condition deteriorate.

[129] By 2007, Aset's language skills had come along a bit thanks to the school she had gone to for a while. However, because her son required so much care, she couldn't be at school and it became too much for her.

[130] Ms. Millions attended every doctor's appointment with Risvan and Aset. Despite the mother's limited understanding of the language, she was on the whole eager to learn and grateful that she had been able to come to Canada to get her son medical attention. However, Aset clung to many of the old ways and had difficulty integrating into Canadian society.

[131] For example, Aset didn't feel that Aminat should wear pants to school because of their Muslim faith.

[132] As her son was severely handicapped a lot of issues arose in the household and he required a great deal of attention. Aminat was also expected to do quite a few things around the house to help out and to get things for Risvan.

[133] It is Ms. Millions' recollection that the family was receiving some counselling at Calgary Catholic Immigration Services. Further, Aminat went to Connaught School along with a lot of other immigrant children. For his part, Ms. Millions believes Risvan likely received help through the Children's Hospital.

[134] Ms. Millions, however, does not recall Aminat receiving any type of counselling for trauma survival. Ms. Millions would take Aminat to the library

every Sunday to choose books and to chat about how to get along with other kids, about politeness and manners and what was expected of her in Canada.

[135] She also took her to sporting activities and other adventures.

[136] Unfortunately, Aminat underwent a rapid change when she started to attend junior high school in Grade 7. Her behaviour, her attitude and her entire demeanour just "flipped." It was Ms. Millions' sense that she wasn't ready for junior high school. Aminat was reading at a Grade 1 level and that was untenable.

[137] Aminat started to deteriorate and Ms. Millions had a talk with the principal who advised her that she behaves like a wild animal in the school. Ms. Millions enquired whether there was any PTSD counselling in the School Board and was advised that there was none. It was clear to Ms. Millions that Aminat required very specialized counselling. From that time on she became a loner, save for meeting up with kids on the fringe who would advise her what her rights were at her age and encourage her to act out.

[138] With Aminat's attitude changes, Ms. Millions became fearful of her as time went on. Aminat would steal from Ms. Millions, leading her to be careful with her belongings and anything she had in the car.

[139] Aminat's behaviour escalated from age 12 onward. She then started having to change schools about every six weeks. Aminat would regularly come to her and say she couldn't cope. She was unable to learn Algebra with a Grade 1 or 2 math competency.

[140] From time to time Ms. Millions would ask for translators to assist, but often they did not have any either at the School Board, the hospital or anywhere else. Ms. Millions would rely on students who spoke Russian to assist.

[141] Ms. Millions recalls the Magomadovas initial involvement with Children's Services in 2006, which she feels arose from a misunderstanding. The children were returned to the family the next day but this was a real blow to Aset and her sister Layla.

[142] Children's Services was suggesting that Aset and Layla were being abusive to the children, but it was Ms. Millions sense that a new social worker assigned to the job had over-reacted and all of this could have been discussed without taking the children out of the home.

[143] It is Ms. Millions' impression that the language barrier played a role in this interaction as a translator was not available.

[144] Ms. Millions also felt that there was a lot of changeover in social workers. She does not recall Children's Services providing any in-home support to the family after the initial removal and return of the children. She also does not recall any supports for parenting skills in Canadian culture provided to Aset by Children's Services.

[145] It is Ms. Millions' sense that Aset would've benefitted from parenting skill assistance, if they had brought the training down to her level. Ms. Millions was unaware of the existence of a Supervision Order, of any direction for in-home supports or of any improvement in the family dynamic as a consequence.

[146] Aminat continued to have educational and behavioural difficulties, bouncing from school to school and ultimately to Hull Home. She was stealing from other kids, not getting along with them, engaging in fights at lunch hours and generally not getting along,

[147] Ms. Millions became concerned about Aminat's safety in 2006 when she wouldn't return home to Aset's house. The police called Ms. Millions saying they didn't know what to do with her but suggested that she go to Exit in the Beltline.

[148] Exit is a safe place for overnight stays. Aset was not keen on this arrangement but Ms. Millions calmed her down by saying that Aminat will be safer there. At 6 am the next day, Exit called to say that Aminat had gone off to a party with a twenty-one year old and advised that the shelter does not enforce a curfew and Aminat is free to come and go as she wishes. Aminat went to a pad in Motel Village, which was the start of downward spiral into drugs and prostitution.

[149] Upon learning of this, Aset was heartbroken.

[150] Aminat was by now fully out of control and was scaring everyone. Ms. Millions learned that she had drug paraphernalia in her backpack, and would appear very glassy-eyed when she came home. Ms. Millions had been told that when the police had picked her up in a pad she was naked so they referred to it as prostitution.

[151] Ms. Millions also says there wasn't good communication. She states that they were going to probation officers, to social workers, to the school and to the police. Ms. Millions would ask what was going on in behalf of Aset. The probation officer said that they don't communicate with the police or the social worker and ultimately Ms. Millions had to become the go-between. She had to deal with a number of social workers. One that she recalls from Eastern Canada with this file being her first experience in Alberta, Ms. Millions recalls was a disaster.

[152] Hull Home phoned and were upset that Aminat had gone missing a couple of times, had come back to school obviously on drugs, and were hoping something

could be done. They advised that the social worker arrived but all she would do was write down assessment notes and ask Aminat questions about what she wanted to do with her life.

[153] Hull Homes felt that Aminat needed immediate help with her problems, not any further assessment.

[154] Another time when Aminat went missing, Ms. Millions got a call from a social worker who wanted her to drive to High River as Aminat had been picked up by the RCMP with her boyfriend. Ms. Millions refused to do it as it wasn't a safe situation at all. Ms. Millions tried to explain this but felt she wasn't getting anywhere.

[155] Meanwhile Aminat was rampaging at home and behaving in a wild manner. However, Ms. Millions was not concerned about Aminat's safety while she was in Aset's care. In her view, Aset was not that type of person. As Aminat's coping skills became worse into 2007, Ms. Millions attempted to get counselling services through the school. In fact, Aset had given Ms. Millions permission to go before a judge and get Aminat placed in an AADAC Program for two weeks. This was a residential program that would get her some help. Ultimately it proved to be too late, as she died that morning.

[156] Ms. Millions recalls that Children's Services did not contact very often to discuss plans for dealing with Aminat's behavior or addressing parent-youth conflict. From time to time they would call Ms. Millions to find out what was going on or to ask her to pick up a family member.

[157] Ms. Millions recollects taking Aminat to a mental health appointment at the Foothills Hospital for assessment and that Children's Services expected Aset to continue to use community supports on her own. Ms. Millions tried to help her out

but each time they attempted to do something it didn't work out. On one occasion, Aminat was acting out at school and ended up in the psychiatric emergency ward of the Foothills Hospital.

[158] Ms. Millions rushed to the hospital only to be told that they were simply going to release Aminat. Ms. Millions argued that she needed to be helped in a hospital setting. The hospital did nothing and simply released her. Aminat attended a psychiatric assessment with Dr. Hosain who recommended that they contact with Hull Home in regard to crisis management. Dr. Hosain also recommended that Aminat take Risperdal but she refused to do so or hid it in her pockets. Aset also tried to convince her to take the medication but she refused (**page 722, Tab 39 Binder Exhibit #2**). Ms. Millions does not believe anything came out of the recommendation. Ms. Millions also doesn't believe that Aminat or Aset were accessing community supports in late 2006 or early 2007.

[159] Hull Home School had recommended that Aminat have residential treatment but Aset wasn't agreeable because she wanted her daughter at home. Aset stated "she's my daughter, and I love her, and she should be with me."

[160] While Ms. Millions did not entirely agree, it was very difficult to say to Aset that she was absolutely wrong. In hindsight, Ms. Millions feels that it was too late for Aminat and that residential treatment at Hull School would have been similarly fruitless. Aminat was totally out of control. She had her so-called friends and they were on the streets of Calgary.

[161] The night before Aminat died on February 26, 2007, Marilyn Millions had spoken to the family to enquire on their well-being. She understood that Aminat had been on a rampage and broken windows. Ms. Millions was concerned that Aminat was in the house in breach of a court order but the police had delivered her there. She was scheduled to go to court the next afternoon because of an assault

charge against a teacher and the family was trying to get her something to wear because Aminat had sold her clothes or traded them off.

[162] On February 26, around noon, Aset's sister Layla called and said Ms. Millions should not go to the meeting in the afternoon at court. When Ms. Millions questioned why, Layla simply said don't go. Later in the day, when Aminat was released from police headquarters, Layla telephoned Ms. Millions and told her what had happened.

[163] Ms. Millions was shocked and upset. With the benefit of hindsight, Ms. Millions believes that there was not enough attention paid on a number of issues including the unique family situation, the PTSD suffered by each member, the fact that they were high risk refugees because of health issues, and the fact that no one really understood the challenges of the family. Ms. Millions is of the view that the Magomadovas were allowed to fall through the cracks with the band-aid solutions that never addressed their real needs.

[164] Ms. Millions identified a number of things which might have been done:

1. The education system should not move a child on into junior high when their literacy levels are so low and they are lacking in knowledge and maturity.
2. Aminat wanted to stay at Connaught School and even travelled back to it, until she was banned from attending the property. She should have been allowed to stay at Connaught for another year and get some English training.
3. It was also unfortunate that Aminat was told very early on that children in Canada have a voice and, if your mother smacks you, you can have Social Services at your door.

4. Aminat felt she could do what she wanted, as she had been told that by her peers. It is a difficult concept for people from another culture to understand. Refugees then become afraid of our system because the kids can be taken away, as they initially were in this case. That is very traumatic when you come from a police state.
5. More translators on the ground are needed.
6. Communication was a big problem. The left hand didn't know what the right hand was doing. Ms. Millions felt really inadequate in what she was doing, but nobody else knew what was going on at all. It was a very unnerving situation, in her view, and she hopes that the different disciplines can get together. Whatever held them apart, they simply didn't discuss the child together and come up with improvements.

Summary of the Testimony of Fariborz Birjanvian

[165] Mr. Birjanvian works for Calgary Catholic Immigration Society and is the CEO. The organization has been in business providing services for immigrants and refugees for forty years.

[166] CCIS assists 10,000 to 12,000 people on an annual basis with some 1,200 to 1,600 new refugees arriving in Calgary every year. They also have return clients so there are about 3,000 to 4,000 people who are described as refugees.

[167] Refugees come from a lot of countries including Syria, Iraq, South Sudan, Afghanistan and Somalia. In the past, when conflict affected the Balkans, they received a lot of former Yugoslavian, Kosovars and many people from Chechnya.

[168] CCIS has about 300 paid staff and around 1,600 volunteers. The organization is funded through all three levels of government, through foundations, donations and fee for services.

[169] Mr. Birjanvian has been the CEO for the past 24 years.

[170] About 50,000 newcomers come to Alberta, in different locations, and there are about 23 organizations to help immigrant refugees in Calgary. The most prominent among these are Immigrant Women's Association, Calgary Immigrant Services, the Mennonite Centre for Newcomers, The Breeze Foundation and the Calgary Immigrant Education society.

[171] Each of these primary six settlement agencies existed between 2003 and 2007 and each does different things intended to complement each other in assisting the three streams of refugees coming to Calgary. The first stream is government-sponsored refugees, based on annual federal targets in partnership with the United Nations High Commissioner for Refugees. Those numbers total about 10,000 nationally per year. Out of those, about 1,000 come to Alberta and 350 to 450 to Calgary.

[172] The second stream is through community sponsorship programs in concert with the government of Canada. Most of these are ethnic and faith-based organizations who wish to sponsor refugees. The total in Canada is about 6,000 with about 400 to 500 coming to Calgary sponsored by the community organizations.

[173] The third stream is a group called refugee claimants or asylum seekers and this involves individuals who find their way to Canada, typically through international smuggling, and, once here, claim to be a refugee claimant. The process for them is different.

[174] The Magomadovas were refugees to Canada who came to CCIS in September 2003, two days after they arrived in the country. They were government-sponsored refugees and participated in the Joint Assistance Program, where a church group from St. James Anglican
Church also volunteered to support the family.

[175] The Joint Assistance Program (JAS) is designed for higher need refugees such as those who have suffered trauma such as torture or had individuals in their family killed or imprisoned. These individuals have much greater needs than the other refugees.

[176] Refugees such as the Magomadovas are picked up at the airport with a representative from the community sponsor group and transferred to the CCIS reception house. Refugees sponsored by the government of Canada remain there until housing is arranged for them in about three weeks. For refugees sponsored by the community, accommodation has already been established before the people arrive.

[177] The path the Magomadova family took through CCIS is detailed in Exhibit 4 and includes airport reception, temporary accommodation, resettlement assistance program services, integrated services and referrals both internal and external.

[178] The goal is to assist refugees, as much as possible, with becoming acclimatized to the new country. They are escorted to set up bank accounts, taught about 911, taught how to use transportation, how to deal with neighbors, how to access the school and how to go shopping. CCIS assigns a counselor to them over the three-week period which gives them the basics for when they move in to the community. After that, a volunteer is assigned to connect with the family and the school, arrange English as a Second Language classes, to do whatever the family requires.

[179] Those needs are identified through an assessment process, and follow-up contacts are made to ensure that they are settling in at school or with employment. As government sponsored refugees, financial assistance is provided to them for up to one year and they are visited at the 10-month stage to see if they are self-sufficient. In cases where children are involved, such as the Magomadovas, Child and Family Services are not involved unless they are contacted by CCIS, if there's a concern for the well-being of the children.

[180] Children are now followed until the 2-year point, a program that did not exist back in 2007. If there are incidents of family violence, CCIS attempts to educate the family and remind them of the cultural expectations in their new country. Another current program is the Support for Survivor of Tortures that deals with refugees who have suffered trauma. CCIS has limited resources but partners with Calgary counselling organizations to ensure the families receive psychological counselling.

[181] It is Mr. Barjanvian's view that the support system built in Canada does one of the better jobs in settling refugees when compared to the rest of the world. The initial services and the assurances of the community connection help them realize that they are in a safe place and needn't worry about the issues they faced in their original homeland.

[182] Some families, however, have suffered extreme trauma, including rape and torture, and require additional support and professional intervention. Refugee children face specific challenges, including their having missed many years of schooling. They struggle to catch up. The younger the children, however, the faster they learn. Children under the age of 10 have a much better chance to adapt and absorb English as a Second Language (ESL) classes.

[183] Teenagers face different challenges and can experience greater anxiety due to an inability to speak English. Often, though, children pick up language much more quickly, so the parents rely upon them to do shopping, translation, answering the phone. This reliance affects the family dynamic.

[184] For children between the ages of 16 and 20, the greatest challenge is staying in school, as many do not finish high school and drop out. Programs are much better developed today and include an organization called the Bridge Foundation that has settlement workers in schools providing services to the children. These programs did not exist in 2006 and 2007.

[185] Another program, the Refugee Child Enhancement Integration Program, was established in 2011 and includes staff members who work with the school closely to monitor the children to ensure their nutrition, their health, their community support and their academic progress. These programs similarly did not exist in 2006 and 2007.

[186] The same is true of parenting programs available through CCIS and associated organizations. Families are encouraged to gain an access to broader community services including the Calgary Refugee Health Clinic. CCIS adopts a wrap-around approach to ensure that those who are not yet self-sufficient are fully supported.

[187] Another program that began three years ago (2014) was the Cultural Brokerage Program. Details are also set forth in Exhibit 4.

[188] Mr. Birjanvian explained that immigrants go through enormous challenges in coming to Canada. Many immigrants can also lose their job and these are not able to provide for their family. This creates anxiety in the household and many kids who are being taken away from families by Social Services is a result of

household friction. It was felt that Social Services would need to be more sensitive and prepared to deal with the issue culturally, not just as a punishment process.

[189] A staff member of CCIS is now embedded in each of the eleven Family and Children's Services offices in Calgary. They are trained social workers who speak the language, have community connections, understand the culture of the individual family, and are embedded in the response team.

[190] Issues can be culturally very sensitive and if problems arise, these individuals do an assessment to determine if there are employment, addiction, family violence, neglect or other issues.

[191] As a result, there has been a drastic reduction in the number of children taken away by Family and Children's Services. In Mr. Birjanvian's view, this should have been done 25 years ago.

[192] Mr. Birjanvian recollects the Magomadovas specifically. The family was getting a lot of support because they were from Chechnya and had no male member in the household. The mother had some of her own disabilities and they were being supported by a church group. The burden to deal with family issues fell on the shoulders of the mother Aset Magomadova. Mr. Birjanvian does not believe that they suffered from a lack of support. He feels that no one caught what was going wrong until it was too late.

[193] Mr. Birjanvian is of the view that back in 2006-2007 there was a lack of good psychological assessment of refugees. So many of these people have gone through high levels of trauma and he feels there are not enough resources to do psychological assessments and crisis counseling, even to this day. He would recommend that a psychological assessment of the mother and the children be done in each case.

[194] In the case of Aset Magomadova, Mr. Birjanvian states that she was very worried about the well-being of her daughter and concerned because Aminat was not listening to her. Aset felt she was failing as a mother to protect her daughter and was fearful that the child would not do well as a young woman.

[195] CCIS did not do an internal review over policy and practices following Aminat's death. They did, however, approach the government to say that for high need children, with parents are not really capable, something must be done for at least a couple of years to look after the children.

[196] As a result, programs had been strengthened and expanded to provide additional support. In thirty years with the agency, Mr. Birjanvian reports that there has only been two suicides and these involved adults, not children.

[197] When asked, with the benefit of hindsight, whether anything could have been done, it is Mr. Birjanvian's view that more resources are needed for refugees. Currently they receive $1,300 to $1,400 which is insufficient to survive in Calgary.

[198] The federal government provides the first year assistance with the people, but no more, as they do not feel they should be paying refugees more than Canadians on social assistance.

[199] Mr. Birjanvian also recommends better access to mental health. If you are bringing people from war-torn countries, they need crisis counseling. Counselors should be available before bringing the family in. It is not a systematic process at present and CCIS must fight with the government to obtain those resources.

Summary of the Testimony of Richard Lemieux

[200] Richard Lemieux is the Manager of Operational and Practice Supports for Child Intervention. He has held the position of manager for 18 months and was a

Policy Analyst in the same area for approximately 3 years. Mr. Lemieux reports to Kimberly Spicer, the Senior Manager of Policy Program and Practice Development.

[201] Mr. Lemieux's role is the development, updating, refining and processing of all intervention policy for the province in child protection.

[202] Prior to becoming a Policy Analyst, Mr. Lemieux was Supervisor of Child Intervention Assessment and Investigations for three years and had been employed as an investigator in Child Protection for three years prior to that.

[203] Mr. Lemieux is not aware of any case practice changes that happened with respect to Aminat Magomadova's file and is not familiar with the findings and recommendations of the case review performed by Children's Services in response to that death.

[204] However, significant policy changes had been implemented since 2007. (Pertinent policies which were in place in 2007 are contained at **Tab 41 in Binder Exhibit #2**. Updated policies in place since 2017 are set forth at the next **Tab 42 in Exhibit 2**).

[205] Mr. Lemieux outlined the significant policy changes between 2007 and 2017 as follows:

1. In 2007, the practice and policy was heavily influenced by the previous *Child Welfare Act.* There was a requirement for investigation with three days of intake, where the worker would review the information that had come to them and determine if it fits the criteria under the *Act* for intervention services. There followed nine days of investigation, at which point the investigator would attempt to determine if a file should

be opened and what kind of services would be required to ensure the safety and well-being of the child or children.

2. Beginning in 2008, the case work practice model shifted to align with the *Child, Youth, Family Enhancement Act* that came into force in 2004. The alignment increased assessment time with families, with intake going from three days to five days and the investigation assessment phase from nine days to forty days.

3. There was a significant shift in both the time to determine what was happening and in the focus, which moved more toward assessment, collaboration and engagement with the families. The new system allowed workers a better opportunity to develop a safety plan.

4. In 2017, there is now a trauma-informed practice to get a better sense of how trauma impacts children and families.

5. Further, cultural connections, reliance on significant persons in the families' lives, such as teachers or neighbors, has led to a more holistic approach to how families are supported. Efforts are ongoing regarding a focus on cultural connections to ensure that children don't feel they are cut off or disconnected from family, friends and the community. Those connections are important to considerations involving safety.

[206] The legislation still makes it clear that if a child is in need of intervention and their safety cannot be planned for, they can be removed from the home. However, cultural connections are emphasized in planning the day-to-day life of the child.

[207] Connecting families to community resources, such as multi-cultural health broker centers, outreach centers or other cultural services in the community religious or otherwise, is looked at.

[208] While front line workers are not in a position to offer mental health services, not being experts, they are able to connect the family with counseling, therapy and Alberta Health Services for mental health issues.

[209] The process continues to evolve but now there is a more concerted effort to develop service teams that can provide wrap-around services for families. In 2007, it wasn't possible to connect families with other service providers and community supports. Today it is an expectation that service providers and case workers collaborate to provide the very best service for families.

[210] Service team meetings, which can be called by any service provider, whether government or private sector, are mandatory on every file. They are sometimes called family meetings or family group conferences.

[211] These meetings must occur at least every three months or in shorter time frames as necessary.

[212] As for file transfers within offices, those procedures are governed by the regional offices. Mr. Lemieux is not familiar with any specific changes made since 2007.

[213] Significant changes, however, have occurred with respect to consultation between team leaders and case workers. Case workers consult supervisors and as appropriate, office managers. Practice procedures continue to evolve but have been improved since 2007. Since 2010, a decision is made at the point of intake to determine if the file meets the requirement of intervention under the Act. If so, consultation with a supervisor is mandatory. There then follows a ten-day safety

phase assessment and a mandatory decision point for the determination of whether the situation is safe or unsafe for the child. A further decision point occurs at the end of the safety phase at forty days.

[214] At that point a decision to open or close a file is made. In addition, before closing a file today, it is determined whether supports for the family are required. Furthermore, a case work practice model was developed and implemented by 2010 across the province. Each case worker receives training with respect to the case work practice model.

[215] In addition, case workers receive delegation training which identifies how they are to do their work such as intake, assessments, court work, evidence collection, service to families and court filings.

[216] Without this formal training, files cannot be delegated to a case worker and they must work in concert with another delegated worker. Only delegated workers can apprehend children. This is the same policy that was in place in 2007.

[217] The assignment of new case workers to files is now within the supervisor's role. They determine the skill sets of workers and allocate the files as they see fit.

[218] Further, there is now a keener focus when working with youth facing homelessness, out of control behaviours, chronic drug use, criminal behaviour and the challenges of high risk where guardians are no longer involved. These programs were not fully developed in 2007.

[219] As for the case worker in this matter, who was undelegated and who was on her first day on the job in receiving the Magomadova file, the expectation today would be that the supervisor would consult with the individual worker and a senior staff member would assist in making delegated decisions in order that the new staff member has an understanding of what circumstances are before them.

[220] As for PSECA, the current name for PChAD orders, the expectations and procedures remain largely the same to extricate children from situations putting them at risk for prostitution.

[221] Under the old PChAD system, for a worker to access services, the Director would have to be the guardian of the child. Otherwise, it would be necessary to work with the child's guardian in order to access PChAD services. In the case of Magomadova, the mother, Aset Magomadova, would have had to make the application under PChAD.

[222] As for communication between crisis units and regular case worker units, there has been a change in practice regarding emergency contact notes. Updated IT tools allow immediate transfer of information. Once contact notes are entered into the current IT system, they are available across the province for emergency after-hours workers who have the capability of going into the system. In 2007, the old system was much more limited than it is today.

[223] Also, decisions are now made by the intake worker and can take five forms:

1. The file could be closed at intake with a referral for community services.
2. A common response can involve an assessor having five days to see the family and determine what's happening.
3. If the facts necessitate a one day response, the assessor has twenty four hours to go and see the family.
4. Facts dictating an urgent response means the assessor drops everything and heads out immediately.

[224] While the practice was the same in 2007, there's a greater level of deliberation in deciding whether there is an imminent risk to the child. If there is no imminent risk, the workers can continue with their assessment to make a

decision at the end of the 40 days. However, they need not wait the full 40 days if they determine the child is at risk imminently. Assessor's work for the first 40 days to determine the presence of imminent risk. Thereafter, a case worker takes over to work with the family. A transfer case conference is held between the assessor and the incoming case worker and any of the service providers which have been attached to the family by the assessor to transition the file.

[225] Transfer case conferences occurred as well in 2007. In response to the facts of this case being put to him, Mr. Lemieux said that he does not see any other relevant policies or policy changes which may have been put in place to prevent a situation like this happening again, other than as mentioned in this testimony.

[226] With respect to the transfer of file between offices to a new case worker who is undelegated and whose direct team lead is on holidays, strategies must be developed internally in the office to support those workers. Training and delegation of workers takes time and these issues will remain continuing challenges.

[227] In Mr. Lemieux's view, the initiatives such as Signs of Safety, Our Lifelong Connections, the new trauma-informed practice and the case work practice model all support families in a more effective way than in 2007.

Summary of the Testimony of Deborah Baldwin

[228] Ms. Baldwin started in May of 1998 as a front line case worker with Native Services Office, where she spent the next 7 years in a variety of positions.

[229] She then became a Team Leader at the Calgary Central Office in 2005. This was a small office with a team of two investigators. She fulfilled that role for two and a half years and then became a Contract Manager at the team leader level for a

further 3 years, overseeing contracted resources to confirm they were getting the outcomes sought for children and families.

[230] She then became Assistant Manager at the After Hours Crisis Unit, in those days known as the Social Service Response Team (SSRT). She continued in that role for 3 further years and then became a manager. For the past 3 years she has been Associate Director of the Calgary region, overseeing 2 child intervention sites in Forest Lawn and Strathmore as well as outcome-based service delivery and contract resources. In September and October of 2006, Ms. Baldwin was a team leader in the Calgary Central Office. She was and is familiar with the Aminat Magomadova matter.

[231] In September, 2006, an investigation was undertaken by Children's Services. Fiona Wilson was the investigator and Maggie Surpa (phonetic) covered Ms. Baldwin's team leader role, as she was away. On September 21, 2006, the officers received a referral expressing serious concerns regarding Aminat's behaviour at school. People at the school were feeling fearful for their safety. Fiona Wilson, normally an assessor, was moved into investigation to look into the matter.

[232] Meetings with Aminat and her mother were held as well as with Aunt Layla. Collateral calls were made to school officials and other people who had contact with the family. There was an allegation of physical violence in the home but it was not substantiated during the assessment. There remained significant concerns about Aminat's mental health.

[233] Mother Aset Magomadova was cooperative throughout but seemed quite overwhelmed as she had a significantly disabled son she was also caring for. As the initial allegation had been unsubstantiated, the file was closed on October 3, 2006. Although the office was aware that the family had contact with CCIS and that Ms. Marilyn Millions, was acting as a liaison and with Access Mental Health,

they did not know the extent to which the family was getting services from each. There was no further follow-up once the file was closed to make sure that community supports were being accessed by the family. The family was told that if there were further concerns, they would call back with a new referral.

[234] On October 17, 2006, another screening originated from the SSRT. Once again, Aminat's behaviour at school was re-occurring, she was running away, other classmates were afraid of her and discussions were had regarding Access Mental Health being involved. Once again, Fiona Wilson was assigned on October 18th to do an extended screening to get more information.

[235] The worker at SSRT decided that this was really the same issue that had just been previously closed and there was no new information to warrant moving it to investigation.

[236] Fiona Wilson spoke with Dr. Hosain, a consulting psychiatrist with the Calgary Health Region, regarding the mother's concerns about the daughter's out-of-control behaviour and concerns that she would be charged with assault on a teacher. Some discussion occurred regarding a referral to the Forensic Adolescent Program. The mother was struggling to parent this out-of-control youth. Fiona Wilson spoke with Aunt Layla who assured her that things were going okay and that they were able to manage and had a lot of people connected to the family. The file was again closed at screening on October 18. The final paragraph in the screening report (Exhibit 2 Tab 39 Page 676), prepared by Paula Sigalet of SSRT states:

> " Writer recommends file be assigned as an exam at this time as concerns are being addressed by mental health system, child's behaviour is under control currently however, if/when child behaviour

is out-of-control then determine whether or not services (secure) be needed."

[237] In order for secure services to be implemented in October of 2006, the youth would have had to demonstrate significant risk to themselves or others and this would have to be confirmed over a 72-hour period.

[238] Once Ms. Baldwin returned to the office, she was involved in a secure services checklist on October 26 and 27.

[239] On October 27, information is received that Aminat is at the school again, after having ran away the day before to avoid meeting with her mother and teachers. The in-school constable, her mother and her aunt spent three hours looking for her in the community. The school went into lockdown to ensure that she could not gain access to the students because they felt she was threatening the Grade 7's. It was suspected that the extreme behaviours were being driven by possible drug use.

[240] Again, the screening of October 27 concluded that the secure services checklist did not reflect the required behaviour, as no threat had been made within the last 72 hours.

[241] Mother Aset was in denial that Aminat had been stealing, and the stress levels were fraying her relationship with her sister Layla.

[242] Furthermore, while Aminat was engaging in chat rooms and some promiscuous behaviour, there was no basis to demonstrate that she was actively involved in prostitution.

[243] Efforts to contact the home by Fiona Wilson were without avail. There was no answer and they had no voice mail. Absent new information, there was not enough to move it to investigation. It was decided that no action would be taken

beyond referring the family to community resources. Ms. Baldwin says the form on page 668 of Tab 39 in Exhibit 2 does not make sense. The family was already referred to community resources.

[244] This was the last involvement of Ms. Baldwin as Team Leader. On October 17, 2006, Dr. Hosain, the consulting psychiatrist for child and adolescent mental health in the Calgary Health Region, made recommendations with respect to Aminat. These included potential benefits from a medication trial of Risperidal to assist with impulse control.

[245] The doctor further recommended ongoing individual therapy and a referral to the Forensic Adolescent Program. If FAP was unable to accommodate Aminat, Dr. Hosain's team would facilitate a referral to Calgary Mental Health for individual therapy, family support and psychiatric consultation.

[246] A further recommendation was made to Child and Family Services to explore the possibility of a Family Enhancement Agreement. It was Dr. Hosain's opinion that Aminat and her mother would both benefit from additional support within the home (Tab 39, Exhibit 2, page 722).

[247] Ms. Baldwin testified that it is still up to Children's Services to establish if there is a risk and if they have the ability to intervene under the legislation. She states that in-home support cannot be offered unless a risk to the child had been established. While they took information from professionals and that would form part of their assessment, they would not have opened a file based on the recommendation from the psychiatrist alone. The worker contacted Dr. Hosain on October 18th. Ms. Baldwin had no dealings on Aminat Magomadova's file after October 26,27.

[248] Back in 2007, unless a file was opened, no formal transfer conference would occur. The file would be closed, with nothing to transfer.

[249] However, the information system is much better now than 10 years ago. All information is maintained and can be reviewed by follow-up case workers or assessors.

[250] On February 26th, 2007, Sheldon Maynes, the Team Leader at Bowness, called Ms. Baldwin to advice of Aminat Magomadova's death, which she described as horrendous.

[251] A Special Case Review was conducted through the Ministry that concluded in August 2007 after several months of investigation and document review. Ms. Baldwin was still a Team Leader at that time and the review was shared with the CEO, Bonnie Johnston, and reviewed with the Executive Management Team. It was also reviewed by the Regional Management Team. Ms. Baldwin's role in the Special Case Review was simply as a witness.

[252] The Special Case Review report is a critical piece of evidence in this Inquiry and filed with the court at **page 312 of Tab 38 of Exhibit 2**.

[253] In response to the Special Case Review, a regional work plan was created in the Calgary region to implement the recommendations. The draft regional work plan was filed with the court as Exhibit 5. The Ministry work plan, which is a summary of the regional work plan at a broader level to address delegation training, is marked as Exhibit 6 in these proceedings.

Special Case Review Findings and Recommendations

Assessment

[254] While CFSA had ensured that the safety and risk assessment tools were completed, a comprehensive assessment of the family strengths, needs, previous experiences and the impact of family violence, as well as an analysis of the family's abilities to address the issues and meet Aminat's needs were not evident on the file.

[255] Domestic violence was checked as "no" on the family's risk assessment tool. The broader impact and influence of family violence on the Magomadovas was not viewed on the context of domestic violence.

[256] The case workers recognized that the family was Chechen; however they were not all aware of the family's Muslim faith. Aminat engaged in pre-marital sex, drug and alcohol use, alleged criminal activity and aggression. Aminat was not viewed as a high risk youth, because her whereabouts were known when she was at the shelter, because she attended school, for the most part, and because she did not present as suicidal. However, Aminat's inappropriate behaviours and the family dynamics were not assessed within the context of the family's culture, language and religion.

[257] Recommendation #1: The CFSA to emphasize the importance of completing comprehensive/thorough assessments of children, youth and families in order to inform decision making and determine the appropriate intervention to assure the safety of children and youth.

[258] Ms. Baldwin testified that the former safety and risk assessment tools are no longer used, as they offered limited information. Now they use a solution-focused, strength-based approach to assessing risk. While the requirements of the

legislation must still be met, the team determines what their role will be with the family and how they may support it. The Signs of Safety Assessment and Planning Framework Tool was developed in 2012 and implemented in 2013-14. Ms. Baldwin testified that this improved document helps workers concretely identify, when they are having conversations with families, what is working well and what are concerns in relation to the legislation.

[259] This tool is marked as Exhibit 7 in these proceedings and contains 3 separate areas as follows:

1. what are the harms and dangers that are of concern;
2. what is working well in terms of existing safety strengths and network; and
3. what needs to happen in terms of safety goal, next steps for immediate safety plan, trigger/stressors, prevention plan for triggers/stressors, warning signs/red flags and response plan.

[260] Workers also receive training from consultants contracted from Western Australia (where this program was developed to challenge and train front-line social workers) to flush out details of the family's network and determination of whether a valid safety plan is actually in place.

[261] A Signs of Safety Work Plan is created for each child's services file they are involved in.

[262] An important component is the 0 to 10 safety scale at the bottom of the document wherein the estimate of current risk is identified. Identification of safety numbers are made by each member of the team and reviewed for variances or discrepancies.

[263] In addition, there are now higher levels of consultation between workers, team leaders and office managers. Sometimes community partners such as Wood Homes will sit in, as will cultural brokers and domestic violence outreach workers.

[264] Using this tool, a Safety Plan is created. An actual redacted Safety Plan for a different child was produced by way of example and marked as **Exhibit 8** in this Inquiry. The Safety Plan reflects the language used by the family and includes information shared with the family much more broadly than back in 2007. Once created, doesn't simply get placed on the file, it goes to every member of the support network and the family.

[265] The current form of Enhancement Plan, which also contains the Safety Plan is marked as **Exhibit 9** on this Inquiry.

[266] Safety plans are used even if a family is not subject to a Family Enhancement Agreement. If a file is open, there is a Safety Plan. And in order for a file to be open, there must be a concern for the protection of the child.

[267] Back in October 2006, files were documented very differently. It was felt that they had a form of safety plan in the broader sense in that community people connected with the family, the mother Aset was, involved and, though challenged, was positive, cared for her daughter and was trying the best that she could.

[268] There was also an aunt involved who was very supportive and telling Child and Family Services that things were okay. The team felt they had an adequate safety plan and that there were sufficient community people involved.

[269] Had this occurred today, it would have been more concrete and clear.

[270] It is Ms. Baldwin's assessment that the **Exhibit 8** example reflects a situation where a parent was unwilling or unable to meet the needs of the child and a concrete plan was necessary to ensure that it happens. In Aset Magomadova's

case, the parent was not unwilling, but probably unable. Ms. Baldwin further testified that today Children's Services would become involved to assist with the setting up of family and individual counselling appointments if the parent was unable to do so.

[271] **Recommendation #2: The Ministry to ensure that a component of the Case Work Practice Model includes the assessment of culture, language and religion. Case workers to work with each family within the context of the family's culture, language and religion to provide relevant services.**

[272] Ms. Baldwin testified that this recommendation has been completed and forms part of the ongoing training for new and old staff to promote cultural sensitivity and identify strategies to build safety networks and bridges with the family. The role of cultural brokers to enhance the process is also part of the training.

[273] Further, cultural brokers are available for the Children's Services offices to consult and involve. Once files are opened, even if the onus is on the parent to arrange for counselling and other community supports, Children's Services are also there to ensure those things happen. This includes the setting up of appointments with particular counselors. As a practice, this should also have happened in 2007 in Ms. Baldwin's testimony.

[274] A cultural broker is available at every single one of the 13 Calgary offices, including after hours. The addition of cultural brokers has been very helpful. They are engaged full time and work like part of the team.

[275] If a broker is unfamiliar with the family's language, background or culture, they call CCIS or Calgary Immigrant Women's Association or Immigrant Services Calgary to get assistance.

[276] Ms. Baldwin confirms that, had cultural brokers been available, they would have been involved with the Magomadova family in September and October of 2006.

[277] The program using cultural brokers is very active in both Calgary and Edmonton and each can consult the other for assistance or back-up.

Effectiveness and Appropriateness of Services

[278] The CFSA provided limited intervention services to Aminat and her family, as they were under the impression that the family's needs were addressed by community agencies.

[279] The *Child, Youth and Family Enhancement Act* supports increased collaborative and multi-disciplinary team approaches to problem solve and work with children, youth and families. While there were several CFSA staff and community service providers involved with the family, there was no one person coordinating the services. Services were neither confirmed nor assessed for their effectiveness.

[280] **Recommendation #3: The CFSA to reinforce with delegated staff, the requirement for collaboration and coordination among service providers to effectively serve children, youth and families.**

[281] **Exhibit 6** indicates that CFSA managers reviewed staff practices in their offices regarding collaboration and coordination, completed a practice review, and amended their screening format to identify collateral resources and contacts at the time of additional screening.

[282] Ms. Baldwin testified that there is now a more robust screening process which continues to be updated on an ongoing basis. More time is taken at the point

of screening, even if it means going out and talk to a youth, to a family or to follow up with an agency. Part of the best practices involves reaching out to collaterals and encouraging them, even if there is no worry at the present time, to call back if one develops. The process is much more rigorous than in the past.

Environmental Factors

[283] Service delivery appears to be impacted by environmental factors. Service gaps were evident, such as the length of time it took to transfer and accept the file; the assignment of the case to a new, non-delegated case worker; and different team leaders providing support and direction to the case worker.

[284] **Recommendation #4: The CFSA to examine their practice around case assignment, support to new case workers, team lead support and case assignment to non-delegated staff. Case assignment must align with the employee's delegated authority.**

[285] Ms. Baldwin testified that what looks different today is that non-delegated staff still become involved, but join a team and are given a reduced case load. It is also a team decision to assign cases based on the risk levels and the level of activity in order that the best person is identified for handling the file.

[286] Further, there are more team leaders to advise front line workers. Most team leaders have 5 staff instead of 7 or 8 as would have happened back in 2006 – 2007.

[287] The team leader-to-worker ratio is much better today and workers are getting delegation training more quickly.

[288] Non-delegated workers do not receive a full case load and have weekly supervision with their team leader as well as daily informal supervision. There are more consultations, more decision-making points, and it is emphasized to workers

that they should not make decisions by themselves. Anyone with a worry or a concern should bring the matter forward for consultation.

[289] Signs of Safety is emphasized in the supervision process. Team leaders are also engaged in more clinical supervision for non-delegated staff.

[290] Ms. Baldwin was asked if a case worker would be given a file such as Magomadova on her first day on the job, when her direct team leader is on holidays, and where the file has an emergency contact note on it from SSRT.

[291] Ms. Baldwin testified as follows:

> "Bad things happen in our work, unfortunately more than we want them to. I wish I could say a hundred percent that it would never [happen again], the practice even around that is so different, so if there is a contact note, contact notes don't go into people's inboxes or their in-baskets, they come over the office, there's a call ahead of time, and they are hand-delivered to whoever is in charge of that case."

[292] There is never just a contact note from SSRT. There is a phone call and people are aware that there's follow-up to be done.

[293] Information is also shared in the computer system but, if a contact note comes from SSRT, it depends on whether it is marked as an emergency or not. Contact notes that are not urgent in nature but require follow-up may be sent over without a phone call. However, emergency notes are generally done by a phone call and the site is notified.

[294] With respect to file transfers between offices, it is mandatory that there be a transfer conference wherein the originating office worker meets with the new team leader or worker together with the safety network and the family and the new team

leader. This occurs before the file is transferred and the transfer office must accept the file.

[295] Ms. Baldwin testified that it is best practice to have the family and the safety network present to ensure a prompt and smooth transition, especially when a Family Enhancement Agreement is in place.

[296] Ms. Baldwin was not aware that the wrong file was transferred in the Magomadova case, one relating to a different family member. She was, however, aware that there was a delay in the transfer.

[297] As for Family Enhancement Agreements today, they all contain a Safety Plan which forms part of the agreement signed by the family so that all parties are clear on what they are agreeing to (**Exhibit 9**).

[298] Documentation has changed multiple times since 2007 to increase the level of detail and the steps necessary to achieve the goals to reduce parent/child conflict.

[299] Family enhancement Agreements are much clearer today, the goal being that the youngest person in the room should be able to pick it up and understand what it means. Efforts are made to use clear language so families understand.

Secure Services

[300] Policy is clear regarding the criteria for secure services; however in 2006-2007, there was a focus on the 72-hour criteria, which resulted in Aminat being deemed as not eligible. In addition, court was not pursued due to the perception that the application for secure services would not be successful.

[301] **Recommendation #5: The CFSA to examine their regional criteria (Criteria for Consideration – Secure Services Application checklist) when**

considering eligibility for secure services and ensure that it complies with provincial requirements.

[302] Ms. Baldwin testified that secure services are pretty much the same, are full almost continually, with all ten contracted beds generally well-utilized.

[303] Ideally, kids are placed in Calgary because their home community is here but if beds are not available there is provincial access elsewhere. While the 72-hour time criterion is still in place, conversations are more robust than they were in 2007.

[304] Furthermore, if there is a difference of opinion with an agency that's providing current care to the child and they recommend secure services, there is a formatted resolution process if Children's Services has arrived at a different conclusion. The management and placement services office, the case team and the agency sit down and discuss the matter.

[305] Ms. Baldwin further testified that the two of the bigger agencies in Calgary, Hull and Woods Homes that deal with the high risk youth, have been empowered to make assessments whether secure services are necessary. As these service providers are on the floor with the kids and the matter can be urgent, decisions can now be made more quickly.

[306] When asked if there was anything else which might be done to prevent a similar death, Ms. Baldwin said that refugee families and mentally ill young children are an enormous concern and challenge for Children's Services. There are simply not enough resources and families are often at their wit's end. With language difficulties and an absence of a network of community connections, managing the household tumult can be very confusing for families.

[307] If a child comes into care, the resources are excellent. There are very good group residential and secure treatment facilities, but they are often not equipped to deal with some of the mental health challenges. Staff as well as other children can often be at risk.

[308] Children's Services worry that sometimes the fit is not quite right for certain children and the process to navigate with police and Alberta Health can be extremely difficult.

[309] It is Ms. Baldwin's assessment that, while there remains a lot of work to be done, significant improvements had been made. Ms. Baldwin does not have any additional specific recommendations beyond the provision of more mental health resources.

[310] In the Magomadova case, the family had mental health challenges, having suffered extremely in Chechnya. Ms. Baldwin believes there wasn't enough communication among everyone or enough opportunities to sit down at the table together given the family history.

[311] Conversations with families today are more clear and candid and support services are agreed upon collaboratively, with Children's Services often taking a lead role.

[312] A great deal of work has also been done, but much more needs to be done, in terms of multi-disciplinary engagement. In closing, Ms. Baldwin testified that she felt everyone had been so focused on Aminat they were shocked when Aset, the mother, killed her child.

[313] There hadn't been much focus on the risk of Aset Magomadova as a guardian physically, because at that point it was really about the security and behaviour of Aminat the daughter as a biggest risk to herself and to others.

[314] Aset had not been a threat to the child, beyond some instances of corporal punishment, and Aset had been instructed and schooled on the inappropriateness of such punishment. There was also a perception that Aminat had perhaps exaggerated her complaints about her mother.

[315] Overall, the experience with the mother was very positive. In Ms. Baldwin's view, even with the new systems today, there's a possibility Aset Magomadova could still have choked her daughter. In Ms. Baldwin's words, "sometimes we have bad things happen and we don't always get it right."

[316] It was felt that there was nothing in Aset Magomadova's presentation that would have worried Children's Services. It was very positive. The mother just seemed very overwhelmed with her disabled son. In Ms. Baldwin's words, "so we didn't see this coming."

[317] Today, the Signs of Safety Program allows the organization to understand better the trauma that kids experience, the grief and loss of guardians and parents who have experienced trauma and how these experiences might trigger risks. A broader assessment about the mother's history and the child's experiences, and what might have been triggers for them, may have assisted.

Conclusions and Recommendations

[318] The Special Case Review Report marked as **Tab 38 in Binder Exhibit 2** sets forth the key findings made by the review panel in the Magomadova file.

[319] It sets forth perceived deficiencies in documentation, procedures and Children's Services intervention for the Magomadova family.

[320] Further, it sets forth five recommendations reviewed above in the testimony of Deborah Baldwin.

[321] To reiterate, those five recommendations are as follows:

> **Recommendation #1: The CFSA to emphasize the importance of completing comprehensive/thorough assessments of children, youth and families in order to inform decision making and determine the appropriate intervention to assure the safety of children and youth.**
>
> **Recommendation #2: The Ministry to ensure that a component of the Case Work Practice Model includes the assessment of culture, language and religion. Case workers to work with each family within the context of the family's culture, language and religion to provide relevant services.**
>
> **Recommendation #3: The CFSA to reinforce with delegated staff, the requirement for collaboration and coordination among service providers to effectively serve children, youth and families.**
>
> **Recommendation #4: The CFSA to examine their practice around case assignment, support to new case workers, team lead support and case assignment to non-delegated staff. Case assignment must align with the employee's delegated authority.**
>
> **Recommendation #5: The CFSA to examine their regional criteria (Criteria for Consideration – Secure Services Application checklist) when considering eligibility for secure services and ensure that it complies with provincial requirements.**

[322] It is the finding of this Inquiry that the documents filed as Exhibits and the *viva voce* evidence presented coincide with and confirm the findings made by the special case review panel.

[323] Moreover, this Fatality Inquiry would not propose any further recommendations beyond the five identified by the special case review panel. The testimony of Richard Lemieux and Deborah Baldwin details the steps taken, the revisions made to procedures and protocols, the addition of more extensive support programs, including cultural brokers, and the broadening of training to focus on cultural sensitivity and trauma-informed assistance for refugee families such as the Magomadovas.

[324] This Fatality Inquiry is satisfied that appropriate steps had been taken having regard to the investigation and recommendations related to the Magomadova file. No further recommendations are proposed.