REPORT TO THE ATTORNEY GENERAL
PUBLIC INQUIRY
THE FATALITY INQUIRIES ACT

CANADA
PROVINCE OF ALBERTA

WHEREAS a Public Inquiry was held at the Provincial Court House, in the City of Wetaskiwin on the 5th day of December 2001, before the Honourable K.L. Rostad, Judge, Provincial Court.

A Jury was not summoned and an Inquiry was held into the death of

of Hobbema, Alberta and the following findings were made:

DATE AND TIME OF DEATH: March 10, 2001

PLACE: Samson Indian Reserve, Hobbema, Alberta

MEDICAL CAUSE OF DEATH: Hanging

MANNER OF DEATH: Suicide

CIRCUMSTANCES UNDER WHICH DEATH OCCURRED:

Up until May 7, 1999, was involved with the Wetaskiwin District Office of the Child Welfare Department; it was on that date that Kasohkowew Child Wellness Society, (hereinafter referred to as "Kasohkowew") took over management of file. The department is a part of the Ministry of Family and Social Services, (hereinafter referred to as the Ministry).

The caseworker for Kasohkowew was Marsha Omeasoo. She was a delegated child welfare worker; Kasohkowew was a delegated agency of the Ministry.

biological father, had little contact with during her life. did live with her mother totether with her mother's common-law spouse, from time to time.

The first five years of her life were spent with her Kokum, apparently a happy

time; however, died in 1991.

had four (4) siblings: who throughout the entire involvement with Child Welfare or Kasohkowew were never subject to a placement, however they had been apprehended. their mother, was able to cope and provide for their needs. There was an apparent feeling of despair when it came to caring for an underlying desire to have at home existed, but frustration would prevent long periods of actualization.

had strong family bonds, she disliked her mother's life-style which often resulted in her leaving home, sometimes AWOL, however, she expressed her desire to be at home and not in a placement. She relished being with her siblings.

The involvement of the Child Welfare authorities arose from substantial substance abuse, as well as some physical abuse, being prevalent in the home; both were subject to this behaviour.

There were two instances of Temporary Guardianship Orders, one on June 12, 1996 and the second application in April 7, 1997. There were numerous custody and support agreements signed with the parent, There was a Permanent Guardianship Order granted on May 13, 1998. These Orders related to

When Kokum died she was placed in her Mothers' care up until February 9, 1996; from that date until August 22, 1996 she was in a foster home on the reserve or in the Montana Receiving Home; she went AWOL and was put into parental care for a few days.

On August 26, 1996, was placed into the foster home of which was off-reserve. This terminated on December 3, 1996.

was placed in the foster home of until December 20, 1996. She was returned to parental care from that date until April 3, 1997. was then returned to until September 4, 1997 when parental care was again directed; there was placement in the household once more from September 26, 1997 until May 28, 1999.

On May 7, 1999, was placed in the Youth Assessment Centre in Red Deer; it was recommended that be placed in a treatment foster home (such a home is one that can specifically deal with children's behavioural difficulties or children that are considered to be at risk like constant AWOL's or anger). She was placed in the treatment foster home of on August 4, 1999. This placement was terminated on December 29, 1999, but was reinstated March 5, 2000 through to May 31, 2000.

was placed into parental care again on January 8, 2001 until her death on March 10, 2001.

was AWOL a number of times during these placements. In August, 1996 she was AWOL on the reserve for one (1) day; on May 20, 1997 for a period of thirteen days she was AWOL in the Buck Lake area; from September 4 - 6, 1999 she was AWOL in the Fairview area; from October 5 - 11, 1999 she was AWOL in Red Deer; from November 28, 1999 - March 5, 2000 she was AWOL in Hobbema and from May 5, 2000 to January 8, 2001 she was AWOL in Hobbema.

There was concern for personal welfare during these absences as she was being influenced by negative peer groups, was indulging in substance abuse and was becoming sexually active.

It was her acting- out behaviour, as well as stealing, that caused her foster home placements to be terminated.

whereabouts during the AWOL's was known in a general sense, but specific locations were often unknown; they were unknown because of the inability of the case worker to personally visit home or suggested relatives homes due to an overwhelming caseload which contained high incident, critical situations.

The AWOL's were reported to the RCMP who did instigate searches. It became apparent that there were two (2) methods of reporting an incident - one was to contact the RCMP dispatch which would result in a formal file being opened with subsequent tracking; the other way was to phone an officer personally with the pertinent specifics which would result in the officer instigating a search, but no file would be generated.

There was testimony that during some of the AWOLs the mother, was aware that was AWOL but resident on the reserve, sometimes with her and sometimes with another relative, this misinformation as to specific locale obviated the case workers' efforts to locate

During the involvement of Child Welfare authorities, there were a number of services offered to the family, some specific to some specific to

was offered and participated in substance abuse programs. There were Family Support Workers offered to to enhance her life skills, parenting skills and counselling her on strategies to work with and her different behaviours.

was offered sessions with a consulting psychologist, Ms. Unrau, which varied from weekly to monthly or sporadic visits. These sessions were seen to be beneficial to who was responsive until discussion of her behavioural problems was approached. Ms. Unrau, in April 1996, identified a high risk of suicide ideation and attempts due to attitude of self blame and perceived lack of control over what happened to her. She suggested placement conditions that should be considered, such as a placement where she can receive a lot of positive individual attention and nurturing as well as supervision for her attempts to harm herself.

Ms. Unrau, in a report dated September 3, 1996, noted that there was some suicide ideation and gestures made by in March 1995 by ingesting Halcyon. She recommended that unsupervised visits with were not in best interest because had been further exposed to substance abuse and difficulties which were a source of great anxiety for

Ms. Omeasoo, the case worker, told this inquiry that would get upset by abusing alcohol or drugs. They would talk about it with the focus that should not always look to her mother, but look to herself and how she could be helped. However, wanted to help her mother, but she didn't know how.

In a later report, December 1, 1998, Ms. Unrau notes that mood appears to have deteriorated; that, along with her increased negative behaviour, resulted in a recommendation that an adolescent psychologist be consulted to determine if medication might be helpful.

This was never carried out; it was not brought to the attention of the case worker, Ms. Omeasoo.

There was Family Therapy for but no follow through, this was offered through Heritage Family Services.

The Youth Assessment Centre offered and conducted an alcohol/drug assessment as well as psychological assessment of which resulted in a report July 7, 1999 which concluded that was a mild risk for suicide - the report recommended that be placed in a treatment foster care home.

On September 2, 1999, a suicide assessment was completed by Heritage Family Services. This assessment was ordered because had expressed to her foster parent a statement about killing herself. The assessment was that presented as extremely sad and that her last suicide thought was two (2) nights ago. Apparently she was seeing a therapist as often as she needed but there are no reports on file.

Again on March 12, 2000, it was reported that was AWOL and upon her return she was making suicide ideation statements. Apparently the treatment plan was continued ie. to educate on drugs, as well the treatment foster parents worked with her one-to-one; therapy continued, also.

It was after lengthy AWOL from May 5, 2000 to January 8, 2001 that it was decided to place in parental care, or other long term placement. It was outlined in a service plan dated January 10, 2001 that a decision had been made to return her to parental care; the service plan outlined the expectation and requirements of each party,

Apparently all parties were confident that they could meet the challenge, notwithstanding that the last consolidation report compiled by Kasohkowew prior to AWOL indicated concerns

with respect to being able to implement parenting skills or her wanting to return home.

Ms. Omeasoo informed this inquiry that there was historical information from the Department that reunification might work in the future. She said there was a desire by to have home and wanted to be with her Mom.

The placement was made on the basis of a home visit but not a home assessment; notwithstanding the expressed concerns of the psychologist, there were never any assessments or interviews conducted by a psychologist or psychiatrist prior to the re-uniting in January 2001.

There were indications from subsequent to the placement, that was not attending school and that did not want back in her home. This was apparently sorted out by the parties, but not documented. There were a series of contact-notes made by Rita Kneller, the service provider who did spot checks on the residence as part of the service plan. It is indicated that were not being cooperative; this was not thought to be an emergency situation by the case worker, so there were no effective follow-ups.

A report from the family support worker, Connie Bacon, indicated that she had concerns with respect to the appearance of the home, as well as with the children that were visible to her. The support hours allocated to Ms. Bacon were increased. The inquiry was told that the report by Ms. Bacon presented for the period January 30, 2001 to February 28, 2001 was received by Kasohkowew on March 1, 2001, but not received by Ms. Omeasoo until sometime later. The report contained information that Ms. Bacon was unable to make contact with during the month as well as information that on February 20, 2001, was found at home watching the children, apparently picked up from school for this purpose, such babysitting to be done while ran errands then went to Bingo. There was no contact or follow-up with by Kasohkowew.

Ms. Bacon's subsequent report for March 2001, set out that indicated on March 8 that hadn't been at home for about two (2) to three (3) weeks. Apparently Ms. Omeasoo had met with on or about March 2, 2001 when it was indicated that did not want at home and that she was staying at a safe home, that being with her biological father, it was stated that she was visiting other members of the family, as well.

Again, this did not appear to be an emergency situation so it was intended that the physical location of the residences would be discovered and subsequent to that a home assessment would be done.

It was learned after death that she was not staying at but was staying at probably since late February. stated he was a cousin, he ensured that attended school regularly when she was living at this residence.

The testimony of and his friends, who were living at his residence with was that [redacted] was usually happy and bright. She did not want to talk about her family other than about her brothers. She did express some of her inner feelings to her friend

On March 10, 2001, seemed sad to her friend it appeared to her that wished to be alone. Apparently took care of some domestic duties on that day, but did not want to go with the friends to Ponoka to swim. stated that she wished to visit the graves of her brother and mother that day, in recognition of their date of death. She referred to her grandmother as her mother.

Upon the return from swimming, was discovered hanging in the basement; she did not recover.

RECOMMENDATIONS FOR THE PREVENTION OF SIMILAR DEATHS

1. There should be a protocol established, by the Ministry and each delegated authority, to ensure that each child in care has a file that is complete, accurate and historical. It is important that anyone who accesses a file can quickly locate a concise history with clearly delineated components so that in an emergent situation an appropriate action plan can be constructed and implemented, considering **all** the facts.

   This protocol would have to include the provision that each interface with a component of the file be documented - there are no acceptable excuses for lack of contact- notes.

2. Delegated authorities such as Kasohkowew, operated by First nations, should make a maximum effort to recruit aboriginal foster homes on the same reserve from which aboriginal children are apprehended. This would ensure that the child remains in a familiar location and enable more home visits with family members. It would enhance cultural awareness.

3. There should be better and more effective communication between the agencies involved in the case management. Kasohkowew is the delegated authority with responsibility for each case, however more effective contact has to be initiated with contracted agencies to avoid compartmentalized strategies which either overlap or do not take into consideration findings or recommendations of other agencies or consultants.

4. A standard should be established to mandate that there is sufficient face-to-face contact between the case worker and the child in need. This will allow for better communication as well as being an effective method of detecting significant but subtle changes in the characteristics of the file.

   A protocol should be designed to ensure that in case situations with a suicide ideation aspect that a specific minimum face-to-face frequency be established.

5. In situations where a child-in-need exhibits suicide ideation, a protocol should be established that will specifically address an action plan for each of the recommendations proposed by the case consultants. This will ensure that the recommendations are consciously addressed as well as allow subsequent care workers to have easy and quick access to the information in emergent situations.

6. The Ministry and the delegated authority should ensure that a satisfactory suicide awareness program is designed and made mandatory training for each delegated case worker; this should be in addition to the component of the introductory training course currently in place. The training should be updated and presented to the delegated case worker with enough frequency to keep the assessment and prevention criteria fresh in the worker's mind.

7. The delegated authority should organize their case load amongst the delegated workers in such a manner that no one worker is unduly burdened with too many high incident cases.

   There should be adequate support services resources provided to allow for proper file preparation and maintenance by each case worker.

8. When a delegated authority realizes that a child-in-care has gone AWOL there should be a formal report to the RCMP in such a manner that there is a file opened which might ensure a more consistent and better followup rather than a report to an individual officer who may be active on the file, however it may be a more parochial action than would be neccessary to be effective.

9. The First Nations, who operate the delegated authority, should make a maximum effort to establish an outreach worker for youth on the reserve. This outreach worker could be attached to a community resource center which operates as a drop-in center that provides recreation as well as social programs to most children in a manner acceptable and more meaningful to the children.

Judge Ken Rostad