ALBERTA

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Court House

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

on the 20th day of January, 2020 (year), (and by adjournment

on the 3rd day of March, 2020 (year)),

before Jacqueline E. Schaffter, a Provincial Court Judge,

into the death of T.D.M. and T.C.M. (Name in Full) 17&16 (Age)

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

Date and Time of Death: March 9, 2017 at 4:15 pm and June 11, 2017 at 4:02 pm respectively

Place: Leduc, Alberta

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

T.D.M. - Carfentanil, Methamphetamine and Diazepam toxicity
T.C.M. - Fentanyl, Heroin, Methamphetamine and Cocaine misuse

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

Accidental

Circumstances under which Death occurred:

Introduction:

T.D.M. died on March 9, 2017 at the age of 17 years from Carfentanil, Methamphetamine and Diazepam toxicity.

T.C.M. the younger brother of T.D.M. died on June 11, 2017 at the age of 16 years from Fentanyl, Heroin, Methamphetamine and Cocaine misuse

T.D.M. was found deceased in a motor vehicle parked in a gas station lot in Leduc, Alberta.

T.C.M. was found unresponsive at his mother's residence in the City of Leduc on June 11, 2017 and was transported to the Leduc Hospital, Leduc Alberta. Despite medical intervention, he died on June 11, 2017.

This is a report to the Minister of Justice and Solicitor General in relation to an Inquiry conducted pursuant to the *Fatality Inquiries Act*, RSA 2000, c F-9 (*the Act*) into the death of T.D.M. on March 9, 2017 and T.C.M. on June 11, 2017. The Inquiries into the death of these two individuals were conducted together, given their sibling relationship and the close time proximity of their deaths.

I am required by section 53 of *the Act* to report on the identity of the deceased, the date, place and time of the death, the circumstances under which the death occurred, the cause of death and manner of death. I am permitted by section 53(2) of *the Act* to make recommendations in relation to the prevention of future similar deaths, but I am prohibited by section 53(3) of *the Act* for making any findings of legal responsibility or coming to any conclusion of law.

The evidence at the Inquiry was presented by Inquiry counsel, Ms. Jennifer Stengel. Children's Services was given standing to appear at the Inquiry and was represented by Laura Leveque. Alberta Health Services was also given standing to appear and was represented by Chelsey Bailey.

G.M., the father of T.D.M. and T.C.M. attended on the first day of the inquiry and was given the opportunity to ask questions of witnesses presented to the Inquiry.

The Inquiry heard from the following witnesses:
1. Cst. J. Pocock - RCMP
2. T. Gillis - Manager, Children's Services, Leduc Office
3. T. Weleschuk - Investigator, Safer Communities and Neighbourhoods (SCAN)

Prior to the start of the Inquiry, I received two binders which were entered as Exhibit 1 and 2 in these proceedings and an Investigative Report from SCAN was marked as Exhibit 3.

Fatality Inquiries were also ordered with respect to two other youth who all resided within the geographic area of Leduc, Devon and Drayton Valley. Each youth who died had unique life experiences that were reviewed during a Fatality Inquiry conducted for each individual youth. Three of these individuals were well known to each other. All four youths died within a period of time from March 2017 to September, 2017. All four youths had involvement with Children's Services at the time of or just prior to their death. All four had substance abuse issues and all four died from mixed drug toxicity.

After the conclusion of the evidentiary portion of the Fatality Inquiry for each of the four youths, the Inquiry heard "round table discussions" from various experts from across various government ministries. Discussed were the commonalities experienced by each of these youth and to determine if there are meaningful recommendations to be made that may help save lives in the future.

Participants in this round table discussion were:

Dr. B. Andres - Alberta Health Services - Executive Director, Provincial Addiction and Mental Health
Dr. N. Mitchell - Alberta Health Services - Provincial Medical Lead for Addiction and Mental Health
M. Pearce - Alberta Education
E. Bellman - Children's Services, Senior Manager, Policy for Child Intervention
M. Craig - Alberta Health, Executive Director, Addiction and Mental Health
R. Pickford - Children's Services, Regional Director for Early Intervention

An Exhibit Binder containing the following reports was submitted prior to the round table discussion:

a) Into Focus: Calling Attention to Youth Opioid Use in Alberta: June 2018 - Report of the Office of the Child and Youth Advocate
b) Government of Alberta's Response to the Office of the Child and Youth Advocate: September 2018
c) Valuing Mental Health – Next Steps: June 2017
d) Moving forward – Progress Report on Valuing Mental Health: Next Steps; February 2019
e) Appendix A: Progress Chart; February 2019
f) Finding Quality Addiction Care in Canada; November 2017
g) Primary Health Care Opioid Response Initiative: PCN Strategic Leads Forum; February 2018
h) A Stronger, Safer Tomorrow; A Public Action Plan for the Ministerial Panel on Child Intervention's Final Recommendations; June, 2018

Life Circumstances of T.D.M. and T.C.M. prior to death

T.D.M. and T.C.M. were the middle sons of C.J. and G.M.. T.D.M. died in March of 2017 and T.C.M. died in June of the same year. T.D.M. was 17 years of age at time of death and T.C.M. was 16 years of age.

The parents of the boys, C.J. and G.M., lived apart and the four boys often moved between the homes. The family became involved with Children's Services in 2006 when the boys' mother, C.J. was arrested on drug-related charges and one of the children was with her at the time of her arrest. All of the boys went to live with their father, G.M., and Children's Services closed their file.

In 2008 Children's Services received a report that G.M. had physically and emotionally assaulted T.D.M. but T.D.M. refused to make any disclosure of abuse and Children's Services closed their file. There was no child intervention with the family for the next six years.

When T.D.M. was 13 years of age, he was convicted of theft and firearms offences. He received a sentence of probation. He was later the target of a drive-by shooting that police suspected was drug related. During this time, the boys were living between their parents' homes and C.J. continued to use drugs. Police believed that the boys were selling drugs.

In November 2016, T.D.M. was admitted to hospital following a drug overdose. C.J. found T.D.M. unresponsive at her home. She called 911 for assistance and later admitted that he had taken heroin. Many people were at the residence at the time, including several who had outstanding warrants.

The police expressed concern to Children's Services at this time that there had been previous ongoing worries for the children. They expressed that all of the children in this family had criminal involvement and there had been significant violence in the homes as known criminals, drug users and drug dealers were regularly permitted entry to the residence. The children had either witnessed or had been involved in fights in the home. The police believed that this information had previously been conveyed to Children's Services; however, no record of such communication was found.

In December, Children's Services commenced an assessment and learned that T.D.M. and his younger brother had poor school attendance and the school expressed concerns about drug use by the boys. The school had given G.M. information on how to apply for a *Protection of Children Abusing Drugs Act (PChAD*) Order however he had not done so. G.M. admitted that he was struggling with caring for the boys. C.J. admitted to prescription and illegal drug use and on occasion appeared under the influence of drugs while meeting with the assessor. While the assessment was being completed. T.D.M. was again admitted to hospital for drug abuse and was discharged into his father's care with appointments for addiction counselling. These however were never attended.

C.J. admitted to Children's Services that all of her children consumed cocaine, meth, heroin, and "Molly" and the eldest child fought with the one of the other brothers. G.M. agreed to sign an Enhancement Agreement with Children's Services but did not follow through with signing the agreement nor accessing any of the community supports offered. He later stated that he did not want any assistance from Children's Services.

Following a case review by Children's Services it was decided to apply for a Supervision Order due to inability of parents to access community supports for children and parental substance abuse. Before the Supervision Order was applied for, T.D.M. was found deceased in a vehicle parked at a gas station on March 9, 2017.

C.J. agreed to work with Children's Services voluntarily with respect to the other children but on June 11, 2017 T.C.M. died from an overdose at his mother's home.

Recommendations for the prevention of similar deaths:

I am permitted by section 53(2) of *the Act* to make recommendations in relation to the prevention of future similar deaths. As stated above, Fatality Inquiries were held for each of the above youths; T.D.M., T.C.M., T.M.B. and D.B. The deaths of each of these young people is unfortunate and each experienced life in their own way.

The recommendations that I have made for the prevention of similar deaths which follows are collective recommendations based on the evidence that I heard in each of the four individual Inquiries together with the information provided by the panel of experts. These recommendations are the same recommendations included in the fatality inquiry reports for each of the other three youth.

1. The experts spoke at length about brain development research and research into the effects of trauma on children and the potential for long term negative impacts on the child in childhood and into adulthood. The greater the number of adverse childhood experiences the greater the potential negative impact. The Report, *Into Focus* by the Office of the Child and Youth Advocate states that "trauma, abuse, family breakdown, parental substance use and lack of connection to school may increase a young person's risk of substance use." Early identification of childhood trauma and education of individuals, professional and familial of the effects of trauma on a child will assist in helping the child to develop resiliency in order to mitigate the effects of the trauma. Programs such as Head Start are geared towards providing young children who are experiencing difficulties with additional supports. Operation of these programs largely falls to not for profit community groups and in smaller rural areas such a group may not exist. **Government ministries should investigate and actively facilitate the operation of early intervention services in rural areas.**

2. Although it appears from the representations of the panel members that education on a trauma informed approach for professionals has increased over the last 10 years, **Brain Development and training in the trauma informed approach should be maintained and enhanced.**

3. Each of the four youths reviewed, experienced school attendance issues and some were expelled at various times for truancy. A greater understanding of the effects of trauma and resulting behaviors, by teachers, school administrators, counsellors is imperative. Interventions in the past have been about consequences, limit setting and punishments as opposed to root causes and developing of individual supports. The Office of the Student Attendance and Re-engagement has now been created (which was not in existence when these youths were attending school) to approach truancy using restorative principles; engaging family, student, supports. **School Administrators should be strongly encouraged to use the services of the Office of Student Attendance and Re-engagement when attendance issues first arise with a youth and prior to proceeding to suspension or expulsion.**

4. At various times, the youths reviewed sought out help for their substance abuse and life circumstances. Sometimes the youth were met with barriers to communication existing between government ministries. The youth were seeking immediate assistance but were referred to other agencies with subsequent appointments. The youth did not follow through with the subsequent appointments which were set up for them. Professional supports for youth are frequently located outside the youth's community which often make them inaccessible. Youth Hubs and other wrap around services such as Graham's Place which was accessed by the youth D.B. have been identified as a means of providing an immediate, one-stop service integrating health, social services and supports. Research, in other countries and elsewhere in Canada, have shown these to be very effective. Although the creation of Youth Hubs was noted in the Government of Alberta's response to the *Into Focus* report by the Office of the Child and Youth advocate in 2018, few Hubs have been created. Again, this program requires an application by a community organization with some "seed money" from the government. Children Services are also not part of these Hubs. Smaller communities do not always have the resources to apply for such programming and further once operational, these programs rely on fundraising and community financial support. **Alberta Health should review the policy, funding and service delivery approaches that would facilitate the creation of more wrap around programs that are appropriately staffed with individuals knowledgeable about substance abuse, mental illness and the supports available for youth, particularly in rural communities. Services must be accessible and responsive.**

5. Not all youth may be in a situation where they are ready to stop using substances. The youth reviewed at various times wanted to stop and other times wanted to continue with their drug use. There is growing recognition that harm-reduction strategies may be effective. Such strategies accept that adolescents may choose to use alcohol or drugs, and acknowledge that alcohol and drug abuse have potential health and psychosocial risks. Unlike abstinence-based approaches, which focus on eliminating the behaviour, harm-reduction strategies aim to reduce the dangers associated with substance use including safe injection sites, Naloxone/Narcan program which reduces harm to the youth until such time as they are willing and able to access other treatment. **Alberta Health should continue to implement and supplement harm reduction programs including:**

    A) Increasing education for youth, and general public in use of Naloxone/Narcan and distribution of such kits;

    B) Creation of more safe consumption services and overdose prevention services sites particularly in rural communities;

    C) Provision of counselling services following a medical intervention for overdose or substance use;

    D) Opioid Agonist therapy programs for youth;

E) Recognition that Youth perspectives in the development of harm reduction programming are needed to ensure that approaches are relatable and meaningful to young people, and effective for promoting the minimization of substance-related harms.

6. The panel of experts noted that youth addiction treatment is an underserved area in Alberta. **It is noted that the Government has previously identified an investment of funding for this area. This investment should be continued.**

7. All of the youth reviewed had been involved in the youth criminal justice system. Adult Drug Treatment Courts provide a pre-sentence alternative for addicted offenders that integrates justice, health services and treatment. These programs have shown a high degree of success and the Alberta Government has committed to the creation of additional Adult Drug Treatment Courts in the Province of Alberta. Drug Treatment Courts for youth could similarly provide assistance to youth experiencing substance use disorders that have brought them into contact with the youth criminal justice system by the provision of the wrap around services. **The Ministries of Justice and Health should inquire into the feasibility of the creation of Youth Drug Treatment Courts**.

8. All of the Youth reviewed were or had been involved to some degree with Child Intervention Services. In one instance, a Permanent Guardianship Order was granted to the Director as a result of parental substance abuse and physical abuse. In the other three cases, Children's Services was involved with the family through Enhancement Agreements which were never followed through by the parents. Personnel from Children's Services were aware of the youths' substance use; having witnessed the youths apparently high on some substances at various times. Children's Services were aware that the youths had been admitted to the hospital for overdose, had been charged with criminal activity, were not attending school, were living at a residence that was well known as a "drug house". Children's Services felt that they were unable, because of legislation to intervene for the children in any greater way than to enter into an Enhancement Agreement which is a contingent upon a parent voluntarily entering the agreement and following through. The parents did not follow through on any of the terms of the Agreements and the youth continued to be at risk. Children's Services representatives advised the inquiry that they felt that their Ministry as well as guardians needed greater legislative assistance in dealing with youth who are struggling with substance abuse. *Protection of Children Abusing Drugs* legislation is designed only to provide detox services and was not implemented to assist in rehabilitation or ongoing safety for the youth.

The *Child Youth and Family Enhancement Act* provides in section 1(2) that a child is in need of intervention if there are reasonable and probable grounds to believe that the safety, security or development of the child is endangered because of any of the following:

(a) the child has been abandoned or lost;

(b) the guardian of the child is dead and the child has no other guardian;

(c) the child is neglected by the guardian;

(d) the child has been or there is substantial risk that the child will be physically injured or sexually abused by the guardian of the child;

(e) the guardian of the child is unable or unwilling to protect the child from physical or sexual abuse;

(f) the child has been emotionally injured by the guardian of the child

(g) the guardian of the child is unable or unwilling to protect the child from emotional injury;

(h) the guardian of the child has subjected the child to or is unable or unwilling to protect the child from cruel and unusual treatment or punishment.

The inquiry was advised that this section was interpreted by the individuals from Children's Services to mean that Children's Services could not intervene in the family unless it was the actions of the parents that was placing the child at harm. The substance abuse of the youths reviewed which was putting the youth at risk and ultimately was the cause of death for the youth was not sufficient to allow intervention unless the parents voluntarily agreed through an Enhancement Agreement.

The Inquiry was advised that the *Child Youth and Family Enhancement Act*, formally the *Child Welfare Act* was amended in 2003 with the deletion of an additional provision that a child is of need of intervention if:

(i) the condition or behaviour of the child prevents the guardian of the child from providing the child with adequate care appropriate to meet the child's needs.

This section was deleted with the amendments in 2003.

Youth Substance abuse is a growing concern for our society and is putting an increasing number of youth at risk. The state has a duty to intervene to protect children who are at risk. When parents are unable or unwilling to protect the child, the state should have the ability to step in to protect the child. **Children's Services should review the *Child Youth and Family Enhancement Act* or consider new legislation that would better able the state to intervene when it is the child's substance abuse that is putting them at risk.**

DATED February 26, 2021,

at At Leduc, Alberta.

"J.E. Schaffter"

Jacqueline E. Schaffter
A Judge of the Provincial Court of Alberta