CANADA
Province of Alberta

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Provincial Court - Criminal Division

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

on the 11 day of June, 2009 (year), (and by adjournment

on the 12 day of June, 2009 (year)),

before Judge C. M. Skene, a Provincial Court Judge,

into the death of C. F. (Name in Full) 16 (Age)

of Black Bear Crossing, Tsuu T'ina Nation (Residence) and the following findings were made:

Date and Time of Death: March 11, 2006, at 10:10 a.m.

Place: Rockyview General Hospital, Calgary, Alberta

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

Hanging

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

Suicidal

Circumstances under which Death occurred:

A. Introduction

On March 11, 2006, CF, a 16 year old aboriginal girl in care of the Director of Child and Family Services committed suicide in the same residence on the Tsuu T'ina Nation where her brother committed suicide 19 months earlier.

CF's mother was from the Samson Nation. Her father is a member of the Tsuu T'ina Nation.

CF had 11 Child and Family Services placements during her 16 years of life, most or all which she ran away from or left without permission. Others broke down because CF was difficult and defiant. She was resistant to permanent placement.

In this Fatality Inquiry, the Court had access to a portion of CF's Child and Family Services files and records. No family members or friends of CF testified.

As will be seen in this Report, CF struggled as she grew up in an atmosphere of neglect, emotional injury, and chronic parental alcohol abuse. As a pre-teen and teenager, CF was on her own, either running from placements or refusing to follow through with efforts made by Child and Family Services and others to assist her. There were repeated interventions by child welfare authorities throughout her life. She grew up without effective parenting and essentially raised herself.

CF's personal circumstances and death have also been referred to in Judge Mandamin's Report to the Minister of Justice and Attorney General re: KC, a Fatality Inquiry report dated August 21, 2007. In that Report, Judge Mandamin referred to "The Three Tsuu T'ina Suicides" being CF's brother's suicide on August 24, 2004, KC's suicide on June 13, 2005 and CF's suicide on March 11, 2006. Judge Manadmin also heard evidence and reported on the circumstances surrounding the residences at Black Bear Crossing on the Tsuu T'ina Nation.

This Fatality Inquiry is not a general inquiry into the availability of child welfare services to First Nations communities. The focus of this Fatality Inquiry is on CF's individual situation and recommendations that flow from the Inquiry which might prevent similar deaths in the future. To the extent that some of the evidence in the Inquiry deals with the involvement of Child and Family Services at the time of her death, it is done in the context of the Inquiry. CF was "in care" and subject to a Permanent Guardianship Order. At the time of her death at age 16, there were plans by Child and Family Services and CF to prepare her to commence living independently pursuant to an Independent Living Program.

B. Summary – Circumstances under which the Death of CF Occurred

On March 11, 2006, CF arrived back at her relative's home in Black Bear Crossing, Tsuu T'ina Nation, at approximately 8:00 a.m. after being out all night. She had indicated she had been involved in a fight but did not want to talk about the circumstances. CF went up to her bedroom. At approximately 9:00 a.m., the relative became concerned when the music playing in CF's room began skipping and CF did not correct it. The relative went into CF's room and found her unresponsive, hanging from a pair of jeans attached to the bar in her closet. She was taken down and 911 was called.

The Reserve police arrived first, and EMS moments later. The police noted a faint pulse, but CF was in full arrest when EMS arrived. Resuscitation efforts began and CF was transported to the Rockyview General Hospital in Calgary, Alberta less than 6 kilometres away.

CF was declared deceased at 10:10 a.m. at the Rockyview Hospital on March 11, 2006.

A toxicology report showed her blood alcohol level just prior to death to be 160 milligrams of alcohol in 100 millilitres of blood. Her blood also showed cannabinoids (marihuana, hashish or similar cannabis material) consumption at some time within the preceding 10 days prior to death.

C. CF's Family and Placement History

1. Samson Nation Years

CF was born on August 25, 1989. At one year of age, CF and her siblings were the subject of a Social Services file with investigations of the family dating back to 1988, before CF was born. As a one-year old it was noted she had lived first at the Samson First Nation town site, and then moved to a more remote location at Ma-Me-O-Beach, Pigeon Lake, Alberta.

There were reports of drinking in her home and being left at home unsupervised and not being properly cared for.

In 1995, there were recorded incidents of neglect, assault and abuse. Her father was absent and her family had been assigned a Samson Band Family Support Worker.

Her family had a long history of alcohol abuse. The file shows concerns with a lack of cleanliness in the house. It is noted that there were concerns about the children's health care.

Between March 1997 and December 2002 there were three screenings and two investigations of the family. Although the date is not authenticated, it appears from the documentation that CF's mother passed away in 1999 when CF was 10 years old.

There is a note on the Child and Family Services file that shows that someone in the department thought CF should be tested to determine whether she suffered from Fetal Alcohol Syndrome, Fetal Alcohol Spectrum Disorder or related disorders. There is no indication that CF was tested. A diagnosis of FAS, FASD or related disorder may explain the defiant and antisocial behaviour exhibited by CF at her numerous home placements, some of which will be referred to in this Report.

2. Tsuu T'ina Nation Years – Black Bear Crossing

By December 2002, the file showed CF, now age 13, was supposed to be residing at the Tsuu T'ina Nation at Black Bear Crossing with her father, his new common law wife and their blended family. CF did not feel welcome at her father's home and the family reported CF was a difficult child when she resided there. All agree that there was family conflict.

Placement with her father was tried on a number of occasions, formally and informally, between

2002 and 2006 with no long term success.

Between December 2002 and January 2003, CF and some of her siblings were living on their own and by themselves at a unit in a Black Bear Crossing residence.

The Social Services file stated that the current "home" was unsafe due to no locks on the doors, burn marks throughout the residence and no adult supervision.

From the early age of 13, there were file notes showing that CF was abusing alcohol and participating in a risky lifestyle whereby she would drink alcohol to the point of passing out, putting herself at risk of being abused and mistreated by others.

In April and May of 2003, there were efforts by Child and Family Services to identify treatment options for CF.

She was placed in a foster home but the foster parent complained in May 2003 that CF was having trouble at school, was disruptive in the home and was abusing alcohol and drugs.

In June 2003, CF was found on a road, in an intoxicated state, suffering from injuries, most likely from a motor vehicle accident.

After a stay at the Alberta Children's Hospital to recover from her injuries, CF was transported to Choices Group Home in Rocky Mountain House, Alberta, where she stayed from July 1 to August 11, 2003.

One objective of her stay at Choices Group Home was to attempt to "stabilize her behaviors." Unfortunately, CF did not get along well with her therapist at Choices Group Home. This attempt to provide CF with counseling was not particularly successful as a result.

By August 21, 2003, Child and Family Services was considering applying for a Permanent Guardianship Order for CF as it was recognized that she had no place at her father's home.

In October 2003, there were reports on the file stating CF, now 14 years old, was doing well at school. This positive progress did not last long as by October 21, 2003, she was AWOL from her foster home placement, was absent from school, and had the assistance from others in her community to hide from her case workers.

On October 30, 2003, CF turned herself in at Chula School and asked to speak to a case worker apparently to get back on track with her care. Notwithstanding that effort, CF would not agree to go away for substance abuse treatment and grief counselling.

Despite the lack of agreement, CF was transported and placed at the Poundmaker's Adolescent Treatment Centre in St. Paul, Alberta, from November 17, 2003 to February 13, 2004. Part of that program was a family program component that her father did not participate in. Having completed her 90 day residential treatment program and she was again placed with her father between March and July 2004.

Life continued to be a struggle for CF. Her file shows being exposed to domestic violence and alcohol abuse during this placement. On one occasion, she was found intoxicated at Black Bear

Crossing. There were reports of her misbehaving at school.

A note in the Child and Family Services file in April 2004 shows CF and a sibling were exhibiting problems; getting into trouble with the law; being defiant; and drinking and using drugs. CF also started acting out violently against others, beating up another youth in the community.

Notes show that in June 2004 it was observed that she rarely attended school, was exhibiting poor hygiene habits, and was a behavior problem. The school reported to Child and Family Services that CF's basic needs were not being met.

By mid July 2004, CF's placement was again an issue as a placement broke down. CF's placement was always an issue for her and Tsuu T'ina Child and Family Services from 2002 onwards, if not before. There is no evidence in this Inquiry to suggest that any of the government placements were not safe, secure, good homes. Rather, the evidence is that despite each placement being an appropriate one for CF, she left each placement on her own initiative.

On August 24, 2004, the day before her 15th birthday, CF's brother, age 17, committed suicide in the basement of a Black Bear Crossing unit resided in by a relative where drugs and alcohol were used, abused and were accessible to youths.

In February 2005, CF wrote a suicide note. She expressed that no one cared for her and she wanted to sign herself up for Children Services in Calgary. At this time CF had again experienced a series of placements that had broken down in close succession.

Because of this suicidal ideation, and other placement issues, counseling was set up for CF in March 2005 including grief counselling and sweats, but CF would not attend.

CF had ongoing Children Services involvement from her birth onward. There were persistent attempts by Child Services to assist her. In addition to attempts to find appropriate and long term placements for her, Child Services provided CF with an opportunity to attend a Treaty and Youth Conference in Utah in March 2005. Many Child and Family Services efforts were defeated as there are file notes showing CF refused to go to counseling when it was offered. Further efforts were stymied as CF would refuse to go to Group Homes where she was placed, would leave her placements without permission and would take up residence at her relative's home in Black Bear Crossing where her brother had died.

On June 13, 2005, KC, a friend of CF and her deceased brother, committed suicide. CF found KC's body and assisted others in attempts to resuscitate him. As indicated earlier, a Fatality Inquiry was conducted into KC's death by Judge Mandamin. CF and her brother were referenced in Judge Mandamin's Report.

On July 25, 2005, Child and Family Services obtained a Temporary Guardianship Order for CF. On September 26, 2005, a Permanent Guardianship Order was obtained for CF, now 16 years old. By October 19, 2005, CF's placement once again had broken down.

D. December 2005 Suicide Attempts

On December 25, 2005 a Tsuu T'ina Constable received a report that CF was threatening to kill

herself. This first incident involved her being caught with an electrical cord downstairs in the relative's residence at Black Bear Crossing attempting to create a noose. The second occasion, on December 27, 2005, was a more formalized attempt at that point involving again an electrical cord. There was also an expressed intent at that point in time to end her life. The Black Bear Crossing residence was where her brother committed suicide in August 2004. The second attempt prompted CF to be detained and admitted, pursuant to a Secure Services Certificate, to Hull Child and Family Services facility.

At the time of her admission, given some of the events that had occurred the night before, she was placed in a close observation situation for three days, the maximum length of the secure service certificate. Thereafter, there was a recommendation that CF be kept for an additional seven days.

Dr. Zelt, Registered Psychologist, PhD Educational Psychology, specializing in Community Counseling in the current role of Clinical Director of Hull Child and Family Services - Safe Directions Programs, testified about CF's stay at Hull.

C.F. was detained for 10 days in Secure Services at this agency specializing in assessing and stabilizing at risk youths, including stabilizing youth with suicidal tendencies who present a danger to themselves. The program CF was in included a phase of detoxification, addressing her basic needs of sufficient sleep, good nutrition and hygiene. Counseling and skill development was then emphasized to assist the young person with strategies and skills to prepare, cope and manage them for their life outside of Secure Services at Hull Child and Family Services. CF was released when Dr. Zelt and his colleagues felt she was sufficiently stable to live in the community.

During treatment and counseling CF showed insight into some of her issues as she acknowledged that substance abuse intensified her suicidal feelings. Alcohol was a significant driver for her in terms of her decisions or choices. Her suicide ideation was related to and intensified by being under the influence of alcohol.

Two other triggering points for her at the time was the death of an aunt earlier in December, 2005. Further, it being Christmas time, there was a resumption of memories and concerns about her brother who had committed suicide in August 2004. One trigger identified for CF's suicidal ideations was missing and longing for her brother.

Dr. Zelt testified that grief and loss were pervasive throughout CF's counseling sessions. It was noted that she had experienced the death of a sister, grandfather, mother, aunt and brother.

Another source of distress was that she reported to have been recently assaulted by two police officers.

Counseling identified issues present in CF's life including her persistently refusing group placement and her struggles with rules. She acknowledged a long standing history of running away and her difficulties maintaining herself in placement settings, which Dr. Zelt stated was not unusual for youth in care at Secure Services at Hull.

Dr. Zelt noted CF was very intelligent and very articulate. She expressed to him her love of school and learning.

E. After Discharge from Hull Child and Family Services, January 2006 – March 11, 2006

1. Counseling

Dr. Richard Amaral, a psychologist specializing in working with youth, adolescents and addiction issues started working with the Tsuu T'ina Nation in November 2005.

Upon CF's release from Hull Child and Family Services, Dr. Amaral was assigned to be CF's psychologist at the request of CF's caseworker. The agreement with Child and Family Services was that Dr. Amaral would see CF weekly at her school.

On January 11, 2006, Dr. Amaral and CF met at the school for their initial counseling session. That meeting took approximately 90 minutes. CF presented as a polite, soft spoken and cooperative young woman in the counseling session. She was forthcoming about the loss of close family members in her life. CF also identified her problems with addictions to alcohol and marijuana. CF reported being sober since her suicide attempt on December 27, 2005.

The intent and agreement was that CF was to receive counseling sessions once per week. Her second counseling session took place January 19, 2006. When Dr. Amaral went to meet with CF on January 26 for her third counseling session, CF did not show up for her appointment. She was also absent from school. On February 2 and February 9, 2006, Dr. Amaral had organized group workshops including counseling for teenagers and CF was asked to attend those counseling sessions in lieu of her one to one counseling. She did not attend.

February 16, 2006, an individual counseling session with CF did not take place as school was closed for a professional development day. On February 23, Dr. Amaral met with CF for her third counseling session.

On March 2, 2006, there was not a counseling session, but Dr. Amaral telephoned CF in an attempt to speak with her. They had a 15 minute conversation. CF said she was dong well. On March 9, 2006, an attempt to conduct their fourth counseling session failed. It was only 48 hours before CF committed suicide. Dr. Amaral stated: (Transcript dated June 11, 2009 p 39 ll 17-36)

> Q Yes. What happened?
> A March 9th I walked into the hallway there and spoke to the receptionist, the secretary at the front, asked her to page C. C came down. I said, hey, C, what's up, you know. I had my colouring toolbox because I was dong some art therapy.
>
> And she said, I don't want to see you. And I said, you sure, C. No, I don't want to see you. I said, well, how about for a few minutes. Can we check in even for a few minutes? She says, no.
>
> And then she walked right in front of me, so if I'm standing here, she was perhaps 2 feet away from me, and there was a desk at this - - at the counter and there's a sign-out book, and the students could sign out for - - I wasn't sure the reason why she was signing out.
>
> But she says, no I don't want to talk to you today. And she went right to

> the book, signed out. And I said, C, are you sure. Like even for a couple of minutes, do you want to just hang out? No. And then she walked away.

Q Was that the last time that you spoke with C?
A Yes.

Dr. Amaral testified that CF had some insight into her issues and challenges, being able to identify the death of her brother and others. She expressed interest in her future and long term goals.

Dr. Amaral reported that CF had a strong female role model at the school, that being Corrine Eagle Tail-Fraser with whom she connected with, confided in and sought advice from.

Dr. Amaral did not believe that CF was deteriorating in any way. CF presented herself to her psychologist as maintaining her mental health and stability.

When asked by the Peace Keeper at the Inquiry why he did not pressure CF into attending her March 9th counseling appointment, Dr. Amaral stated: (transcript dated June 11, 2009 p 47 ll 28-41, p 48 ll 1-3)

> …I often really tried to navigate … finding a balance between my concerns as a psychologists and the client's freedom to refuse a service.
>
> I mean I hear - - I - - I came to see her, and she said, I don't want to see you. And out of respect for her intention, I - - I honoured it. I asked her, even for a few minutes. You want to do a check in, talk to, ten minutes? And she said, no, so that's - - I made at least a couple attempts.
>
> I - - I saw her. I said, Hey C. She goes, I don't want to talk to you. And I said, even for a few minutes. No. And there was really nothing in that that made me concerned about what she was going to do that weekend.
>
> But again, I was really trying to respect - - because it was my fourth time seeing her, I still wanted to have a healthy therapeutic relationship. And part of the things that make a healthy relationship is to respect the intention of the client when they don't want to see you.

2. Tsuu T'ina Child and Family Services and CF

After discharge from Hull Child and Family Services facility in January 2006, Tsuu T'ina Child and Family Services continued to monitor CF and assist her. In additional to the counseling they arranged with Dr. Amaral, they attempted to place CF in an appropriate, safe living placement.

On January 3, 2006, CF met with her caseworker. They discussed a plan for CF including asking her to abstain from consuming alcohol and getting an Alberta Alcohol and Drug Abuse Commission counselor. The AADAC counseling was not pursued. CF was advised that she should not be around people who drink or in a home where there was alcohol consumed. Further, CF was told arrangements were being made for her to attend grief and loss counseling.

CF was consulted regarding her living placement. CF wanted to live with her father.

Her initial placement back with her father failed almost immediately. She reverted back to living with her relative at Black Bear Crossing. CF refused to reside in a safe, secure environment, despite Child and Family Services knowing and advising CF that she required a home setting where her safety and security needs would be met. Family Services attempted to place CF in a group home and that placement was refused by CF.

CF's caseworker and others at Tsuu T'ina Child and Family Services continued to be very concerned that CF was staying with the relative at Black Bear Crossing, an unsuitable, unapproved residence.

A case conference was held with CF at the Tsuu T'ina High School on March 7, 2006. The objective was to review CF's circumstances with her and her support system. It was reported that CF was attending school regularly and doing well. She reported meeting with her counselor, Dr. Amaral. CF had obtained a social insurance number and stated that she was considering looking for a part time job. Once again, placement options were reviewed with CF. CF was adamant that she wanted to continue to stay with her relative at Black Bear Crossing. The caseworker spoke to CF about Supported Independent Living and the process and preparation for this program. CF had expressed interest in this program in 2005, and it was agreed that CF and Child and Family Services would work toward this goal. The program would enable her to develop the knowledge, skills, attitudes and ability to make a successful transition into Supported Independent Living and adulthood. In this program, CF would be trained and assisted in developing the skills to be able to live in a safe place on her own, with financial and institutional support from Child and Family Services.

On March 9, 2006, the caseworker received a telephone call from CF's school. CF and another girl had left school without permission. CF was suspended as a result.

On March 10, 2006, a Tsuu T'ina Child and Family Services employee reported that she spoke to CF on March 9, 2006, after a chance meeting. She assured CF that things would work out and suggested CF stop by the office more often to stay involved and demonstrate some effort on her part to work with Child and Family Services. This was the same day she refused to meet with Dr. Amaral at her school. CF contacted the office by telephone on Friday, March 10, 2006, to inquire about a food voucher that she had been promised. She was told it was ready and would be delivered to her on Monday. At that time, Services would also transport her to school to have her reinstated. CF agreed.

On Saturday, March 11, 2006, in the morning, CF committed suicide at the relative's home where she had been staying and where her brother had committed suicide in August 2004.

F. Recommendations from Witnesses in the Fatality Inquiry

Each witness and participant in the Fatality Inquiry into the death of CF was asked whether they had any recommendations that may prevent the suicide death of any child in the custody of a director under the Child, Youth and Family Enhancement Act.

Dr. Amaral stated that at the time CF was referred to him for psychological counseling, it would have been useful to receive a brief summary of her file from Hull including the observations by

other professionals made during her stay and treatment there. It would have provided him with more insight into CF's issues and problems. His information was a self report from CF herself. Someone advocating for CF would have to ask the Director under the Child Youth and Family Enhancement Act (presently) for the release of that documentation.

Ms. Yolanda Youngpine recommended that considering CF's lifestyle and other circumstances, more community support for her would have assisted CF and possibly prevented her suicide death after she was discharged from Hull Child and Family Services.

Ms. Audrey Pipestem, Peacemaker, recommended that grief counseling be mandatory for all youth, whether at risk or not, after youth or family member suicide in the Tsuu T'ina community. She noted that there were a number of Nation elders who took it upon themselves to reach out to these children who had lost their friends to suicide, but that there were not enough elders "to go around."

Ms. Maria Onespot, Peacemaker, added, "C was amazing and beautiful and I just think that if she was supported more" her death may have been prevented. Alcohol and drugs were readily available to the youth on the Tsuu T'ina Nation. She recommended that the Tsuu T'ina Nation have more resources and more programs to address the needs of the youth and to support personal growth of youth in the care of the Director.

Recommendations for the prevention of similar deaths:

CF, as a result of alcohol abuse and neglect by her parents, came into the care of Child and Family Services at an early age. She was never adopted and had been in foster care, formally and informally, for over ten years with eleven placements into foster homes or group homes. On March 11, 2006, she committed suicide in the same residence on the Tsuu T'ina Nation where her brother committed suicide 19 months earlier.

Youth in care suicide has been addressed in Fatality Inquiries before, most recently in the Report to the Minister of Justice and Attorney General – Inquiry into the Death of DKLB, Judge Marlene Graham, May 6, 2009, and Report to the Minister of Justice and Attorney General – Inquiry into the Death of KC, Judge Tony Mandamin, August 21, 2007. The recommendations in those two reports and other Reports contain valuable specific and general recommendations that have relevance to CF's circumstances as well.

In an older Report to the Attorney General: Inquiry into the Death of DL, dated November 17, 1995, Judge Delong made a recommendation, among many others, that all Fatality Inquiry Reports be accessible and "organized such that they may be easily identified and recovered by subject matter and recommendations made." That recommendation has been adopted to a large extent by the Government of Alberta as I, with the help of a government researcher, was able to obtain a list of all reports dealing with Inquires into the death of children in care, and review the same and consider the recommendations made.

As seen in my findings of fact, numerous efforts were made to place CF in an appropriate home and have her attend counseling for her psychological issues, including grief counseling and substance abuse counseling.

These efforts were largely thwarted by a strong willed, intelligent girl, who was resistant to placement and resistant to counseling. Her father described her as the kind of person that always wanted and got her own way. CF lacked strong, consistent and safe family support and had been missing this integral part in a stable life for her entire life.

When her brother committed suicide, followed shortly thereafter by the suicide of one of her peers, those occurrences, may have set up more difficult circumstances, more emotional issues, that contributed to her death.

CF's suicide was not the result of a single event. She had been struggling with all of the issues outlined earlier in this Report. Despite the efforts of the Director, her school, placements and counseling, she did not have the social support systems in place that a child in a traditional, stable nuclear family would have.

She was supported by the Director and by her school and counselor. More support may have prevented CF's death, but that is not obvious from the evidence presented in the Fatality Inquiry. Her personal situation, her own choices regarding residing in an unsafe house, although these were obviously poor decisions of a 16 year old without family support and a tortured upbringing, increased her risk.

From the website of *The Canadian Mental Health Association – Youth and Suicide*:

Adolescence is a time of dramatic change. The journey from child to adult can be complex and challenging. Young people often feel tremendous pressure to succeed at school, at home and in social groups. At the same time, they may lack the life experience that lets them know that difficult situations will not last forever. Mental health problems commonly associated with adults, such as depression, also affect young people. Any one of these factors, or a combination, may become such a source of pain that they seek relief in suicide. Suicide is the second leading cause of death among young people after motor vehicle accidents. Yet people are often reluctant to discuss it. This is partly due to the stigma, guilt or shame that surrounds suicide. People are often uncomfortable discussing it. Unfortunately, this tradition of silence perpetuates harmful myths and attitudes. It can also prevent people from talking openly about the pain they feel or the help they need.

Recognizing the warning signs are one thing; knowing what to do with that information is another. Suicide was a taboo subject for a very long time. Even talking about it is still difficult for most people. But being able to talk about suicide can help save a life. Learning about suicide is the first step in the communication process. Suicide is about escape. Someone who thinks seriously about suicide is experiencing pain that is so crushing, they feel that only death will stop it.

Recommendation

As seen from my findings of fact, CF had what appears to be overwhelming challenges throughout her life. CF had significant assistance in the weeks and days before her tragic death. I noted no obvious failings in her care or in the services that were offered to her at the time. As seen in a meeting just before she took her own life, there were Child and Youth Services, school and volunteer community involvement in assisting CF with her care, future plans and education. As

stated in Dr. Amaral's case notes, quoting an aide at the school who worked closely with CF, "the help was there; she just never reached for it."

To assist in the prevention of similar deaths, I recommend that psychological counseling of youth in the Tsuu T'ina Nation schools be continued. Information should be shared between the Director and the counselors, with respect to the needs of the individual at risk child but also the needs of the Tsuu T'ina Nation youth as a whole. While CF was an identifiable "at risk" child considering her connection to the two earlier community suicides, and her suicide ideations and attempt in December 2005, other youth would benefit from counseling when there is a prevalence of suicide in the children's community.

Specific grief counseling addressing suicide of a classmate or suicide of a child's peer is also recommended.

DATED March 1, 2010,

at Calgary, Alberta.

Judge C. M. Skene
A Judge of the Provincial Court of Alberta