IN THE MATTER OF: **Commission of Inquiry into the Circumstances Surrounding the Death of Phoenix Sinclair**

AFFIDAVIT OF MICHAEL BEAR
SWORN the 11th day of May, 2012

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IN THE MATTER OF: **Commission of Inquiry into the Circumstances Surrounding the Death of Phoenix Sinclair**

AFFIDAVIT OF MICHAEL BEAR

I, MICHAEL BEAR, of the City of Winnipeg, in the Province of Manitoba,

MAKE OATH AND SAY THAT:

1. I am the chief of staff of the Southern Chiefs Organization.

2. I was the Executive Director of SouthEast Child & Family Services ("SECFS") from 2004 to 2008. In that capacity I managed a staff of approximately 100 persons. SECFS provided child protection services for nine First Nations communities: Berens River, Bloodvein, Brokenhead, Buffalo Point, Hollow Water, Black River, Little Grand Rapids, Pauingassi, and Poplar River. During the time I was Executive Director, SECFS expanded its mandate to provide urban based services pursuant to the recommendations from the Aboriginal Justice Inquiry CWI. (AJI-CWI).

3. As Executive Director of SECFS I was responsible for overseeing the work of SECFS which included case management, family reunification, interventions, crisis response, child protection, counseling, family support, as well as foster and group home placements. In managing the work of SECFS we worked in close cooperation with other agencies and entities.

4. Between 1999 and 2004, I was the Deputy Children's Advocate for the Province of Manitoba. The Office of the Children's Advocate is an Independent office of the Manitoba Legislative Assembly which represents the rights, interests and viewpoints of children and youth throughout Manitoba who are receiving, or are entitled to receive services under *The Child and Family Services (CFS) Act* and *The Adoption Act.*

5. Between 1993 and 1999 I was employed as a case worker in Winnipeg with Cree Nation Child & Family Services. My job was to provide case management services to children placed by the agency in Winnipeg. I do not hold a degree in social work.

6. I have personal knowledge of the matters set out in this affidavit, except where they are stated to be based on information or belief, in which case I believe the matters to be true.

Identification of Social Workers and other Child Welfare Services Providers

7. During my last year as executive Director of SECFS the agency implemented staff photo identification cards for all SECFS staff. This was for both introduction to clients as well as to collateral service providers. Normally there was a photograph of the social worker on the card. When social workers attend at a client's home they are expected to show this identification, identify themselves verbally and identify the purpose of their visit. Most social workers had business cards with similar information to provide to clients. Currently it is my belief that all CFS workers as well as support

staff working in the field are required to carry photo identification cards, this would also be for non-mandated services providers who are working with clients in the field, such as support workers and teaching homemakers.

8. Social workers providing services in rural communities and reserves typically are already or become members of the community. As a result, their identities and occupations are very well known to the people in the communities they serve.

9. Child welfare agencies must sometimes deal with members of the public who are under stress and who may be unstable. Agencies must always be aware of this reality and take appropriate precautions, particularly in respect of staff who must deal directly with the clients in the field.

10. SECFS had responsibility for some communities with the harshest living environments and social conditions in Manitoba. Staff of SECFS were directed to attend at client homes in teams of two. If there was any concern on the part of the agency or staff, the police attended with the social workers. Attempting to keep staff identities unknown was not a useful risk management took. It was a social worker's behaviour in the field that was critical, not his or her identity.

11. I cannot recall any incident of a physical attack on staff of SECFS while I was the Executive Director. I also do not recall any incident of physical attack upon a social

workers or other staff member during by employment with Cree Nation Child and Family Services.

Public Proceedings Examining the Death of a Child in Care

12. During my term as Executive Director of SECFS Tracia Owen, a First Nation youth from Little Grand Rapids, committed suicide while she was in care. SECFS was the agency with jurisdiction which managed Tracia Owen's placements. There was a public inquest at which I and other members of the SECFS staff testified.

13. There was no order restricting publication of the names of social workers and other professional witnesses who testified at the Tracia Owen inquest. Their identities and testimony were covered in the media and the public report of The Honourable Judge John Guy issued January 11, 2008 listed the names of witnesses. Attached hereto as Exhibit "A" is a copy of the report.

14. Given the nature of reserve and other rural communities as described above, the affected community was already well aware of the Tracia Owen tragedy and of the agencies and the social service professionals who played key roles in the case.

15. Agency staff and the other professionals involved in the case of Tracia Owen and her family were extremely upset by this tragic death. It was not easy for those involved to scrutinize the case in hindsight, although it was necessary to have the public

discussion about what happened and what changes were required to reduce the likelihood of such tragedies occurring in the future. It was no surprise to me or my colleagues that such an event would attract public scrutiny or that the public servants involved would be expected to come forward to explain what happened and discuss strategies for avoiding such outcomes in the future.

16. In the end the agency, its staff and the community learned from the experience and I did not perceive any negative impact of the process on the ability of our staff to continue to provide services to the communities we served. The public inquest gave participating staff members an opportunity to present to the community and decision-makers, their perspectives about the specific case, the child welfare system and the challenges faced by the men and women who administer it.

SWORN before me at the City of Winnipeg, in the Province of Manitoba, this 11th day of May, 2012.

A Commissioner for Oaths in and for the Province of Manitoba.
My Commission expires: 2013/06/16

MICHAEL BEAR

Release Date: January 16, 2008

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT.***

AND IN THE MATTER OF: TRACIA OWEN (Deceased)
D.O.D. August 24, 2005

This is Exhibit "A" referred to in the
Affidavit of Michael Bear
SWORN before me this 11th day
of May, A.D. 2012
A Commissioner for Oaths in and for
the Province of Manitoba
My Commission expires 2013/06/16

Report on Inquest of
The Honourable Judge John Guy
Issued this 11th day of January, 2008.

APPEARANCES:

Mr. L. Allen, Counsel to Inquest
Mr. I. Frost, Q.C. & Mr. S. Boyd, for the Department of Family Services and Housing
Ms H. Van Iderstine, for Project Neecheewam Inc.
Mr. J. Harris, for Southeast Child and Family Services Agency
Mr. H. Cochrane, for First Nations of Southern Manitoba Child and Family Services Authority
Ms N. Watson, for Dr. J. Szelazek and Dr. L.M. Collison
Ms C. Dunn, for Ka Ni Kanichihk Inc.
Mr. L. Bushie, family representative

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: TRACIA OWEN

Having held an inquest respecting the said death on February 5, 6, 7, 19, 20, 21, 23, April 10, 11, 12, 13, 18, 19, May 8, 10, 16, June 11, 12, 13, 25 and 29, 2007 at the City of Winnipeg, in Manitoba, I report as follows:

The name of the deceased is: TRACIA OWEN

The deceased came to her death on the 24th day of August 2005, in the City of Winnipeg, in the Province of Manitoba.

The deceased came to her death by the following means:

Suicide by hanging.

I hereby make the recommendations as set out in the attached report.

Attached hereto and forming part of my report is a schedule of exhibits required to be filed by me.

Dated at the City of Winnipeg, in Manitoba, this 11th day of January, 2008.

"ORIGINAL SIGNED BY"

_____

John Guy
Provincial Judge

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THE FATALITY INQUIRIES ACT
SCHEDULE ATTACHED TO PROVINCIAL JUDGE'S REPORT RESPECTING THE DEATH OF: TRACIA OWEN

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1	Copy of letter from CME of February 6, 2006, directing an inquest
2	Group of photographs depicting garage at 557 Victor Street
3	Booklet of photographs
4	Large yellow document
5	File material from Project Neecheewam
6	Manitoba Adolescent Treatment Centre (MATC) client file & Southeast Child and Family Services file – Binder 1
7	Southeast Child and Family Services file – Binder 2
8	Section 10 report and Provincial Review (Residential Child Care Facility Review)
9	Letter from Dr. Balachandra including autopsy report, investigator's report from Chief Medical Examiner's Office, police information
10	Criminal record of Leonard Bushie
11	Curriculum vitae of Michael Bear
12	The Child Death Review: A Report to the Minister of Family Services & Housing, by Billie Schibler and James H. Newton

Exhibit No.	Description
13	Curriculum vitae of Jane Runner
14	Sheet of Statistics on the Sexual Exploitation of Children and Youth in Winnipeg
15	Pamphlet entitled "Promise of Hope, Commitment to Change (Aboriginal Justice Inquiry – Child Welfare Initiative)"
16	Pamphlet entitled "Neighbourhood Solutions – Working Together to Address Sexual Exploitation on our Streets"
17	Bio for Wendy Scheirich and Position Description for "Coordinator of Services to High Risk Youth"
18	Booklet entitled "MAISEY (Media Awareness Initiative about Sexually Exploited Youth)"
19	Informational pamphlet about The Safer Communities ad Neighbourhoods Act
20	Two posters
21	Small booklet entitled "A Sex Trade REALITY CHECK"
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38	Package of 8 articles on antidepressants and depression in children, with cover page
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Exhibit No.	Description
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41	Child and Family Services Standards Manual, partial
42	One-page document, "Tracia Owen, Days Care Analysis"
43	Section 22 of the Foster Family Manual, "Attachment and Separation Issues in Placement"
44	Authority Relations Director position description, 4 pps.
45	Curriculum vitae of Linda Burnside, 8 pps.
46	Press release dated October 13, 2006 regarding "Changes for Children", 2 pps.
47	The Child Death Review Process, 1 page
48	Changes for Children: Strengthening the Commitment to Child Welfare/Response to the external reviews into the Child and Family Services System
49	Strengthen the Commitment – An External Review of the Child Welfare System
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Legislative Framework

CME assessment of agency

10(1) If the chief medical examiner receives an inquiry report about a deceased child who, at the time of death or within the one year period before the death,

(a) was in the care of an agency as defined in *The Child and Family Services Act*; or

(b) had a parent or guardian who was in receipt of services from an agency under *The Child and Family Services Act*;

the chief medical examiner shall assess the quality or standard of care and service provided by the agency by

(c) examining the records of the agency respecting the child and the parent or guardian; and

(d) reviewing the actions taken by the agency in relation to the child and the parent or guardian.

CME has ME powers under subsection 9(7)

10(2) For purposes of an examination or review under subsection (1), the chief medical examiner may exercise the powers of a medical examiner under subsection 9(7).

CME to report to minister

10(3) Upon completion of an examination or a review under subsection (1), the chief medical examiner shall, in the form and manner prescribed, immediately submit a written report to the minister charged by the Lieutenant Governor in Council with administration of *The Child and Family Services Act*.

Confidentiality of CME report

10(4) A report under subsection (3) is confidential and, for this purpose, is governed by the provisions of Part VI of *The Child and Family Services Act* as if the report formed part of a record to which Part VI applied and is not governed by section 42 of this Act.

CME to prepare summary for annual report

10(5) Despite subsection (4) of this section and Part VI (confidentiality) of *The Child and Family Services Act*, the chief medical examiner may

(a) not later than December 31 of each year, prepare a summary of recommendations contained in reports prepared under subsection (3) in the previous year, without disclosing the name of an individual or agency or any information that might identify a child or the parent or guardian of a child; and
(b) include the summary in the report referred to in subsection 43(2) (annual report by CME).

CME review of investigation report
19(1) Subject to subsection (3), upon receipt of an investigation report, the chief medical examiner shall review the report and determine whether an inquest ought to be held.

CME to direct holding of an inquest
19(2) Where the chief medical examiner determines under subsection (1) that an inquest ought to be held, the chief medical examiner shall direct a provincial judge to hold an inquest.

Duties of provincial judge at inquest
33(1) After completion of an inquest, the presiding provincial judge shall

(a) make and send a written report of the inquest to the minister setting forth when, where and by what means the deceased person died, the cause of the death, the name of the deceased person, if known, and the material circumstances of the death;
(b) upon the request of the minister, send to the minister the notes or transcript of the evidence taken at the inquest; and
(c) send a copy of the report to the medical examiner who examined the body of the deceased person;

and may recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest.

In camera evidence and culpability
33(2) In a report made under subsection (1), a provincial judge

(a) may disclose in camera evidence that is received during the inquest

where the judge is satisfied that disclosure of the evidence

(i) is essential to setting forth when, where and by what means the deceased person died, the cause of death and the material circumstances of the death; and

(ii) is in the public interest;

(b) shall not express an opinion on, or make a determination with respect to, culpability in such manner that a person is or could be reasonably identified as a culpable party in respect of the death that is the subject of the inquest."

Mandate of the Inquest

On February 13, 2006 the Provincial Chief Medical Examiner called an inquest into the death of Tracia Owen, age 14 years, of Winnipeg, on August 24, 2005.

The inquest was called under Section 19(1) and Section 19(2) of *The Fatality Inquiries Act* for the following reasons:

(1) to determine the circumstances under which Ms Owen's death occurred.

(2) to examine certain social factors (availability of "street drugs" and sexual exploitation of youth) that appear to have played a role in her death.

(3) to determine what action, if any, can be taken to prevent similar deaths from occurring

INTRODUCTION

A very brief synopsis of Tracia Owen's life in the child care system may be helpful prior to a review of the testimony given. Brief, because hundreds of pages of documents were filed, although all was not referred to, in order to document the Agency's contact with Tracia Owen. Although this synopsis will not cover all the efforts made, it is hoped it will provide some sense of the environment in which Tracia Owen was living.

The family in which Tracia Owen was born had a history of dysfunction largely due to alcoholism, parenting issues and domestic violence. Because of this history a community health nurse in Little Grand Rapids in a letter dated March 27, 1991, prior to Tracia's birth, warned of the dangers associated with Tracia being raised by this family without substantial changes by them with respect to substance abuse issues. As a result, Tracia was apprehended but then began the years of placement in foster homes, extended family and group homes hoping that improvement by the parents would result in her being returned to them. Although both the parents went for treatment for alcohol abuse, the successes were short-lived. When incidents occurred Tracia was picked up and placed in a foster home until the parents were once again able to provide some care. Although Tracia, for the most part, was kept in the Little Grand Rapids community, either in foster homes or group homes for the first twelve years of her life, the constant movement from place to place coupled with safety risks had to have a serious toll. As might be expected, Tracia began acting out and became involved in gasoline sniffing.

This resulted in Tracia being placed in Kirkos House in Winnipeg in September 2003 for substance abuse treatment. While at Kirkos House, Tracia continued to be out of control – running away, skipping school, aggressive behaviour and threatening suicide. Her acting out behaviour culminated in her threatening staff with scissors as a result of being denied privileges. She was discharged from Kirkos House January 7, 2004.

Upon discharge she was placed in a foster home awaiting another placement. In January 2004 she was moved into a four bed group home in Winnipeg. But Tracia continued to have difficulties – absent without leave, out on the streets at night and behavioural problems.

More placements resulted - Kitigas Group Home in Little Grand Rapids, foster homes in Winnipeg, group home in Poplar River and behavioural problems continued including AWOL, aggressive behaviour, and a possible suicide attempt resulting in her attendance at the Psychiatric Centre of the Health Sciences Centre.

Upon release, more placements including hotel placements until December 14, 2004 when she became a resident of Project Neecheewam, her final placement.

Although the number of placements may be disputable, the return to her parents' care on 17 occasions demonstrate the state of turmoil and the lack of permanency in this child's life.

Finally, at her arrival at Project Neecheewam improvements with respect to stability, care, treatment and programming appear to have put Tracia on a more promising road for the future. Although her concerns for her family and her desire to live with them were ever-present, there was room for optimism. Tragically this came to an abrupt end on August 24, 2005.

The purpose of this inquest is to try to ascertain how Tracia Owen came to this tragic end and what steps can be taken to try and prevent reoccurrence.

I. TO DETERMINE THE CIRCUMSTANCES UNDER WHICH Ms OWEN'S DEATH OCCURRED.

[1] The evidence called surrounding the circumstances of Tracia Owen's death consisted of police personnel (Constables Peters and Bell), medical examiner investigator (Susan Hamilton) and friends of the deceased (Rebecca Wilson and Brittinie Chartrand).

[2] Rebecca Wilson testified that she and Tracia spent many hours together on the streets in the weeks before Tracia's death. On the day in question in the vicinity of the Discount Everything Store on Victor Street they earned some money as a result of sexual activities and proceeded to buy crack cocaine and marijuana. They attended an abandoned garage behind 557 Victor where after smoking the crack they fell asleep on a mattress. Rebecca Wilson was awoken by Brittanie Chartrand who arrived around noon to see Tracia hanging by a yellow rope attached to the garage door counter spring. Rebecca Wilson ran down to Sargent Avenue to get a knife which she used to cut down Tracia and then phoned an ambulance. Rebecca testified that Tracia's head hit the garage floor when she was being cut down

[3] As a result of the discovery, police were dispatched to the rear of 557 Victor with respect to this medic incident. Medical personnel were on the scene and while Constable Peters investigated the scene, collected evidence, and spoke to witnesses (Wilson and Chartrand), Constable Bell took photographs of the scene (Exhibit 3).

[4] Susan Hamilton, an investigator from the Medical Examiner's Office, attended to the scene to assist in determining the manner of death. Ms Hamilton viewed the body, examined the scene, spoke to the police investigators and the witness Chartrand, made arrangements for identification of the body and transfer of the body to the Health Sciences Centre for autopsy.

[5] The only area of contention was with respect to the identification of the body by group home staff at the scene of the death. Although staff was apparently willing to do so at the time, subsequently the identification became a very traumatic experience for the individual. The medical investigator felt the necessity of ruling out foul play and to maintain continuity with respect to the body therefore identification was necessary at the scene. (Vol. 2, p. 18)

[6] It is my respectful view the two issues of ruling out foul play and continuity of the body can be satisfied by identification at a place other than

the scene. Asking a staff member of a group home who worked with the deceased to identify her is extremely traumatic in itself but the added feature of identification being made in the squalid surroundings of this garage would certainly add to this trauma. In my view, such identification could have been made at the Health Sciences Centre in appropriate surroundings without endangering the two valid concerns. This will be further considered with respect to the recommendations of this fatality inquiry.

[7] It would appear from the medical investigator's investigation that Tracia Owen met her death by suicide by hanging and this is consistent with all the evidence presented at the inquiry.

[8] The medical investigator's evidence was further confirmed as a result of the autopsy performed by Dr. Susan Phillips, a pathologist at the Health Sciences Centre. Her report indicated a ligature mark on the deceased's neck, the small laceration of the back of the head consistent with her fall from being cut down and the results of toxicology indicated cocaine and cocaine metabolites. The cause of death was asphyxiation, in this case by hanging. Again consistent with the circumstances surrounding the death of Tracia Owen.

[9] The only surprise in the autopsy findings was the lack of Prozac in the blood. None was found yet evidence was presented at the inquiry that the deceased was prescribed Prozac and according to staff at the group home was taking this drug.

[10] In order to try and clarify this possible discrepancy the toxicologist, Robert Meatherwell, testified. The qualitative drug screen found only cocaine and Ibuprofen and no anti-depressant Fluoxetine, commonly known as Prozac. After an extensive inquiry, the best evidence is that even taking into consideration the amount taken, the shelf life of the drug and the metabolism, there should have been some indication of Prozac found in the drug screen if it had been taken one to three days prior to death. It would appear therefore that this discrepancy will remain despite the efforts made to find a concrete answer. With us left with the possibility that although staff were giving Prozac to Tracia and watching her take it, she might not have been swallowing it and later discarding it.

[11] To complete the issue of Prozac, I will say the following. Evidence was called on the issue of prescribing Prozac or other anti-depressants for adolescents. Besides *viva voce* evidence from Dr. Linda Collison, a number of medical articles were filed by the respective parties. Needless to say, the subject of anti-depressants for adolescents is fraught with controversy with

distinguished exponents, for and against its use. The Court is not capable of drawing a conclusion one way or the other. But do I feel that it is fair to say that Dr. Collison was well aware of the controversy, her and medical colleagues constantly monitor the issue and despite some opposing medical opinion, are prepared to prescribe the drug in the appropriate medical circumstances and with the appropriate monitoring. I am satisfied they were aware of the issue, consulted medical opinion, monitored its use and followed the best practices as dictated by their medical body. I believe the "common and accepted course of conduct has been adopted based on the specialization and technical expertise of the professionals". There is no way that I could distinguish Tracia's Prozac behaviour from her pre-Prozac behaviour in order to draw any negative conclusion as to the effects of Prozac. Therefore, in my view, on the basis of the evidence it was not a material circumstance surrounding Tracia Owen's death.

[12] In conclusion, the circumstances under which Tracia Owen met her death were tragic but incontrovertible death by hanging.

II. TO EXAMINE CERTAIN SOCIAL FACTORS (AVAILABILITY OF "STREET DRUGS" AND SEXUAL EXPLOITATION OF YOUTH) THAT APPEAR TO HAVE PLAYED A ROLE IN HER DEATH.

[13] After hearing the evidence surrounding the hanging death of Tracia Owen, seeing the photographs of the scene of her death in an abandoned, filthy garage with a mattress and various drug paraphernalia, one wonders what could possibly lead a fourteen year old to a life of crack cocaine, sex on the streets and ultimately to her tragic death in such conditions.

[14] Witnesses such as Rebecca Wilson, Brittanie Chartrand, Detective Sergeant Coates and the dedicated staff who work with these children paint a sad and tragic picture of a too common aspect of our inner city.

[15] Rebecca Wilson, literally, drew a picture depicting their activities on the Victor Street corner during the course of a day. (Exhibit 4)

[16] The inquiry had the advantage of having two female youths, friends of Tracia Owen, experiencing the same lifestyle, who painted a vivid picture of life on the streets.

[17] The first, Rebecca Wilson, through the use of a drawing she drew depicted a life on the street – everyday spending endless time on the street, engaging in sexual activities, receiving money, purchasing crack or other illegal drugs, smoking, being threatened, sleeping on a mattress in an abandoned garage. This occurring in the middle of the city on a busy thoroughfare at all times of the day and night by fourteen year old females or younger.

[18] A second similar witness, Brittanie Chartrand, on the street at thirteen years of age, told a similar story of drugs, owing drug debts, need to work the streets to repay the debt and to buy more drugs – "make all my problems go away". She emphasized that "you do stupid things when you are on drugs".

[19] These two individuals were either with Tracia Owen prior to her suicide or awoke to see her hanging and took action to get help albeit, help would be too late.

[20] These witnesses offered some hope in that they appeared to be turning their lives around for the better but also they gave some practical suggestions when asked.

[21] They both commented favourably about the presence of the Street Connections van that toured the streets and gave practical advice about keeping safe on the streets – from bad dates and diseases. Secondly, they supported the availability of a drop-in centre run by Ma Mawi, a place to get off the streets to relax and get information if they wished.

[22] However, most poignantly and importantly, the request for information and education from peers that have been there. People that will "tell it straight – this is what happens – and the effects of it". Usually because of their backgrounds these youths' trust of people is non-existent and until that trust is established the educational process will not have too much effect. Trust takes time.

[23] How did these kids get here? The experts testified in detail about how this can occur but with the three individuals in question including Tracia Owen the last stop before the streets was a group home in the area. It would appear, probably due to cost of housing, the group homes are in the very area that the activity – drugs and sexual exploitation is prevalent.

[24] But it is crystal clear this activity by these youths is not voluntary in the sense we understand the word. To make the myriad of problems go away, drugs and the means to obtain the drugs, consume their lives.

[25] The inquest was told the ages of these youths were from 11-17 and some were younger. It should be absolutely clear to all of society, children in these age categories neither have the judgment nor maturity to live a secure life. Both our common sense when we raise our own children and the laws of our country with respect to both child welfare laws and laws under the Criminal Code, dictate youth of this age are not capable of exercising good judgment nor possess sufficient knowledge to do so. That is why all manner of laws allow parents to guide, inform and educate their children until they are capable of making those decisions of safety and health, etc. on their own. Isn't that what raising a child is all about – educating, advising, preparing them to make the best decision. When this process breaks down, for whatever reason, society needs to step in to protect this most valuable resource – our children. These statements may sound platitudinous to some, trite to others, but are they nevertheless true? Our laws, supported by our moral and ethical standards, certainly mirror these precepts – protection of our young.

[26] If I am correct, then it is difficult to understand why there is not public outrage about fourteen year old children standing on the street at all times of the day and night selling their bodies to support a drug addiction.

[27] It is conceded that the sexual exploitation of our youth is a serious problem in our city. Fortunately, through the office of the Coordinator of the Sexually Exploited Youth Strategy under Family Services and Housing, initiatives are being taken about which I will speak about later. However, there is no doubt that more needs to be done when we hear that 400 children a year are being exploited in the visible sex trade and even more in the invisible sex trade. In some way public awareness must be raised so the public accepts the fact that sexual exploitation of addicted youth is child abuse, is unacceptable and must be combated strenuously.

What should the response be?

[28] Although the evidence presented at the inquest demonstrated many initiatives being undertaken, one was left with the frustration of many roadblocks (evidentiary, legally, multi-disciplinary and resource wise) preventing an effective response.

[29] Detective Sergeant Coates of the Winnipeg Police Service spoke to many of these frustrations from an enforcement point of view. At the present time the investigation of youth being sexually exploited is complaint driven. The complaint can come from a variety of sources - parents (difficult children), group homes (runaways), schools/teachers (observing signs of addiction, absenteeism), neighbours (street traffic).

[30] Unfortunately, due to high rates of serious crime, lack of resources and limited results, kids on the street, at the present time, are not a high priority.

[31] These factors coupled with the lack of cooperation given by the sexually exploited youth due to a myriad of factors such as need for a source of drugs for their addiction, threats by their suppliers, shame, and guilt make for a frustrating experience for law enforcement.

[32] The third major factor, after low priority and lack of cooperation, is the limited power to intervene. Without an act being observed or being complained about, the police lack reasonable and probable grounds to intervene and conduct a criminal investigation. There are powers to apprehend if, in need of protection, but trying to ascertain runaways, missing persons and others is a difficult task without coordination, exchange of information and a multi-disciplinary approach.

[33] The description given by Detective Sergeant Coates of the large number of 11-17 year old females being groomed to earn money by sexually exploiting themselves to buy drugs either on the street or in crack houses is

horrific. Something that any parent of a child in that age category would find unacceptable. Let there be no misunderstanding - these are not twenty something year old sex trade workers being solicited on the streets by Johns. These are children being exploited by men who drive around our streets looking for these young girls believing they can engage in this kind of activity with impunity. This must change.

[34] The inquiry heard about some possible solutions to the roadblocks presently being encountered.

[35] Certainly in conjunction with tackling the present situation, efforts should be made to try to prevent this problem from escalating. One obvious way is through education. Not just education in our schools to dispel the false lure of drug involvement but also to dispel the false assumption of easy money and lifestyle. Also to educate the public about the extent of this problem, the abusive exploitation of our youth and the long-term damage being done to them through these activities of drug abuse and sexual exploitation.

[36] In order to brainstorm and coordinate possible solutions to this problem, a summit of all the disciplines involved even in a peripheral way is required. For example, law enforcement, justice personnel, child welfare personnel, group home personnel, foster homes, educators, government departments, private agencies providing services to youth, community groups and many others too numerous to mention whose mandate is to work with children.

[37] I am confident a frank and open discussion of the problem and possible solutions will result in a multi-disciplinary approach.

[38] It is hoped the following would at least be looked at as possible solutions:

- *Criminal Code* provision including new federal legislation including the Age of Protection (C-22)
- *Child & Family Services Act* legislation – Sections 17 & 18
- Youth Identification Project
- *Youth Drug Stabilization Act*
- Possible new legislation to be recommended
- Possible enforcement of present legislation not being used to its full extent

- Possible curfew legislation – enforcing curfew breaches
- Enforcement of breach of conditions
- Surveillance
- More aggressive investigation re Johns
- Intelligence gathering

[39] These are merely examples to be supplemented by those experienced in dealing with this problem. Hopefully such discussion will result in new innovative plans to attack this problem.

[40] Such an approach is not without precedent. In 1978 I was a founding member of the Provincial Child Abuse Committee which was created because of the frustration in investigating and prosecuting child abuse cases involving young children. Some of the same roadblocks were present – lack of testimony evidence, lack of coordination of resources, lack of a multi-disciplinary approach, etc. One would be amazed at the changes in this area, mainly due to evidentiary and legal changes in the Criminal Code and a multi-disciplinary approach from all the disciplines concerned with the protection of children.

[41] In my view such a renewed effort will only have success if it is part of a multi-disciplinary dedicated unit specifically to use their knowledge, information and all the legislative support available. Only if this becomes a priority involving everyone dedicated to the protection of children will it have a chance for success. Obviously "dedicated" and "priority" entails a unit that is properly resourced and supported perhaps by a variety of agencies and disciplines. The evidence at the inquest showed a great variety of dedicated people who by exchange of information, proper resources and singular focus could make a huge difference in this area.

[42] Such a Task Force created specifically for this task – the sexual exploitation of youth – properly resourced will in a very short time, in my view, be able to create the necessary tools for a more proactive approach to this problem.

[43] Tracia Owen, as we will see, had a myriad of problems. In some ways she represented the "typical" young person caught up in the drug culture and being sexually exploited – hoping her problems would all go away.

[44] Finally, hand in hand in getting and keeping these youths off the street and from being exploited, it is necessary to provide the necessary support.

[45] The inquest heard from Jane Runner of the TERF Program (Transition, Education and Resources for Females), the purpose of which is to assist sexually exploited females to exit that lifestyle by providing them assistance of various kinds.

[46] Ms Runner confirmed the general theme the inquest had been hearing – to wit: there are a large number with hundreds under the age of 16. 70% are aboriginal and 72% are in the care of child welfare; 52% have been sexually or physically abused. Common factors are a history of abuse, fetal alcohol affected, runaways, not in school, exposure to violence, and addiction issues. Because of such issues the process to assist them is a long one involving the need for a good trusting relationship, stabilized living situation, good programming and positive reconnections. Because of their vulnerability these youth are easy prey for predators to victimize.

[47] Ms Runner also confirmed that a first step is the need for prevention. Awareness and information to be provided before they get to the street corner. To dispel myths about the sex trade and provide the realities of involvement in such exploitation. These individuals are victims and the public has to understand their needs.

[48] In conjunction with the prevention thrust the resources need to be available to provide the necessary support to enable them to exit the sex trade. This requires a holistic, coordinated, individualistic approach involving all disciplines. Besides the basic life skills and basic living support the approach will obviously need to provide for the cultural aspect, mentoring and support for the family as a whole in order to bring about the necessary change.

[49] Obviously providing a safe, supportive, non-judgmental environment for these individuals is not an easy task. And that is why it will require a concerted, coordinated, multi-disciplinary effort in order to provide the necessary stabilization, programming and support for future growth.

[50] Finally there was further confirmation that because of the huge variety of issues that may be involved with a single individual, a dedicated unit is necessary to deal with child exploitation. Only in that way can the necessary knowledge, specialized training and strategies be developed to tackle this immense problem.

[51] It must be said it appears there is some hope the issue of sexually exploited youth is finally receiving the attention it needs. Ms Wendy Scheirich, Coordinator of the Sexually Exploited Youth Strategy for Family Services and Housing testified as to the efforts being made by the

government to tackle the issue. The government certainly should be applauded for some of the efforts they have made. The evidence presented was that over eight separate government departments are involved and many community agencies involved in the area of children. The purpose of the strategy is to reduce and prevent child sexual exploitation through a multi-disciplinary and multi-jurisdictional approach with different initiatives. Their intention is to raise awareness (schools, etc.), be involved in training of foster parents, addressing issues and developing responses. Ms Scheirich confirmed once again the numbers involved, their presence in the child welfare system, the number of aboriginal victims and the nature of the issues – abuse, homelessness, runaways, vulnerability, addictions.

[52] She was able to detail the response of initiatives taken, partnership with different government departments and agencies, training programs and new legislation. They have provided valuable resource documentation and intervention strategies.

[53] It was obvious from Ms Scheirich's testimony that the deceased Tracia Owen fit in what might be described as the profile of a typical sexually exploited female youth.

[54] Although the strategy for Sexually Exploited Youth is an excellent first step, it is essentially preventative. The coordination of existing initiatives and programs is important, however, in my view it is necessary to have new resources to create new initiatives, both preventative and service delivery. In other words, new additional resources are needed to augment the present initiatives by the variety of organizations under the Strategy's umbrella.

[55] The new resources could provide a more direct, hands-on, cultural approach, directed by a dedicated unit to the problem of sexually exploited youth. This unit may have people from many of the government departments and agencies involved at present but it must be augmented by aboriginal organizations that have experience in the field of sexually exploited youth and can address the obvious cultural issues in a meaningful way.

[56] It was clear from the testimony given by many that one of the serious gaps in any programming is the insufficiency of residential programs available to sexually exploited youth when you consider the number of young people involved. That is not to say that residential spaces are the only answer, for example, foster homes are another possible resource to be

developed, but it is clear that more spaces in residential facilities are necessary to tackle the numbers involved that need 24 hour support.

[57] "There are huge gaps in the child welfare system and law enforcement system that allows for this to happen and despite the good intention and efforts of all those working within both those systems. - Discussion Paper

These are the gaps that must be filled through a multi-disciplinary approach – child welfare, police, aboriginal agencies, community groups, justice officials, etc. Collaboratively the players in the system must look for the tools to fill these gaps. Specialization of personnel with specialized knowledge of the problem is required. Every possible tool should be on the table for consideration – accepted or rejected.

[58] The problem is immense:

> "Poverty, class, racism, social isolation, marginalization, peer pressure, past abuse and trauma, sex abuse discrimination, mental health, neurological and developmental disorders, system gaps, inaccessible services and other social, financial inequalities contribute to children's and youth's vulnerability to sexual exploitation."

[59] The solution will be difficult and requires a specific and directed response beyond a prevention strategy.

[60] In conclusion, this inquiry has had the advantage of reviewing the present legislation, law enforcement and educational responses now being employed to deal with the problem of street drugs and exploitation of youth. Although there have been renewed efforts particularly in the educational and preventative area, more needs to be done. This problem cannot be adequately attacked without dedicated, full-time, specialized and multi-disciplinary resources to examine and implement new strategies to attack this unacceptable plague on our youth.

III. TO DETERMINE WHAT ACTION, IF ANY, CAN BE TAKEN TO PREVENT SIMILAR DEATHS FROM OCCURRING.

Leonard Bushie

[61] The inquiry heard from the deceased's father, Leonard Bushie of Little Grand Rapids. Mr. Bushie conceded the many problems facing himself, his wife Elizabeth Owen, and the community of Little Grand Rapids. Tracia was born in May 1991 and three other children were subsequently born to Leonard and Elizabeth. Tracia was taken into care when she was only two months old but subsequently returned over the years as many as 17 or 18 occasions depending upon the alcohol or domestic abuse problems Leonard and Elizabeth were facing.

> "I guess the reason they're taking my kids is because of my alcohol problem". (Vol. 2, p. 40)

[62] Elizabeth had a similar problem and the Local Child Care Committee and the social workers were constantly trying to get Elizabeth and Leonard in treatment while moving Tracia from each of her grandmothers and other extended family until treatment was completed. This process literally went on for years. Mr. Bushie acknowledged his eight convictions for assaultive behaviour, many with respect to Elizabeth, which were largely alcohol fueled. He tried to get help on the reserve from a therapist or from the NADAP (Native Addictions Drug & Alcohol Program) worker with various degrees of success for various periods of time. He indicated he began drinking at the age of 9 or 10 and bootlegging was a common occurrence on the reserve. Leonard hoped that if he was successful with his alcohol treatment and received some support, perhaps Tracia and his other children would be returned to him.

[63] Leonard had seen Tracia blowing into a plastic bag, sniffing gasoline, and therefore was aware why she was taken to Winnipeg – "I guess she was in need of help". He last saw Tracia in June or July 2005 in a family home visit and was looking forward to her perhaps coming home for a summer job.

[64] Leonard acknowledged that Tracia had spoken to him about the sexual abuse allegation and he admitted the problem it caused – "like even my own

parents didn't like what they – what Tracia told, told my parents." (Vol. 2, p. 76)

[65] Mr. Bushie presented a newspaper clipping which he wished the court to see:

> "Sergeant Brett Summers of the Winnipeg Police Service, child abuse unit said he hopes the inquest will show people there is a cost to children and, and teens getting caught up in the drug and sex trade. We want people to be aware that there are consequences to sexual exploitation of young children. One of them is suicide.
>
> Almost half of the children and teenagers who killed themselves last year were receiving different levels of care from CFS. Three had been in foster care while CFS was involved with the family in nine of the cases. Thirteen of the children – and teens were from aboriginal reserves."

Mr. Bushie hoped the Inquiry would deal with these issues.

[66] The other issue raised by Mr. Bushie concerned the depression pills Tracia was taking, which I have commented upon.

[67] Finally, he suggested:

> "Like I think they should like have like programs or like maybe workshops like, like in the gray home, eh, like ... or like people are talking about that on my reserve there, like they should like try and like teach like kids not to like smoke up or like do drugs like that." (Vol. 2, p. 26-63)

Young Spirits Group Home

[68] From January to March of 2004 Tracia lived at the Young Spirits Group Home under the auspices of Southeast Child and Family Services with three other girls – 12-17 years of age. This foster home was a house with seven staff who assisted the high-risk girls but each girl had their own worker.

[69] The importance of this testimony which became a reoccurring theme was the lack of information accompanying Tracia Owen. Information that she had been expelled from Kirkos House because of violence, that she was often absent without leave and that she had solvent abuse problems, should have been shared with the caregivers. Even if the caregiver is not involved in therapy or counseling per se this type of information is surely important for the safety of this youth, other youth in the home and the staff. Receiving this information prior to receiving the youth would be of assistance to all concerned to be able to provide help and safety to Tracia. I think the foster parent was correct in saying, "If I had some history of her prior history, then we could have worked with that." As it turned out, little could be done to assist Tracia due to the shortness of the stay and her attendant problems.

Provincial Placement Desk

[70] With respect to the placement that Tracia Owen was in prior to her death, the inquest heard lengthy testimony from Ms Patricia Alphonso Cox who was the Provincial Placement Desk Coordinator. The function of this position is to be responsible for the selection, priorization, maintenance and development of placements for children in residential and specialized resources in Manitoba. After Tracia's difficulties at Kirkos House it was obvious to Southeast Child and Family Services that assistance and support was needed for Tracia and so a referral was made to the placement desk. Once the Agency has made the referral to the placement desk the Desk's function is to try and match this particular child (Tracia) and her needs to a facility that would be best able to match those needs. Ms Cox's experience with the resources, their philosophy, the approaches, the kinds of kids they responded to (cultural and ethnically) is one of the keys to making the appropriate match. This is done in collaboration with Tracia's Agency worker.

[71] Besides the above factors and many others, there is the obvious hurdle of availability of space and the priorization of someone like Tracia with numerous other individuals in similar circumstances needing similar support and care (300 referrals a year). The numbers needing such facilities greatly outnumber the spaces available and therefore there is a constant comparing and contrasting of each individual against each other to assess the greatest need.

[72] Also the risk the child presents is extremely important and is determinative of the greatest need. The risk denotes the safety of the child and of others and therefore must take priority. Risk factors include risk of extreme harm or death, risk of sexual exploitation or abuse, risk of gang involvement, risk due to mental health issues and suicidal behaviour.

[73] The placement desk will also provide additional support to the facility chosen if requested.

[74] As one can see many, many factors come into play in making the determination of which facility is best able to answer the particular needs of this particular child and obviously making the appropriate placement is more of an art than a science.

[75] This having been said it should be obvious that the more information whatever its nature or source would be important at least to consider in

making the appropriate placement. If the placement desk is not aware of certain factors that may be important, the decision process is being made in a vacuum and the proper emphasis might not be made. This would particularly be true if one or more of the risk factors has not been indicated. For example, if there is a history of suicide attempts the staff's knowledge of this would make them extra vigilant.

[76] Now it must be said that due to the lack of residential facilities available and the lack of specialization in them, most facilities and their staff are more generic in their approach and are prepared for most eventualities. But surely forewarned should be forearmed and such information would be of assistance. As Ms Cox testified:

> "I believe that having all of the information will always help an individual to make the best assessment of a child and their needs."

[77] Surely the best assessment is the ultimate goal and I think it was beyond dispute more information and better detailed information should be the standard rule and not the exception.

[78] I accept the testimony that on the basis of the knowledge of the placement desk, a secure facility was not the best choice. Upon the evidence presented the placement at Project Neecheewam was the appropriate choice and I believe it would still have been the best choice even if all information that was subsequently revealed would have been in their hands. Ms Cox conceded as much in that many of the facts subsequently revealed to her, still could have been managed, in her view by Project Neecheewam. Her options were limited in any event. There being few so-called secure facilities and in most cases a long waiting list to get in. One also has to take into account many of the most dangerous activities participated in by Tracia, such as sexual exploitation on the streets and cocaine usage had not participated in by Tracia at the time the Placement Desk was making a decision concerning her placement.

[79] The decision-makers were of the view supported by their experience and by the information they had received, Tracia required a community facility (specialized foster home) offering a stable, secure, home-like atmosphere where she could stabilize by developing a trusting, supportive relationship with the staff in order to meet her needs.

[80] And despite the lack of information which should have been provided in order to assist the placement desk in matching the child to the right

facility, I believe the appropriate placement was made despite the ultimate tragic result.

Project Neecheewam

[81] Tracia Owen was staying at a residential care agency called Project Neecheewam at the time of her death. This is a facility for six girls usually around the ages of 11 to 14 who are overseen by three key counselors. The hope is to create a home-like living accommodation (life skills) that would provide stability, security and counseling for the residents. As the progress of the residents is monitored the counselors would recommend external resources, as they see fit, to respond to the individual needs of the residents – i.e. medical, educational, recreational programming (Pow Wow). By determining individual needs the staff can respond by using programs already in existence in other agencies such as Klinic, MaMawi, Manitoba Youth and Care Network, Ndinaiwe Resource Centre. Psychotherapy counseling can be provided as well as a mentorship program. The residents usually offer a great many socialization challenges and the staff is prepared to meet those challenges by references to whatever program may offer support to the resident while she lives at Project Neecheewam.

[82] When Tracia Owen was placed at Project Neecheewam by Pat Alphonso Cox, a social history accompanied her. The very brief social history raised areas of concern and obvious need for treatment in many areas. This social history cried out for more information concerning previous placements and the nature of past victimization. This information allows the staff to monitor and counsel the resident with knowledge of past issues. This information is essential to allow staff to provide the necessary counseling and referrals to outside resources to meet these needs. It makes sure the staff is not planning in a vacuum which is essential with respect to family contact and safety concerns.

[83] The residence keeps a running documentation through its log notes in order to stabilize the resident, arrive at goals of treatment and to manage outside resources to assist. Without going into all the details contained in the log it was apparent Tracia would need long-term residential care. It was obvious she had had attachment issues with respect to her parents not being able to nurture, an inability to interact appropriately with the other residents, and other behavioral interactions. At one point the mobile crisis unit was called in order to assist in stabilization. Despite the lack of appropriate and timely information and despite the many challenges Tracia presented, the staff of Project Neecheewam proceeded to take whatever steps were necessary in order to stabilize her and move on to fulfilling her needs. The

first determination made was that she needed a medical treatment plan in order to combat depression and to assist her becoming more stable. This led to the appointment with Dr. Collison and Dr. Szelazek and to the prescribing of Prozac. The staff was aware that the dosage would be raised and they were to monitor the drug's side effects on Tracia and to keep the doctors advised. The staff recorded and controlled dosage and were satisfied Tracia was taking the meds. Although there was outward effects, these were not clearly distinguishable from previous presenting issues. The staff was also now aware of a solvent abuse history and were taking appropriate steps to prevent access to gas, white-out, etc. Further medication was given to address anxiety and for awhile improvements were made as illustrated by her involvement in Hip Hop, Pow Wow and mural painting.

[84] As Tracia presented a different concern or issue the staff reacted through counseling, referral, medical or psychiatric response or seeking more thorough assessment or greater information. The goal being to stabilize her in order to be able to tackle the many issues she presented to them. The plan was to stabilize Tracia through specific programming – safe activity, age-appropriate, building self-esteem keeping in mind cultural awareness and identity. To normalize her life by building up a trusting relationship with her caregiver over time so not to overwhelm her. Except for the very last days of her life many of the issues Tracia was presenting were not unusual for a youth with her background. The AWOL's, the behaviour problems, the depression, the incident reports were not out of the ordinary for a child with her background. Progress, although slow, seemed to be being made until the disclosure of sexual abuse. Such disclosure, in itself, would confirm her stabilization and her ability to trust.

[85] In her evidence, Rhonda Wasicuna detailed the steps taken with Tracia. She indicated it would have been valuable to have more information upon Tracia's arrival (i.e. discharge report from Kirkos House) so they could have continued where Tracia had left off. She indicated there was support available - for school difficulties (Youth Emergency School Supports – YESS), sexual identity counseling (PASS – Positive Adolescent Sexuality Support at MaMawi) and a FASD (Fetal Alcohol Syndrome Disorder) assessment. A psychological assessment was undertaken. In other words, Project Neecheewam was responding to her individual needs as they gained insight into them.

[86] The staff took the position, even with the many problems presented by Tracia, they would exhaust all efforts in trying to support her before abandoning the open setting approach. It is hard to fathom but closed setting

institutions like Marymound have waiting lists for youths far worse than Tracia.

[87] Irene Drabik, a mental health clinician, had a partnership with Project Neecheewam and through this contact provided advice and assistance to the Project and thus to Tracia Owen. She was informed that Tracia's depressive symptoms were being dealt with and improvement was being shown after her psychiatric assessment and subsequent medication. Ms Drabik's contribution was important in getting an early psychiatric assessment date which appeared to help Tracia's condition.

[88] Once again the issue appears concerning the availability and timeliness of information concerning Tracia being given to the appropriate parties. For example, the nature of previous assessments and cognitive assessments would assist in the planning of treatment. Although this appears to be agreed upon the absence of such material does not appear to be fatal to proceeding in the initial stages of working with Tracia. The process appears to be a slow one involving getting the person fully engaged in a secure placement and in a trusting relationship. More than once the inquiry was told that unless the individual is stabilized in such surroundings there can be no healing. Furthermore, therapy, if it can be called such, is just as much a part of the creation of this trusting relationship and stability as is any insight oriented therapy.

[89] Ms Drabik indicated that on August 18th, in her first one-on-one session with Tracia, the issue of "bad thoughts" versus "good thoughts" and the risk of suicide was canvassed. Tracia denied wanting to die or having thoughts of dying and expressed optimism for her future. She was positive about Neecheewan and her staff person, Tina. For although she was guarded and cautious, she appeared to becoming engaged in the process. Ms Drabik was satisfied that there was a circle of care involving therapy, treatment and intervention surrounding Tracia.

> "I felt optimistic that she was, had these future plans and she had some goals. She was interested in doing some positive reading for herself. She wanted to go back to school. Like, I felt optimistic and when we three left we felt it went well."

[90] Less than one week later Tracia Owen had hung herself. What went wrong?

[91] After a July 3rd phone call with another brother in which the family's response to the disclosure was discussed, progress stopped and deterioration

began. Not immediately but anxiety began to appear. Staff through July and into August tried to provide support.

[92] One report indicated as follows:

> "Tracia has recently disclosed sexual abuse perpetrated by her older half brother and has been under extreme stress due to concern of her family's reaction. According to placement staff, Tracia was worried her family would think badly of her for making the disclosure. She was feeling isolated because she was not allowed to have regular contact with her family due to the investigation. She started therapy again on Thursday, August 18th to begin addressing issues and saw Irene Drabik of MATC."

[93] From later evidence given, many thought that this disclosure and the family reaction to it was the possible triggering event which led to the suicide.

[94] After hearing all testimony concerning the efforts of Project Neecheewam one can only draw the conclusion that when presented with Tracia and her myriad of problems, many long established, they tackled her issues with love and care and through the appropriate usage of all the resources at their disposal. It is tragically ironic that Tracia Owen should die while in residence at a facility that was, for perhaps the first time, offering the care she always needed.

[95] There are some concerns hearing the testimony from Project Neecheewam. The absence of specific, detailed, confirmed documentation concerning Tracia's history was the most obvious. Planning for treatment and safety requirements for the victim, other residents and staff can only be helped with as much detailed information as possible being provided. The sooner this information is in the staff's hands the sooner they can assess the situation in light of the information. The clearest example would be that staff would not consider sending a resident back to a familial situation where sexual abuse had been alleged. Imagine the possible ramifications if that was done and a second allegation of sexual abuse was alleged because such information was not in the hands of the decision-maker in a timely manner. You may not keep the gas tank locked if you did not know a resident was a chronic sniffer. It was testified that documentation has been better since the incident and that is important to hear. Enough said.

[96] Secondly, it becomes clear there is a dearth of residential beds and facilities such as Project Neecheewam to respond to the number of children

such as Tracia. Whether the facilities should be locked or not is a question that needs to be arrived at by the individual assessment of these youth. However, whether they are locked or not there obviously needs to be more of both to meet the demand.

[97] The final issue raised concerned the disclosure of sexual abuse and the lack of a place for these victims during this very traumatic time. Hand-in-hand goes the lack of resources to deal with those abused and the lack of resources to conduct efficient, expedient investigations of the allegations. At the time when the victim is most vulnerable it would appear the necessary resources for support, care and investigation are lacking. Things appear to be put on hold pending the investigation of the allegation of sexual abuse which may take some time – crucial time This is not the time for everything to go into limbo. More rather than less is necessary or the consequences may be fatal.

The Section 10 Report

[98] Most importantly in the context of this inquest, the Chief Medical Examiner's Office is responsible for conducting a review of agency files pursuant to Section 10 of the *Fatality Inquiries Act* This requirement is based on two criteria: a child in care has died or a child has received services within the previous 12 months.

[99] The Section 10 report is a review of the agency's record of service – what services were provided to the family for whatever time period the agency had been involved with that family. It is an examination of the agency files. This report may result in recommendations being made which may be addressed by the parties involved – Agency, Authority, Child Protection Branch – as to their soundness and possible implementation.

[100] In this case, as a result of the Section 10 report, the Chief Medical Examiner called an inquest and he set out his reasons for doing so as previously indicated.

[101] As a result of the Section 10 report and its recommendations prepared for the Office of the Chief Medical Examiner, it would appear the Chief Medical Examiner thought an inquiry would assist in answering the three questions he outlined as the mandate for the inquiry.

[102] This section will deal with these recommendations and the evidence called at the inquiry on the subject-matter of the recommendations.

[103] Ms Ginette Abraham was a special investigator with the Office of the Chief Medical Examiner and her function was to prepare a Section 10 report with respect to the death of Tracia Owen.

[104] Section 10 of *The Fatality Inquiries Act* reads as follows:

CME assessment of agency

10(1) If the chief medical examiner receives an inquiry report about a deceased child who, at the time of death or within the one year period before the death,

(a) was in the care of an agency as defined in *The Child and Family Services Act*; or

(b) had a parent or guardian who was in receipt of services from an agency under *The Child and Family Services Act*;

the chief medical examiner shall assess the quality or standard of care and service provided by the agency by

(c) examining the records of the agency respecting the child and the parent or guardian; and

(d) reviewing the actions taken by the agency in relation to the child and the parent or guardian.

CME has ME powers under subsection 9(7)

10(2) For purposes of an examination or review under subsection (1), the chief medical examiner may exercise the powers of a medical examiner under subsection 9(7).

CME to report to minister

10(3) Upon completion of an examination or a review under subsection (1), the chief medical examiner shall, in the form and manner prescribed, immediately submit a written report to the minister charged by the Lieutenant Governor in Council with administration of *The Child and Family Services Act*.

Confidentiality of CME report

10(4) A report under subsection (3) is confidential and, for this purpose, is governed by the provisions of Part VI of *The Child and Family Services Act* as if the report formed part of a record to which Part VI applied and is not governed by section 42 of this Act.

CME to prepare summary for annual report

10(5) Despite subsection (4) of this section and Part VI (confidentiality) of *The Child and Family Services Act*, the chief medical examiner may

(a) not later than December 31 of each year, prepare a summary of recommendations contained in reports prepared under subsection (3) in the previous year, without disclosing the name of an individual or agency or any information that might identify a child or the parent or guardian of a child; and

(b) include the summary in the report referred to in subsection 43(2) (annual report by CME.

[105] This investigation involves a file review of the material possessed by Project Neecheewam and the parent child care organization Southeast Child and Family Services. As a result of her examination of the files she made four of the six recommendations contained in the Section 10 report. There were areas where clarification was asked for but these were not forthcoming at the time but responded to by witness, Glory Lister, at the inquiry.

[106] The recommendations made were as follows:

Recommendation One

The Chief Medical Examiner recommends that the Southern Authority, in conjunction with Southeast Child and Family Services and local child care committees use comprehensive family, child risk assessment plans to devise permanency plans for children where familial circumstances resemble those of the deceased child and her family.

Recommendation Two

The Chief Medical Examiner recommends that the Director of Child Welfare for the Province of Manitoba, in association with the four authorities, ensure that a protocol is in place with police services in the

province regarding identification of a child in the event of the death of child in care.

Recommendation Three

The Chief Medical Examiner recommends that Southeast Child and Family Services maintain its case records in accordance with provincial standards, including placing on its files ongoing summaries of events in the lives of the families and children they serve.

Recommendation Four

The Chief Medical Examiner recommends that Southeast Child and Family Services review its policies on the placement and replacement of children in the foster care system, with a view to how multiple placements can be minimized.

Recommendation Five

The Chief Medical Examiner recommends that Southeast Child and Family Services, with the assistance of the Southern Authority, review with its foster care department as well as its foster parents the placement and replacement of foster children in their homes.

Recommendation Six

The Chief Medical Examiner recommends that the Child Protection Branch and the Authorities ensure the province's foundation standards include a provision for pre-placement visits when children are placed in non-emergency or replacement situations.[1]

The Chief Medical Examiner further recommends that Southeast Child and Family Services, in the interim, ensure that children in care are provided with pre-placement visits (in non-emergency or replacement situations) prior to being placed.

[1] The Province's website at http://www.gov.nb.ca/fs/cfsmanual/index.html indicated (at the time of writing) that standards for children care and foster care are not yet complete and "will be added as the Child Protection Branch in consultation with the child and family services authorities approves them."

[107] One result of these recommendations was the Chief Medical Examiner called for an inquest to examine the issues raised.

[108] One of the recommendations dealt with the inadequacy of the assessment process data with respect to Tracia Owen (Recommendation One). The assessment process, in my view, is extremely important because it in effect gathers and analyzes the information in order to determine the child's needs and how those needs can be met – e.g. in the community or elsewhere, by the extended family or other options. Assessment is the basis for case management planning and must be constantly updated to take into consideration the changing circumstances. The standards in the Child and Family Services Standards Manual go into a great deal of detail. There was an issue raised with the number of standards, when they were published, whether they were new or old. This is obviously a concern in the sense everyone should be operating from the same page. Having said this I thought the standards were for the most part codification of common sense application of child welfare issues. It is obvious that assessment should be in writing so workers can add to and build upon previous issues dealing with the child. This is an ongoing process that should be flexible, constantly trying to match the child and family to appropriate services. Without detailed records being kept no one can determine what has been done or what should be done. Each child needs a plan for their safety and their growth but the plan may need extensive changes as circumstances dictate.

[109] Failure to adhere to this standard does not assist supervision and certainly does not assist situations where there is a change of workers or the child is being moved from one environment to another.

[110] The other issue frequently raised during the course of the inquiry is the reality of child welfare practice in Winnipeg in contrast to Little Grand Rapids. There is no question that resources, training of staff, options, etc. can be substantially different depending on the reserve and its social problems. So this does have to be taken into consideration. However, the danger I fear is that the excuse of this inequality can mean the creation of a two-tier system of child welfare. If we accept the standards cannot be applied in Little Grand Rapids and the standards are minimum expectations, are we not left with children in Little Grand Rapids getting less than minimum expectation of the child welfare system. This, in my view, is unacceptable. Obviously the resources must be available so the standards are attainable. One cannot expect standards to be met without the means provided to meet them. Until this can be achieved it is important that the standards try to be achieved wherever possible.

[111] Written plans on file can assist in providing stability and permanency for the child and if the plan is not working then the plan can be re-evaluated (Recommendation Three).

[112] Ms Abraham reviewed the standards in her testimony and commented candidly on where she thought inadequacies were present. I believe most of the standards although specific are largely based on common sense – assessment, planning process, written plan, safety plan, service provision decisions, contact with family, ensuring services are provided, evaluation, monitoring, progress reviews.

[113] Ms Abraham was aware and conceded many of the points raised in Strengthen the Commitment, an External Review of the Child Welfare System (Exhibit 49) having to do with inadequate resources in remote areas, the application of the Child Welfare standards in the context of such environments, issues unique to aboriginal families, the importance of family, extended family and community, the lack of options with respect to placement and the existence of severe social problems.

[114] Even in this context, Ms Abraham felt there was no evidence of sustained changes by her family that would point towards permanency for Tracia in the family home. The addiction issue for the parents was a constant struggle and although it was hoped to keep Tracia in the community and that the parents would be successful in attaining sobriety and thus function as parents appropriately this was not occurring. The question became how many chances do the parents get before the adverse effect of their behaviour affects the safety of Tracia. When does the desired goal of keeping the family together change to protect the child. Obviously she wanted to stay with her family and felt responsible for them but the issues of family violence, victimization, substance abuse were too much.

[115] The lack of pre-placement visits was another issue raised (Recommendation Four). It was noted such visits are for the agency to let their expectations be known to the family caring for the child and to smooth the transition for the child.

[116] Some of the concerns raised may not be valid but there was no documentation or written record to confirm what was or was not done. The most obvious example is the incident where Tracia was allowed to return home over Christmas and yet there is no confirmation of her being monitored. No one knows for sure. In my view, for a child of her age with substance abuse problems, someone should have known and such

monitoring documented. It is an inadequate answer to say Tracia may have been lying. The agency should have been able to substantiate the truth.

[117] It appears to me to be common sense to ask the question are the factors that made us remove this child from the home still in place – documentation of the factors and the risk they present should be answered.

[118] Once again it was agreed that the community itself needs to initiate some healthy change. This will often require the providing of tools to support the agency's work in the community and to assist in making the community healthy for the child rather than removing the child.

> "What I really believe, in the spirit of this young girl, was that there was need for her to know where she belonged in this world and there was a need for her to know that she was valued and important, and she needed to know that from everyone involved in her life, not just the, you know, the, the alternate caregivers. She needed to feel that in her community, in her family, in all of the people that she saw as being important in her life."

Southeast Child and Family Services

[119] As a result of the section 10 report and its recommendations concerning Southeast Child and Family Services it was important to hear from Southeast Child and Family Services to better understand the conditions under which they have to provide their services.

[120] Michael Bear, Executive Director of Southeast Child and Family Services was the first of several to articulate the manner in which child welfare is administered in remote reserves. Mr. Bear accepted the following philosophy:

> "The difference relates to the concept of 'the best interests of the child' and whether that interest can be considered in isolation from the child's family. This is not about putting the interests of the child aside for the greater benefit of the family, but rather the concept that the two are inextricably linked."

[121] In this regard he emphasized the need to maintain the family connection, to search for extended family placements, in short, to do everything possible to maintain the child safely in the community. Removal of the child from the home community needs to be the last resort. If every possible resource in the home community is exhausted then removal may be necessary with the fear the child will be lost and lose the ability to attach. He felt that if some connection to who they are or where they came from is not maintained they will be lost only to seek that connection once they turn 18 years of age and are out of the child welfare system.

[122] His answer to this quandary is to create resources on the reserve (foster homes), increase training for staff, lower caseloads, support the families in the community rather than taking the child in care.

[123] His recommendation in order to achieve these aims would be to negotiated parity in the funding formulas between the provincial and federal governments. The approximate 22% difference of federal funding to provincial funding means preventative services in First Nation Communities lose out.

[124] These themes reoccur throughout the testimony of the First Nation child welfare workers, have been supported by many reviews of the system and are undoubtedly supportable.

[125] However, it was equally clear that while the Agency was waiting for many years for the parents of Tracia Owen to solve their personal problems, Tracia herself was sniffing, needing treatment (Kirkos House), acting threatening, suicidal (discharged from Kirkos) and placed in a four bed placement, where difficulties continued, and finally to Project Neecheewam.

[126] Contributing to this spiral was the lack of long-term planning, proper assessment, insufficient documentation, lack of accountability to standards, lack of oversight.

[127] Somewhere opportunity for the parents should have been replaced by opportunity for Tracia.

[128] Ms Glory Lister was the policy and program advisor to Southeast Child and Family Services with 20 years of experience in the field of social work. One of the purposes of her testimony was to describe the conditions on the Little Grand Rapids reserve which was the home reserve of Tracia Owen. Little Grand Rapids was described as lacking efficient infrastructure, overburdened by poverty and isolation, whose population was largely unemployed, undereducated, marginalized with health, alcohol and crime problems. Because of lack of housing, overcrowding and the lack of infrastructure, people who are needed to help support the community cannot live there and are flown in throughout the week. There are approximately 525 children under age, 206 children in care and because of inadequate funds (approximately $424,000) when the needs warrant $1,000,000.00, the community is unhealthy in all senses. As a reserve it is under federal jurisdiction and apparently considerably underfunded with respect to the most basic needs. Because of such things as travel costs (bringing people in) and training costs (train local people because no one wants to move there to live) it is impossible to run a child welfare system as it should be run. Money flows for the apprehension of children rather than the support for the children and their families in the community.

[129] Ms Lister argues that in light of the severe problems facing child welfare services in an unhealthy community like Little Grand Rapids one has to consider different approaches and different services. Such a community needs to be raised in an integrated, developmental, holistic, lifespan way. If the community becomes healthy the child will become healthy. Shared parenting with multiple caregivers (extended family) and a sense of connectedness to the community are essential goals. She would argue that without the child having a sense of belonging during this time of identity formation and shared cultural values, they will be lost no matter

where they are located. In her view, bringing them to the city may help financially and expose them to better resources, it also places them in an unfamiliar territory, without family and without protection from the social problems of the city. The problem of over-representation of aboriginals in crime, running away, street culture (drugs and prostitutes) are evidence of the difficulties being faced by Tracia.

[130] Ms Lister confirms the approach of Project Neecheewam but knowing the hope Tracia placed in reuniting her family, Ms Lister was not surprised that the family's reaction, their denial and their lack of support could be the precipitating factor in Tracia's spiralling downfall. Despondent by this reaction, needing to belong (street culture – prostitutes) and drug taking resulted in Tracia's death.

[131] Ms Lister concluded that keeping kids in the community, a community with resources, and to provide support to the family is the long-term answer. Parallel with this, obviously, is the need for the necessary community development – economic, housing, education, training – to make the community well so it can raise a healthy child.

[132] Fortunately significant changes have been in the works on how Southeast Child and Family Services does business. Many have been the result of assignment of staff, etc. as of June, 2005 – supervisor, staff, program manager, community supervisors and staff, quality assurance position, financial unit, child abuse workers, support worker co-ordinator, educational coordinator, drivers, foster care department, staff to input the data base and the Child & Family Services Information System. Also more accountability structures are in place – annual reviews, 90 day review. Phases of case management are followed – intake, assessment, planning, review, transfer, closing and evaluation.

[133] Although those changes are steps in the right direction, they have been largely made because of the provincial government funding. In the long-term the community has to be made healthy by attacking problems of infrastructure and the basic needs of life – food, clothing and shelter. Unless these areas are dealt with the result of poverty and neglect will continue to be crime, violence, abuse, neglect, substance abuse, suicide and the children will bear the brunt of these problems. These areas fall within the mandate of the federal government and all evidence indicates they are falling short in their financial support to rescue these communities. Testimony was given that the federal government's funding is based on population where the provincial government is based on need. It is obvious from this funding

mechanism that any community in greater need because of the above-mentioned problems is going to be shortchanged by the federal government. This would certainly appear to be the case in the northern communities such as Little Grand Rapids. Programs, treatment, etc. that are available in the cities, some of which are inadequate, have no hope of being implemented in Little Grand Rapids because the child welfare agencies get more money when the child is made a permanent ward and removed. It is argued the money would be better spent improving the conditions in Little Grand Rapids so the children stay in the communities with the proper support for families. Even if they are removed, once they are returned to the same broken community the problems are still there. Examples of needs were addiction treatment, school attendance, mental health issues, abuse programs, foster parenting.

[134] In the meantime, it is clear, despite the changes made, some mechanism must be devised to trigger cases like Tracia Owen which fall under the radar of quality assurance and review. It is obvious that, if possible, a child should be with her family, extended family or at the very least in contact with her family. No one will disagree with this being the best option. However, when the family is dysfunctional through alcohol abuse, familial abuse and neglect, other options must be considered. And when the dysfunctional family cannot make the necessary improvement to provide a safe, nurturing environment for the child, long-term planning for the child's future must be taken.

[135] It is difficult to understand if reports were being maintained and updated, if reviews were being conducted and standards were being respected how Tracia Owen's situation could have been missed. Something must be in place in the system to recognize such a situation so immediate action can be taken. At some point Tracia's safety and future well-being must trump her family interests even if this is not Tracia's desire.

[136] One can only have profound sympathy and understanding for the frustrating environment in which Southeast Child and Family Services operates with the children in their care. But one must operate within the present realities and not in contemplation of the way things should be.

Southern Authority

> "She's a child who died in care and she died by her own hand, so yes, the system failed her. It's a system that ideally protects children. It's a system that doesn't always achieve that did not do that for Tracia and clearly in my mind it failed her." (Vol. 20, p. 126)

[137] Ms Elsie Flette, with 27 years of experience in child welfare practice, became the CEO of the Southern First Nation, Child and Family Services Authority in May of 2003. Ms Flette was responsible for, among many other things, the restructuring pursuant to the AJI recommendations for putting control over aboriginal children and families with aboriginal people. This mammoth task of implementation was completed in May of 2005 and the Southeast Child and Family Services is one of the agencies mandated by the Southern First Nation Authority. Not only does the Authority mandate an agency but they are responsible for funding of the agency on the portion of provincial responsibility and they are the oversight body and responsible for the service delivery system. Ultimately the Authority is responsible for making sure the Southeast Child & Family Services are doing what needs to be done according to established standards and are responsible for compliance and quality assurance of that agency.

[138] Thus, the interest of the Inquiry in hearing her testimony on the Southeast Child and Family Services Agency and its responsibility for Tracia Owen.

[139] Tracia Owen would have been under the oversight responsibility of the Authority for approximately 17 months. But because of the numbers involved (3,000 in care) and unless something triggers a specific review of the file it would be impossible for every single file to be reviewed.

[140] It is expected through the legislative framework, regulation, standards, internal monitoring, complaints made, licensing applications and the like, such cases would be flagged.

[141] It would be a particular expectation that adherence to the standards of case planning and case assessment would have caught this case.

[142] It should be noted that this was not a child who was lost in the system as such. She was one requiring constant attention and needs to be met. In

March of 2003 she was in Kirkos House to try and meet those needs. She was made a permanent ward in December 2003. She was in a number of emergency resources, the four bed units both at Kitigas at Little Grand Rapids and in Poplar River, in emergency shelters in the city. Because of behavioural problems she kept being moved because placements seemed to be unable to meet her needs until Project Neecheewam. Yet despite being constantly in the Agency's eye little seems to have been done with respect to long-term planning for Tracia Owen.

[143] The really frightening aspect is the view expressed by many that despite these constant behavioural issues they were not sufficiently unique or different from other youth to bring any particular attention to her file. Her struggles were not unusual in the child welfare system.

[144] It was conceded there needs to be a strengthening of the governance of the system, to improve oversight, compliance, monitoring and to build capacity within the agency to do so. The Southern Authority is responsible now for nine agencies as opposed to the 22 under the Child Protection Branch. Therefore there should be a more focused workload, easier to address shortages and deficiencies and to consider best practices.

[145] Exhibit 50 filed at the inquest is an audit conducted to examine areas needed to be considered when the devolution was taking place. The systemic problems of the old system needed to be addressed by the new Authority. Ms Flett and the Authority are in the process of implementing those recommendations some of which bear directly on the inquest which have been mentioned and others which are important but less relevant to our issues.

[146] One recommendation which I believe is extremely relevant and may assist in preventing future tragedies is the mandatory requirement to use the Child and Family Services Information System, the database system, to maintain and track files. Although there are some system issues in some locations the potential for the proper use of this system may be an answer to the lack of information on a file and to keep the file current and updated. A current central database provides a better tool for case management and some of the information placed on a file may be used as a trigger or flag to warrant review of the file.

[147] There should be some sort of criteria established such as too many placements, sexual abuse disclosure, sexual exploitation, that flags that particular case file for review and immediate attention.

[148] Another possible way to monitor a child is through the financial monitoring or maintenance billings. It would appear this would not be possible with a federal child (the responsibility of the federal government) because the agency does not have access to the federal billing information.

[149] This led to evidence concerning the two different regimes and how they impact on child welfare in the province.

[150] Federal agencies have two types of funding – operations and maintenance. Up to 1993 there was also service and families funding (support, etc.) but that was discontinued and allegedly placed in operations. If not maintenance it must come out of operations funding. Maintenance is any cost related to maintaining a child in care – that is – a child having a legal in care status – apprehension, temporary ward, permanent ward, voluntary placement. The federal government will pay maintenance according to the provincial rates. They will pay on actuals on children in care.

[151] The problem being that on the operations side it is formula funded based on child population, not on caseload or service issues with respect to caseload. It is not the number of children that dictates the cost but the needs of those children and thus if the needs are great like in Little Grand Rapids, the federal formula on the operations side will prove inadequate. A flat or fixed rate does not answer the question of need. Because the federal grant does not feel that child welfare is their responsibility as such they are only interested in the financial information and numbers rather than the child welfare issues involved. They are responsible for the fiduciary relationship with First Nations but not the issues of specific funding issues related to child welfare.

[152] As the result, one is left with the incredible result that the only way to access sufficient funds is to put the child in care and therefore access the maintenance side of the federal ledger. There are numerous other issues at the negotiation table between First Nations and the federal government but they have been there for some time and have been commented on in previous inquests involving similar issues.

[153] The provincial government has three financial lines - operations, maintenance and Family Services. The operations and maintenance are self-explanatory and the same as the federal government. The Family Services financial line is money to families intended for services for kids in their own home. There is also a Family Innovation Fund to support projects with families to keep their kids in homes. Finally, Changes for Children

initiatives promote workload relief money which assists in bringing the workload down to 1 to 20 ratio whereas the lack of similar federal money keeps it at the 1 to 30 ratio. Since workers carry a mix of federal and provincial cases it would be unfair to segregate the workload and therefore the impact of the workload relief is lost – 1 to 25 ratio.

[154] Also part of the initiatives is a plan called Differential Responses or Preventive Dollars which is a prevention focused approach for early intervention to try and keep kids out of the child welfare system, if possible. Next year 17 million dollars will go into this fund. Obviously the government's Change for Children initiative and its 45 million new dollars can provide a significant impact on the child welfare system and the problems revealed.

[155] Generally the Southeast Child and Family Service's position was that the province was doing their part and a corresponding influx of money by the federal government would have a tremendous positive impact on the children of Manitoba.

[156] Although the amount of money is obviously important but just as important is the flexible use of the money being given in order that creative ways can be used and developed rather than just maintaining the expensive not very successful status quo.

[157] For example, the creation in the community of support – economic, social, cultural, problem-solving, in order to improve the community and its families so that removal of the child from the community is the last resort. Funding rights limit the responses available. Child protection should not equate with child removal simply because of funding.

[158] In her evidence Ms Flette commented on issues raised in the Auditor's Report – pre-AJI – having to do with plans not being updated, reviews not being documented and outcomes not being measured. It should be noted that these problems are associated with all agencies and largely workload related. Resources need to be commensurate with the standards to be met. Strides have been made, in her view, with respect to CFSIS, hotel stay reductions, worker qualifications, corrective action plans and accounting.

[159] The most important point raised, in my view, is the concession that the better the record-keeping and file management the easier for the workers involved with care and for supervisory review to make sure that Tracia was getting the services she needed. Secondly, it was again emphasized that there is no capacity to review each and every file so the need for a flagging

system is essential in order to bring the file to a supervisor's attention for review, etc.

[160] With respect to permanency planning for Tracia, Ms Flette was extremely honest and candid:

> " So in a case like Tracia, if you have a family and I believe where the Agency fell short in making the decision about a good permanency plan for Tracia was in their attempts to maintain Tracia in her community and with her family. And at some point perhaps the decision should have been made that there was some stability needed for Tracia, at the same time maintaining her connections to her family and to her community, but recognizing that at that point in time her family was not demonstrating an ability to care for her and they needed to find some other option for her." (Vol. 20, p. 93)
>
> " True, the right to a permanent situation, there's also rights about the child's contact with family and community and culture and heritage and it's finding those balances, I think, that's the challenge." (Vol. 20, p. 95)
>
> " I'm not convinced in this case that Southeast could not find a permanent home for Tracia. I think that perhaps there wasn't a concerted effort made to that because there wasn't attention being paid to what was, what was happening with Tracia going in and out, in and out. Parents numerous times in treatment and still failing to resolve their situation. Had someone sat down and taken a good look at the case, had the documentation been there and more of a concerted effort made to say we need to find a home where this, this child can stay where she can go back to community and visit, where she can maintain connections with her family, that that could not have happened." (Vol. 20, p. 95)
>
> " I think there was a lack of case review and case oversight and supervision, yes." (Vol. 20, p. 95)

[161] It is important to note that the figure of 65 placements has often been given with respect to Tracia Owen's case. The testimony explained what a placement entails. I think the clearest example given is if Tracia was moved in the course of a long weekend from one place to another place to another place the records could very well indicate three placements during that period of time. That, in my view, is not representative of what a placement

should mean. However, taking Tracia away from her parents 17 times and returning her certainly indicates the instability of the situation and the lack of permanency planning. Certainly by whatever method of counting, this is far too many.

[162] Ms Flette concedes that without proper oversight and appropriate planning tragedies may occur in any agency. Case practice cannot improve without dealing with the workload issue – adequate funding and adequate resourcing.

[163] Money, however, is only part of it although an important part. Staffing communities such as Little Grand Rapids is a challenge and access to proper training programs. Providing child welfare in remote communities such as Little Grand Rapids require performing services differently - from money for houses for kids, preventative programs to support facilities and to provide after care. Certainly the federal government has failed to address this resource issue.

[164] The issue of quality assurance review is being examined and a quality assurance unit has been established. However, it must be emphasized that even though this is important and necessary it is more general than case file specific and would not necessarily have caught Tracia's case. A quality assurance review would indicate systemic shortfalls and non-compliance with standards, etc. The key is to have more regular oversight without micromanaging which is impossible in any event.

[165] An examination of how child welfare can be practiced in remote areas, through more flexible funding, using the available money differently to building resources and capacity in the community to assist families in the community is necessary.

[166] There is no question one of the most glaring features of this tragic case is the fact that on March 25, 1991 a nurse at the Little Grand Rapids nursing station wrote a letter (Section 10 report) summarizing the Bushie family's activities and history and pleading for intervention in order to prevent Tracia Owen from undergoing a difficult life and possible tragic consequences. This was not a case of 20/20 hindsight. The warning was there from the beginning making it exceptionally tragic.

[167] Once again Ms Flette is frank and forthright:

> "Yes, I would agree that a permanency plan and a good case plan should have been developed for Tracia and her siblings much earlier." (Vol. 20, p. 115)

"Yeah, no, I believe file documentation was lacking in this case." (Vol. 20, p. 115)

[168] The issue of a fetal alcohol affect disorder assessment or diagnosis is a little more problematic. There is no question the earlier the assessment the better for the child. But I also think it is fair to say that we know much more today than in 1991 (Tracia's birth) about assessment, how to get them, more aware of the need for them. Also as was testified to, getting the assessment must be only the first step – service provision to the child if diagnosed with FASD must be provided or the diagnosis is useless.

[169] Having said all this, keeping in mind there are difficulties involved in such assessments, these are an important tool and should be obtained whenever FAS is suspected. Fortunately it appears resources to increase the diagnostic capacity in the Province is forthcoming and a FASD specialist is being attached to each Authority.

[170] Much can be said about the extensive problems Tracia was having – violence, sniffing, suicide or suicide ideation and other behaviour episodes. The issues surrounding this behaviour is basically two-fold. One was the issue of locked setting which the majority of testimony seems to reject as not the answer for Tracia and certainly not the long-term answer.

[171] Secondly, the issue of counseling and the form that it should take. It is arguable that in every setting the individuals were trying to assist and counsel Tracia, however, her behaviour was out of control and therefore counseling was not an option. It was the consensus that stabilization, a willingness to cooperate and a trusting permanent relationship were essential ingredients before counseling would be effective. A good case plan assists that stability and can overcome lack of continuity of workers and the like.

[172] It is hoped that with devolution, the system will be improved with better monitoring, culturally appropriate authorities, more cooperation and willingness to work together between agency and community.

[173] However, as long as there are conditions of extreme poverty, inadequate housing, and addictions that fester in these surroundings, there will be challenges to the child welfare system wherever these conditions exist. Proper housing, day care centres, good support services in the community can assist in child welfare's ability to keep children safe.

"No, sadly, I mean, I don't think just Little Grand Rapids. When you look at children in the child welfare system, you know, what I see on Tracia's file, children who act out and are

> AWOL and don't co-operate, and are sniffing and drinking and on the street, unfortunately, you know – and we see where many of these kids graduate and when, when they turn 18 they fill our prisons." (Vol. 20, p. 138)

It would appear although more resources are needed to assist in many of these areas – particularly federal money to assist in creating healthy communities to produce healthy children – the present resources will have to be used differently in order to prevent such tragedies in the immediate future.

Department of Family Services & Housing

[174] Tragedies such as occurred in this case unfortunately are not as rare as we would like. There have been other cases, other fatality inquiries and reports from various institutions providing numerous recommendations. As was suggested at the inquest is there anything new that we can learn from these tragic deaths. Well, perhaps not, but until the recommendations previously made are implemented or new recommendations are considered there will always be a public concern about what is being done to prevent further occurrences.

[175] One of the witnesses at the inquest testified as to what steps government had implemented to assist in preventing further deaths. Linda Burnside is the Authorities Relations Director with the Department of Family Services and Housing and as such works assisting the four authorities, ensuring standards are met and helping them to address other issues. In this particular case the governing Authority is the First Nation of Southern Manitoba Child and Family Services Authority which is responsible as of November 2003 for the Southeast Child and Family Services. This is the divesting of Child and Family Services to four Authorities for governing responsibility for child welfare agencies in the province. The Southern Authority takes on the role of the former Director of Child Welfare and the Child Protection Branch works with the Authority to meet its obligations under the legislation.

[176] As a result of the death of Phoenix Sinclair in March of 2006, reviews were conducted and two reports were prepared and issued with recommendations. One report was from the Office of the Children's Advocate called "Honouring Their Spirits" (Exhibit 12) and the other was under the auspices of the Ombudsman's Office called "Strengthening the Commitment" (Exhibit 49). These two reports contained approximately 220 recommendations which were given to an implementation team to develop strategies for implementing the recommendations. The result was the "Changes for Children" action plan (Exhibit 46) which committed 42 million dollars to strengthen the child welfare system.

[177] Ms Burnside in her evidence gave a synopsis of the general themes covered by the recommendations of these two reviews:

- Workload relief
- Fetal Alcohol Spectrum Disorder

- Youth transitioning out of care when they reach 18 years of age
- Suicide prevention and intervention
- Funding issues with respect to the federal government funding on-reserve services
- Prevention and early intervention support for families
- Enhancement to the information system to improve communication – CFSIS
- Foster home recruitment especially on emergency basis
- Differential response – exploration of creation of a different service delivery model

[178] Funding was allocated to each of these strategies and some were implemented upon the announcement.

[179] It is important to note, in light of testimony at this inquest, the foster care recruitment strategy which has increased foster care beds and funding for 10 foster kids for the specific challenge of sexually exploited youth. This is in addition to beds under the Youth Drug Stabilization Act.

[180] Secondly, a strategy was introduced to reduce the usage of hotels as emergency placements and have emergency foster homes instead. This we are told has met with some success.

[181] Another program of interest to the inquest was competency-based training and the use of different training modules to cover areas of importance and need, i.e. suicide intervention training module.

[182] Ms Burnside further indicated the nature of case management standards – being a set of policies and guidelines developed by the government through consultation setting out the minimum expectation of service delivery. The collection of policy statements are tested in the field, enhanced or changed depending on circumstances, inquests, recommendations or the like.

[183] The final component of Ms Burnside's evidence had to do with the Child Death Review Process which outlines the roles and responsibilities of the various parties in the system when a child dies in care. The circumstances will dictate who notifies whom - and all agencies - Branch, Authorities, agency, Chief Medical Examiner, police, hospital – will simultaneously be involved and communicating with each other.

[184] The Agency, pursuant to standard 182 must gather information about the child's death and provide it to the governing authority and to the Child Protection Branch.

[185] It does appear from the testimony given that many of the issues raised at this inquest are being recognized and addressed. However, time is always of the essence when dealing with issues where lack or delay of action can be fatal.

The Child Advocate's Report

[186] The Child Advocate, Ms Billie Schibler, was called to bring further information to the inquiry concerning some of the issues raised during the hearing. The role of the Child Advocate is to ensure the best interests of children receiving services or entitled to receive services through the child welfare system are being met and to ensure their voice is being heard on any matters related to them. The Office of the Child Advocate has issued a report dated September 2006 called "Honouring Their Spirits" (Exhibit 12) which canvasses many of the issues being dealt with at this inquest. Some examples of which are:

- Development of suicide prevention materials
- Conducting a review of current child and adolescent mental health services available in remote areas
- Need for a better seamless service delivery and adequate resourcing in a collaborative way between the federal government and the province.
- Provide funding for a mental health Telehealth program to improve availability of psychiatric and mental health expertise throughout the province.
- Availability of traveling psychiatrists to provide better access to their services and the use of mental health support people – the community to assist with accessing expert services
- Funding for five additional beds in the girls crisis stabilization unit
- Creating a standardized culturally appropriate assessment tool that can be used in the community
- Training people to be able to deliver services in the community to a standardized level
- Funding to provide services equitable to services in the South
- Develop a risk assessment tool to be conducted and to become a continual process
- Clinic for Alcohol and Drug Exposed Children at the Health Sciences Centre to be funded and allowed to provide diagnosis and consultation for youths age 10 to 18 who are suspected of being periodically exposed to alcohol and drugs

- Availability of somebody that can come to communities and be able to provide assessment for fetal alcohol and resources to support the assessment
- The issue of aboriginal suicides
- Development of a protocol for assessing children who came to hospital emergency rooms with feelings of depression, self-harm or suicide – the protocol should include follow-up services and informing the agency involved as to the safety of the child
- Expand funding for out-patient treatment services
- Fund family counseling through preventive programs
- Training to recognize signs of drug and alcohol abuse
- More youth addiction treatment beds
- More effective community services between agencies

[187] These are only some of the recommendations referred to and are not specifically quoted from the report, however, I do feel they give a sense of some of the issues and concerns raised in this inquest and these issues are obviously matters of long standing concern and not unique to this inquest. (Phoenix Sinclair death)

[188] I wholly recommend the report and its conclusions for implementation as of assistance in possibly preventing future tragic deaths such as we have heard in this inquest.

[189] I particularly note the following in Ms Schibler's evidence as being specific to this case:

- A larger circle of care to be developed

"Recognizing that children need to be in a safe environment, I think it is really important to know that while the whole philosophy in child welfare supports or should support that the primary focus should be on preservation of families, at no point should a child's safety and well-being be compromised in order to have that happen."

- Good risk assessment tools available
- Nuclear family, extended family, community – to support the child
- Resources for in-home supports, mentors, safety net for the child by alternate caregivers

- Early intervention with early assessments with respect to safety and stability for the child.

[190] These issues are obviously very pertinent to this inquiry.

IV. CONCLUSION

" She was a child in care and she died by her own hand, so yes, the system failed her. It's a system that ideally protects children. It's a system that doesn't always achieve that and did not do that for Tracia and clearly in my mind it failed her." (Vol. 20, pp. 126-127)

[191] Provisions of *The Child and Family Services Act*:

"**Declaration of Principles**

The Legislative Assembly of Manitoba declares that the fundamental principles guiding the provision of services to children and families are:

1. The best interests of children are a fundamental responsibility of society.

2. The family is the basic unit of society and its well-being should be supported and preserved.

3. The family is the basic source of care, nurture and acculturation of children and parents have the primary responsibility to ensure the well-being of their children.

4. Families and children have the right to the least interference with their affairs to the extent compatible with the best interests of children and the responsibilities of society.

5. Children have a right to a continuous family environment in which they can flourish.

6. Families and children are entitled to be informed of their rights and to participate in the decisions affecting those rights.

7. Families are entitled to receive preventive and supportive services directed to preserving the family unit.

8. Families are entitled to services which respect their cultural and linguistic heritage.

9. Decisions to remove or place children should be based on the best interests of the child and not on the basis of the family's financial status.

10. Communities have a responsibility to promote the best interests of their children and families and have the right to participate in services to their families and children.

11. Indian bands are entitled to the provision of child and family services in a manner which respects their unique status as aboriginal peoples.

Best interests

2(1) The best interests of the child shall be the paramount consideration of the director, an authority, the children's advocate, an agency and a court in all proceedings under this Act affecting a child, other than proceedings to determine whether a child is in need of protection, and in determining the best interests of the child all relevant matters shall be considered, including

(a) the child's opportunity to have a parent-child relationship as a wanted and needed member within a family structure;

(b) the mental, emotional, physical and educational needs of the child and the appropriate care or treatment, or both, to meet such needs;

(c) the child's mental, emotional and physical stage of development;

(d) the child's sense of continuity and need for permanency with the least possible disruption;

(e) the merits and the risks of any plan proposed by the agency that would be caring for the child compared with the merits and the risks of the child returning to or remaining within the family;

(f) the views and preferences of the child where they can reasonably be ascertained;

(g) the effect upon the child of any delay in the final disposition of the proceedings; and

(h) the child's cultural, linguistic, racial and religious heritage.

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> "So in a case like Tracia, if you have a family and, and I believe where the Agency fell short in making the decision about a good permanency plan for Tracia was in their attempts to maintain Tracia in her community and with her family. And at some point perhaps the decision should have been made that there was some stability needed for Tracia, at the same time maintaining her connections to her family and to her community, but recognizing that at that point in time her family was not demonstrating an ability to care for her and they needed to find some other option for her." (Vol. 20, p. 93)

[192] This quotation coincides with the conclusion I reached after hearing all the evidence presented at this inquiry. The above-noted legislative mandate anticipates such an approach and the standards and regulations support such an approach.

[193] In my view, the decision concerning Tracia with Kirkos House, the four-bed facility and Project Neecheewam were sound based on good child welfare practice. The problems were analyzed and efforts made to try and place Tracia in the best resources available in order to assist her with her difficulties. I believe this approach was particularly evident with respect to Project Neecheewam. Every problem Tracia presented was responded to with assistance and treatment in order to assist her. The evidence presented indicated stabilization was taking place and there was justifiable optimism. If stabilization is necessary before the problems can be attacked then Tracia's disclosure of sexual abuse indicated that stabilization and her need to disclose and deal with her problems. Unfortunately I believe this disclosure was the proverbial straw that broke the camel's back and led to a very quick disintegration which despite attention and effort could not be prevented. This being all the more tragic because at the time of her death Tracia was finally receiving the attention, effort and support that she required and needed.

[194] In my respectful view, supported by the testimony, the attention and effort was given years too late and if given earlier might have prevented Tracia being in the situation she found herself even prior to Kirkos and the efforts that followed.

[195] A concerted effort to establish a permanency plan, a good case plan, a connection to the community and a decision that for the near future the

parents were not going to be the answer was necessary for the well-being of Tracia.

[196] No, Tracia did not die due to lack of documentation but documentation, planning, monitoring, goal-setting and establishing outcomes are all essential to making good decisions on the information available and making them earlier.

[197] One of the major weaknesses revealed by this inquest was the inability to have a specific file flagged or brought to someone's attention for review and possible action. The quality assurance system does not catch this aspect.

[198] Obviously, a file lacking in documentation, etc. is not likely to be flagged.

[199] This area and other concerns raised during the inquiry I have tried to deal with in a general way to encourage action by the appropriate authorities. Only by their consideration and public concern will changes be made and hopefully through change Tracia Owen's death will not be in vain.

[200] Obviously making recommendations is one of the most difficult components of an Inquiry. In submissions made by counsel it was suggested that there is little more that can be said that has not already been said in government reviews and previous inquests (two Redhead inquests) involving the death of a child in care, eg.:

- Changes for Children: Strengthening the Commitment to Child Welfare – Response — Exhibit 48
- Strengthen the Commitment — Exhibit 49
- Auditor-General's Report — Exhibit 50
- The Child Death Review — Exhibit 12
- Section 10 Report and Preview Review — Exhibit 8

[201] The government has received over 200 recommendations from various sources and initiatives have been taken as a result of these reviews and reports. It is also true there is perhaps little more that can be usefully said. I am cognizant of my duties under *The Fatality Inquiries Act.*

[202] However, even though it may seem repetitious, I believe it needs to be said even if only to constantly remind the authorities and agencies of their

responsibilities and duties under the appropriate governing legislative mandate. I do intend to confine myself, as much as possible, to issues relevant to the death of Tracia Owen. Although I received excellent submissions from counsel with respect to recommendations, I only accepted those I felt the evidence warranted.

[203] There is no question about the dedication, industry and caring of the people working in the child welfare system. The child welfare system, even if working well, is fraught with difficulties and unlike some fields of endeavour the consequences can be tragic. The realities of practicing child welfare in places like Little Grand Rapids can never be fully appreciated by anyone who has never practiced child welfare there. The problem of numbers, lack of community supports, lack of sufficient resources, social problems and behaviour problems are immense. In many places child welfare is the only show in town.

[204] However, unfortunately since they are the last resort for these children, good intentions have to be supported by best practices and adherence to standards cognizant of the reality in which they work.

[205] Although Tracia Owen died in August 2005, a review of the testimony suggests the foundation for her tragic death was laid many years before.

V. RECOMMENDATIONS

[206] Almost all of the persons testifying at the inquiry were asked what changes they would propose to prevent a future tragedy of this nature. Also at the end of the inquiry counsel for the parties were offered the opportunity to make submissions including recommendations for consideration. Finally, as referred to in my report, several reviews have been conducted on the same or similar subject-matter. I certainly accept the recommendations contained in those reports and urge their implementation – The Child Death Review, Changes for Children: Strengthening the Commitment to Child Welfare, Strengthening the Community: An External Review of the Child Welfare System, Auditor's Report – Audit of the Child and Family Services Division, among others.

[207] I have considered all the suggestions made (all of which were good) but felt obligated only to accept those in which I felt there was a factual underpinning presented by the testimony.

Examination of Social Factors – Availability of "street drugs" and sexual exploitation of youth.

RECOMMENDATION ONE

A summit should be held involving all the stakeholders – police, child welfare workers, justice officials, community groups, aboriginal groups, government agencies, etc. – to examine all possible law enforcement, legislative and legal means to create a strategy for the attack on sexual exploitation and drug abuse of children on our streets.

RECOMMENDATION TWO

Creation of a dedicated, specialized, multi-disciplinary unit to implement the strategy decided upon as a result of the summit.

RECOMMENDATION THREE

Programs or workshops presented on the reserves to educate children and their parents about the dangers of drugs. (Leonard Bushie)

Recommendations to Prevent Similar Deaths.

RECOMMENDATION FOUR

The Chief Medical Examiner recommends that the Southern Authority, in conjunction with Southeast Child and Family Services and local child care committees use comprehensive family, child risk assessment plans to devise

permanency plans for children where familial circumstances resemble those of the deceased child and her family. (Section 10 Report)

RECOMMENDATON FIVE

The Chief Medical Examiner recommends that the Director of Child Welfare for the Province of Manitoba, in association with the four authorities, ensure that a protocol is in place with police services in the province regarding identification of a child in the event of the death of child in care. (Section 10 Report)

RECOMMENDATION SIX

The Chief Medical Examiner recommends that Southeast Child and Family Services maintain its case records in accordance with provincial standards, including placing on its files ongoing summaries of events in the lives of the families and children they serve. (Section 10 Report)

RECOMMENDATION SEVEN

The Chief Medical Examiner recommends that Southeast Child and Family Services review its policies on the placement and replacement of children in the foster care system, with a view to how multiple placements can be minimized. (Section 10 Report)

RECOMMENDATION EIGHT

The Chief Medical Examiner recommends that Southeast Child and Family Services, with the assistance of the Southern Authority, review with its foster care department as well as its foster parents the placement and replacement of foster children in their homes. (Section 10 Report)

RECOMMENDATION NINE

The Chief Medical Examiner recommends that the Child Protection Branch and the authorities ensure the province's foundation standards include a provision for pre-placement visits when children are placed in non-emergency or replacement situations.

The Chief Medical Examiner further recommends that Southeast Child and Family Services, in the interim, ensure that children in care are provided with pre-placement visits (in non-emergency or replacement situations) prior to being placed. (Section 10 Report)

RECOMMENDATION TEN

The development of a mechanism which flags or triggers a review of a specific file due to the attainment of an established criteria – that criteria

may be an event (a disclosure of sexual abuse), passage of time (no review within past year) or a number of placements (over 5). These are merely examples and it is left to the authorities to establish an appropriate criteria which will prevent a specific file not receiving the appropriate attention and monitoring in such an event. Obviously such triggering mechanisms presupposes proper and current documentation or such process is worthless.

RECOMMENDATION ELEVEN

Resources need to be found to create and buttress the preventative services necessary in any child welfare system. In order to try and keep the child in the family, support needs to be given to assist the family in areas in which they are lacking. The local child care community can provide much needed advice in this area.

RECOMMENDATION TWELVE

Urgent and continued discussions need to be participated in to reappraise appropriate funding mechanisms between the Federal and Provincial governments to deal with the critical child welfare issues plaguing our First Nation communities.

RECOMMENDATION THIRTEEN

The steps being taken to ensure all of the child in care files are entered into the Child and Family Services Information System and the files be updated and maintained.

RECOMMENDATION FOURTEEN

The Southern Authority, together with the Province, seek to find and implement a solution to the connectivity challenges faced by the Agency with respect to CFSIS.

RECOMMENDATION FIFTEEN

Southern Authority to undertake a quality assurance review of Southeast Child and Family Services Agency as a priority item. This should be a comprehensive review of the agency and should include (but not be limited to) a review of the agency's governance structure, funding, workloads, case practices, expenditures (operations and maintenance, federal and provincial), staffing, and organizational structure. The review should include a review of the case files of the agency, including a review of every child in care to ensure proper assessments and case plans are completed. The Southern Authority to develop a corrective action plan for the agency where deficiencies exist.

RECOMMENDATION SIXTEEN

Southern Authority to work with the agency to establish outcomes and outcome measures for the agency, particularly with respect to children in care. This could assist in earlier identification of cases where there is a lack of planning and/or where the agency's practice does not meet standards. For example, one of the outcomes could be a limit on the number of moves within a specified time frame. The data to measure this outcome would identify children who have multiple moves beyond the acceptable level. This would assist both the agency and the Authority to become aware of such cases and to take corrective action.

RECOMMENDTION SEVENTEEN

That the agency, with the assistance of the Province and the Southern Authority, ensure that all of its staff re fully trained in CFSIS and the Intake Module and that both are fully used within the agency.

RECOMMENDATION EIGHTEEN

The agency, with the cooperation of the Southern Authority, should provide training to staff in the following areas:

- How to manage and maintain a case file
- Best practices in the placement of children in out of home care
- How to complete comprehensive assessments, make diagnostic statements and then develop case plans based on such an assessment
- How to develop goals and services for contract planning in casework
- How to maintain the primacy of a child safety focus in the intervention while still considering the needs of the family
- How to provide social work counseling and intervention at the case management level with children and with families
- Suicide prevention and intervention
- Working with sexually exploited children

RECOMMENDATION NINETEEN

Establish a mentorship program, where community workers are paired up with a mentor that can assist the worker in case management. This

mentoring can be done by distance (e-mail, phone) or face to face where feasible.

RECOMMENDATION TWENTY

Supervisors are an important part of the case management process and serve a needed quality assurance role/function. The Southern Authority, in conjunction with the Agencies, should develop and implement a management and supervisor training program, mandatory for all agency supervisors and management and that Manitoba provide funding for this purpose.

RECOMMENDATION TWENTY-ONE

The Southern Authority, together with the agency, INAC, and the Province should participate in a redesign of the services and service approach used in the four remote communities that SECFS serves (Little Grand Rapids, Paungassi, Berens River, Bloodvein). A child safety focus must be maintained, but it should be done in the context of building communities and families that are safe for children. All options should be explored, including flexible funding arrangements. The large numbers of children in care from these communities makes that an imperative.

RECOMMENDATION TWENTY-TWO

The Southern Authority, together with the agency and the Province, should develop a training program specific to the four remote communities that focuses on training staff for CFS. Curriculum and training delivery model should be suitable to the geographic, language, and cultural factors, while still ensuring that graduates of this training program will be able to meet the workforce qualifications standard.

RECOMMENDATION TWENTY-THREE

The Province of Manitoba should jointly with the four Authorities complete the foundational standards. The four Authorities should also complete development of culturally appropriate standards and the Province of Manitoba should work with the Authorities to expedient their development.

RECOMMENDATION TWENTY-FOUR

Consideration be given for payment of the expense and availability of legal counsel to non-profit organizations which organization might contribute to the deliberations of future Fatality Inquiries.

RECOMMENDATION TWENTY-FIVE

Funding be examined in order to make available mental health resources to benefit agencies, etc. as a resource to their clients.

RECOMMENDATION TWENTY-SIX

The prevalence and danger of sexual abuse in families needs to be examined in depth as a major concern in the child welfare system. Resources need to be dedicated to such an examination.

RECOMMENDATION TWENTY-SEVEN

Need for increased resources for the creation of more residential beds in facilities for youth at high risk for sexual exploitation and drug addictions.

RECOMMENDATION TWENTY-EIGHT

Creation of a protocol that increases resources and support for a youth who discloses an incident of sexual abuse and which protocol emphasizes the immediate investigation of such disclosure.