



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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the _____ Court House
in the _____ City _____ of _____ Lethbridge _____, in the Province of Alberta,
(City, Town or Village) (Name of City, Town, Village)
on the _____ 13th to 15th _____ days of _____ November _____, _____ 2007 _____, (and by adjournment
year
on the _____ 7th and 8th _____ days of _____ July _____, _____ 2008 _____),
year
before _____ Lloyd E Malin _____, a Provincial Court Judge,
into the death of _____ Sharla Marie Collier _____ 20 _____
(Name in Full) (Age)
of _____ Lethbridge, Alberta _____ and the following findings were made:
(Residence)

Date and Time of Death: _____ November 16, 2002 at 13:40 hours _____

Place: _____ Lethbridge, Alberta _____

Medical Cause of Death:

Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – The Fatality Inquires Act, Section 1(d)).

blunt force injuries of the head

Manner of Death:

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

homicidal

Circumstances under which Death occurred:

see attached

Recommendations for the prevention of similar deaths:

see attached

DATED December 3, 2008 ,

at Edmonton , Alberta.

Original signed by
Lloyd E Malin
A Judge of the Provincial Court of Alberta

Circumstances Under Which Death Occurred:

A. Summary

The deceased sustained head injuries as a consequence of the application of three blunt force impacts to the left side of her head. A 14 year old male youth (the offender) who was resident in the DIAD Home (operated by Lethbridge Family Services) in Lethbridge was on a walk with the deceased who was a careworker at the home. The offender confessed to hitting the deceased with a log (more likely a tree branch). The homicide occurred in a somewhat secluded river bottom area of Lethbridge near the University of Lethbridge. The homicide was not witnessed.

B. Detailed Examination and Description of Circumstances

1. Explanation of Terms

For simplicity, this report uses the words “careworker”, “group home”, “resident” (and their plurals) to describe, respectively:

- (i) “careworker”, as an individual who was in charge of a resident in a group home,
- (ii) “group home”, as residential facility including the TRIO and DIAD homes operated by Lethbridge Family Services, and
- (iii) “resident”, as an individual who was a resident in a group home, including the offender.

It is acknowledged that Lethbridge Family Services (LFS) employed individuals with various titles and job descriptions, as for example, Ms. Collier as “Community Rehabilitation One”, and that the term “careworker” is not used in any of the documents put before this Inquiry. Similarly, LFS would likely draw a distinction between a group home, such as Westside Group Home (where the offender was briefly resident) and the TRIO and DIAD homes where only three and two individuals resided. For the purposes of this report, these distinctions are not considered material.

2. The Offender

The offender was a 14 year old male. Approximately one year prior to the fatality, the offender weighed 41 kg and stood 163 cm tall. It is assumed (although not established through any testimony or exhibits) that, having regard to his age, he likely weighed more and may have been slightly taller at the time of the fatality.

The offender was apprehended by provincial authorities when he was two weeks old and until coming under the care of LFS in 2000, had been in at least six foster homes. After a short stay in the Westside Group Home (while awaiting a more permanent placement), the offender was placed in the TRIO group home managed by LFS. He was one of three youthful residents. He remained in that home until October, 2002, when because of an alleged sexual assault on him by another resident, the offender was moved to the DIAD home in which there was only one other resident.

The offender had been previously diagnosed as suffering from fetal alcohol spectrum disorder (FASD) and Attention Deficit Hyperactivity Disorder (ADHD). In 1998, a psychiatrist confirmed these diagnoses and noted some symptoms of depression and low self esteem. He was seen to be developing a mood disorder and was noted as having no boundaries or fear. That assessment stated that he may be at some risk to the community, especially younger children, unless he is highly supervised. There were no indications of a propensity for violence to adults. In 2001, a psychiatrist consulted by the offender’s personal physician suspected that the

offender had residual symptoms of Attachment Disorder and Post-traumatic Stress Disorder. Despite these difficulties, the offender was generally described as being easy to get along with, fairly happy and at times, meek and mild.

In an assessment of the offender prior to his residency in the DIAD group home (where he was placed in October, 2002), he was identified as “very emotional but not violent towards staff”. A *Referral and Evaluation of Service* report prepared by Children’s Services in October, 2002, stated that the offender “keeps his emotions to himself until he explodes”. The first service objective noted in the report is “1. Anger management strategies & healthy expression of feelings”. The explosion of his emotions involved the destruction of his own property and not violence towards others.

3. Fetal Alcohol Spectrum Disorder (FASD)

The Inquiry heard testimony from the offender’s personal physician who had treated the offender from age six months to approximately seven months prior to the fatality, from a psychiatrist who had examined the offender some 19 months prior to the incident, from a retired clinical forensic consulting psychologist who examined the offender after the fatality, and from an expert pediatric neuropsychologist who had examined the offender four years prior to the fatality and two months following it.

The weight of that testimony was to the effect that individuals correctly diagnosed as suffering from FASD frequently perform adequately on intelligence tests but display problems with inhibition, memory and language and difficulty with emotional regulation. Such individuals generally like routine but are nevertheless prone to moodiness and restlessness. They may also suffer from sleep disorders and can be excessive in any number of ways (e.g. eating). Whereas most children start to develop restraint systems when they are 7 or 8 years old, FASD children tend to have trouble with this, and as they grow older, they start getting into trouble because they have no effective control management systems. FASD individuals generally experience learning difficulties, have difficulty socializing, display frequent mood disorders, are prone to substance abuse, often develop ADHD and engage in criminal activity which may occasionally involve violence. The affects have statistical probability but not predictability.

The offender had been tested. He was found to be verbal and fluent but could not communicate his ideas well. He could not think in a flexible manner, had a short attention span and was impulsive. It was concluded that he had a conduct disorder, was prone to breaking rules and would be difficult to manage. It was noted that in 1998, the offender was seen as someone who might well get into trouble even though he could be well supervised in a group home. There were no homicidal concerns expressed at that time and none were seen to be predictable. The areas that were seen to be likely for the offender’s aberrant behavior were, for example, breaking and entering, car theft and drug abuse but not homicide.

The offender’s personal physician testified that the offender was on prescribed medications to control his impulsivity and mood changes. She testified that in looking back at her interactions with the offender, she could not see the risk of his homicidal behavior.

The pediatric neuropsychologist who interviewed the offender in 1998 was shocked when he learned of the fatality. He stated that nothing in his previous assessment could have predicted it.

4. Previous Aberrant Behavior of the Offender

The offender did not have a notable record of violence towards others. The Inquiry heard testimony from a male careworker that the offender had attacked him on one occasion. That

incident occurred about 15 months prior to the fatality. Other than its unpredictability, the circumstances surrounding that incident bear no similarity to the circumstances of this fatality.

The offender was easily frustrated when things did not go his way. Group home records and the testimony of witnesses demonstrate that the offender would vent his frustrations by yelling, swearing, slamming doors and damaging his own personal property and room. There were no reported incidents where he appeared to take out his frustrations by violence towards group home staff or other individuals. His legal guardian, while noting that the offender was impulsive, sexually interested, frustrated and prone to going AWOL, did not see him as a threat to the physical safety of the staff.

Although the offender had once sniffed gasoline and engaged in the theft of a truck and a brief joyride, there were no reported incidents involving alcohol or drugs and none had ever been found in his room or on his person.

Daily Shift Summaries maintained by the careworkers who looked after the offender throughout the month of November, 2002, reported no material violent incidents. He was reported as having gone AWOL on several occasions but either returned voluntarily or after being picked up by Lethbridge police.

On the day of the fatality (November 16, 2002), the offender was noted to be quiet and calm. He followed his regular morning routine and demonstrated no behavioral concerns. He apparently welcomed and perhaps even encouraged the idea of an outing from the home; in this case a walk with his careworker at that time, Sharla Collier. There is no evidence that he displayed any behavioral indicia that he was on the edge of violence or was going to pose any particular difficulty to Ms. Collier on this outing. Ms. Collier expressed no concerns to other staff.

5. Sexual Preoccupation

The TRIO and DIAD group homes in which the offender resided since 2000 maintained incident logs which recorded that as the offender came into puberty, he developed an interest in sexually explicit behavior and material (notably magazines and photographic pornography). One careworker testified that notes were found in the TRIO home where the offender agreed or offered to perform sexual favours for other (male) residents. On one occasion, the offender was found with another (male) resident attempting to engage in sexual activity. He may have been sexually abused as a young boy and involved in a sexual encounter when he returned from a visit to his father in Saskatchewan some years earlier. He may have had other sexual encounters with other (male) residents but the details of the alleged incidents are sketchy and were relayed solely by hearsay. His move from the TRIO home to the DIAD home in October, 2002, was prompted, in part, by the belief that he had been sexually assaulted by another (male) resident in the TRIO home. The offender's interest in sexual matters was well known and documented and room searches frequently revealed the presence of printed sexual materials. His conversations with other careworkers occasionally strayed into inappropriate personal matters that had a sexual edge to them. The psychiatrist who had examined him in 1998 reported that the offender's interest in sexual matters and the possibility of him engaging in sexual activities was seen as a predictable risk as he was growing through puberty and adolescence.

6. Risk Assessment of the Offender

Apart from isolated and unsupported testimony expressing concerns about the offender, the DIAD group home staff and managers did not assess the offender as a risk to the personal safety of the careworkers. The risks identified concerned the safety of the offender and the

likelihood that he would go AWOL as circumstances permitted and might engage in petty criminal activity while AWOL.

7. The Deceased

Sharla Collier was 20 years old at the time of the fatality. She weighed 75 kg and was 155 cm in height.

Ms. Collier had obtained a Grade 12 diploma from Raymond High School. She received a Rehabilitation Services Diploma from the Lethbridge Community College in the Spring of 2002. Her resumé notes that she was certified in Crisis Prevention and Intervention (February 7, 2002) and was certified in Medication Administration for Para-Professionals in March, 2001.

Her work experience was essentially as a rehabilitation worker from the summer of 2001 and involved a number of care responsibilities with adult individuals in both vocational and residential settings. She had logged a number of hours in a practicum devoted to supporting children with various needs.

She successfully applied for a position as a “Community Rehabilitation (One)” employee with LFS on September 26, 2002 and signed an employment agreement with that agency on October 10, 2002. In her employment application, she stated “I am a ‘People person’! I love working with people especially when I am supporting individuals with disabilities.” One of her references stated that in a crisis situation she would react “very well, stayed calm & asked for help-followed policies and procedures”. Two other references could not say how she would handle a crisis; one noting that she had never seen Ms. Collier deal with a crisis. One noted that she was always punctual, had a good sense of humour, was a good leader and displayed good common sense.

In her interview, she professed to some awareness of FASD but had not worked with any individuals suffering from FASD at the time of her application. It is not known of the extent of her specific knowledge and experience with the behavior of FASD youth beyond that gained in her brief tenure with LFS. Her knowledge of safe working practices with FASD youth is also not known. There is no indication that she received any specific personal safety instructions in dealing with FASD individuals.

Her orientation involved access to policy binders and familiarity with procedures regarding cash management, administration of medications, handling AWOL residents and incidents, home security practices and systems and some personal safety matters (e.g. taking a cell phone with her on all outings).

Her orientation was to involve a one day program entitled “Nonviolent Crisis Intervention” (CPI) developed by Crisis Prevention Institute, Inc. out of the United States. (See section 9. on Careworker Safety Policies.) On the LFS Orientation Checklist it was marked as completed on (or as of) October 10, 2002 (the date her employment started). This item was considered completed because of Ms. Collier’s earlier completion of a program with the same name.

8. The DIAD Home

The DIAD home was a residence operated by LFS as part of its so-called DaCapo program. LFS is a private, non-profit organization with a volunteer board of directors. It was under contract with Sun Country Child & Family Services, the latter an agency of the provincial ministry, Children’s Services. At the time of the fatality, the DIAD home was the residence for only two male individuals one of whom was the offender. Careworkers collectively provided 24 hour per day, one on one, supervision.

Ms. Collier was one of several the careworkers who worked various shifts at the DIAD home. On date of the fatality she was working the day shift and was solely in charge of the offender for that shift. Daily Shift Summaries record that she had supervised the offender on one previous occasion in November, 2002, but it was during a night shift and there was little interaction with the offender. It was without incident.

Daily logs concerning each resident of the DIAD home were completed and open to inspection by the careworkers. Those reports were brief, shift by shift, summaries of the activities of the resident. The summaries for the offender for the month of November, 2002, to the date of the fatality recorded some aberrant behavior – mostly AWOLs, one incident of anger where he broke his own personal property, and one incident concerning the discovery of pornographic materials hidden in his room - and various episodes of moodiness.

In addition to daily Shift Summaries, an Incident Report was to be completed whenever a resident's behavior or actions broke the house rules. Those reports were available for review by all careworkers. Consistent with all other assessments of the offender to that time, the reports gave no indication that the offender was prone to be violent to others.

9. Careworker Safety Policies

The Inquiry was advised of a number of policies touching on the safety of individuals under the care of group homes. At the time of the fatality there were very few regulations or policies that dealt directly with the personal safety of group home careworkers.

As previously noted, it was to be part of the orientation of Ms. Collier that she be familiarized with the CPI program. That program involves a one day session dealing with early intervention and non-physical methods for preventing and managing discipline behavior. The CPI program also provides for a second one-day workshop dealing with the study and practice of crisis prevention methods including knowledge and practice of restraint positions, transport techniques and team strategies. It is not clear whether Ms. Collier completed the full program in February, 2002. She was deemed to have completed the CPI program because of the reference to completing a similar sounding program on her resumé.

While the CPI program appears to be very useful, it is of questionable relevance to the incident resulting in Ms. Collier's death; that is, the program focuses on the recognition and management of an evolving crisis and not on a sudden and unexpected attack as appears to be the case with this fatality.

Overall health and safety issues concerning careworkers fall under the *Occupational Health and Safety Act*, R.S.A 2000, c. 0-2 (the Act). A number of regulations have been passed pursuant to the Act, including the *General Safety Regulation* (Alberta Reg. 448/83).

In 2000, the *General Safety Regulation* was amended (Alberta Reg. 210/2000) by adding a new section (14.1) covering employment situations where employees work alone. It requires employers to conduct hazard assessments, establish communication systems between the employee and persons capable of responding to the employee's needs, and to eliminate or control hazards identified during a hazard assessment in part, conducted with affected employees. That section states in part:

(2) *When a worker is required to work alone, the employer shall*

(a) *first conduct a hazard assessment to identify existing or potential hazards arising from the conditions and circumstances of the worker's work,*

(6) *The employer shall take all reasonable steps*

- (a) *to eliminate any hazard identified during a hazard assessment,*
- (b) *to control any hazard identified during a hazard assessment if it is not reasonably practicable to eliminate the hazard.*

(7) *If practicable, the employer shall have the workers affected by a hazard assessment participate*

- (a) *in conducting the hazard assessment, and*
- (b) *in the elimination or control of any hazard identified during the hazard assessment.*

This was the only legislation addressing the risks associated with an individual “working alone”. It appears that it was drafted in the context of industrial risks and physical site hazards and only broadly covered the risks that a careworker might encounter in dealing with a resident who might, himself, be the “hazard”.

In a paper entitled *Working Alone Safely - A Guide For Employers and Employees* prepared by the Minister’s Committee to Promote Health and Safety-Working Alone Best Practices (September 2000), the overarching recommendation is the elimination of risk by having employers organize work schedules and procedures so that they are not working alone. Thereafter, the paper delves into matters of employee training to ensure that they are trained and competent to work alone safely.

The paper identifies as a “working alone situation that may put an employee at risk”, “(5) Employees who are at risk of a violent attack because their work site is isolated from public view. This includes security guards and custodians.” In the section of “best practices” related to this risk situation, the paper concerns itself with checking the “security of the work site”, “how to behave when confronted with an intruder”, proper security systems as a “primary defense against break-ins”, “remote and personal alarms”, “video surveillance” and the security of windows and doors “with heavy duty locks and suitable barriers”. The risks posed by a resident in a group home or on a supervised outing are not addressed.

Significantly, the paper emphasizes that the employer must:

- (1) conduct a hazard assessment,
- (2) eliminate or reduce the risks,
- (3) establish an effective means of communication, and
- (4) ensure employees are trained and educated.

A checklist of safe work procedures (e.g. addressing unsafe areas, isolation away from public view) and eliminating the presence of dangerous items follows. It is not known whether the checklists suggested in the paper had ever been addressed by the LFS careworkers in the context of the risks posed by the residents or their care. More likely, and because walks and outings of the sort taken by the offender and Ms. Collier were not uncommon and the site of the particular walk was not seen as particularly dangerous, the suggested checklist of concerns might well have been “ticked off” in apparent compliance.

In January, 2002, LFS added to its program manual, section D5.8 headed “Working Alone”. At the outset of section D5.8, a Policy is set out stating: “Lethbridge Family Services DaCapo will

take preventative measures to minimize or eliminate wherever possible, any risks to employees that are associated with working alone”. Then follows 20 “procedures”, all of which are no doubt useful, but none of which would have prevented this fatality with the possible exception of procedure 2 which simply states: “Personal Safety Training will be offered to employees on an annual basis.”

In procedure 5, employees who work alone in residential settings are “encouraged to carry personal cellular telephones which can be used in case of an emergency”. The Inquiry heard that Ms. Collier did not have her cellular phone with her at the time of the fatality and a number of witnesses suggested that this should be a requirement. While it is no doubt a good practice to follow, the evidence heard in this Inquiry suggests that it would have been of little assistance in preventing this fatality.

Policy D5.8 was superseded by a revised policy in February, 2003, some 3 months after the fatality. That policy added to the cellular phone requirements and added a new section 12:

When selecting community outings with clients, staff should continually monitor for safety risks. Under no circumstances will staff take clients on outings prohibited as referenced in their service plan. Exceptions must be authorized by a coordinator prior to implementation.

Both the original Policy D5.8 of January, 2002, and the superseding policy of February, 2003, contain a requirement to do a risk assessment of each “residence” prior to occupancy and as scheduled. Nowhere is a risk assessment mandated for the “residents”. Neither the original nor the superseding Policy identifies any specific safety measures to be undertaken by careworkers, as for example, never turning one’s back on a resident or mandating that careworkers should not individually accompany a resident to an isolated location.

Documentation maintained by LFS and testimony heard in the Inquiry suggests that Ms. Collier was made aware of the policies. That documentation indicates that Ms. Collier signed out a binder of the policies shortly after she commenced her employment. There is no indication that she ever returned it. The policies are simply too voluminous to have been covered in any detail in her orientation session. It is not known if she ever read, understood or questioned the policies. There is no testimony that she questioned Policy D5.8. There is no evidence that she took any personal safety training program as required by the policy (albeit on an annual basis) mindful of the fact that she was barely a month into her employment when the fatality occurred.

In its broadest terms, as it turns out, the hazard confronted by Ms. Collier was the offender himself. There was considerable information about the offender on the files maintained by LFS. Apart from the post-fatality concerns expressed by some of the (former) careworkers, there was a general belief that the offender posed no significant risk to the careworkers and that his aberrant behavior was often self-directed to his own harm or that of his own property or to going AWOL and possibly committing minor misdemeanors. The likelihood that his growing sexual interests and aberrant sexual behavior might manifest itself in an act of violence to a careworker was never expressed or identified as a concern. Thus, it is doubtful that either the offender or the kind of activity undertaken by the offender and Ms. Collier on the day of the fatality would have been identified as a hazard or concern to Ms. Collier’s personal safety.

10. Immediate Events Leading to the Fatality

On the date of the fatality, Ms. Collier reported to the DIAD group home at approximately 7 am or 8 am to begin the morning shift. She was debriefed on the events observed by the evening staff. The Daily Shift Summary for November 15 gives no indication of any aberrant behavior, anger, or impulsive acts. The Daily Shift Summary for November 16 indicates that the offender

took his medications, ate his breakfast, did his chores, watched television and ate lunch. Ms. Collier originally intended to go bowling with the offender but discovered that the funds necessary for that activity were not immediately available. Because a (female) co-worker had just taken the other (male) resident for a walk, the offender may have suggested that he and Ms. Collier go for a similar outing. When the co-worker and the other resident returned from their walk, Ms. Collier and the offender left the residence. The co-worker observed the offender to be quiet. She did not observe any anger in the offender, having observed his anger on previous occasions. She had no concerns about her safety on previous interactions with the offender which included one on one walks with him.

The offender and Ms. Collier headed for the Bull Trail Park South pathway and at approximately 1:30 pm and while Ms. Collier likely had her back turned to the offender, he picked up a fallen tree branch and struck Ms. Collier on the left side of her head. He then continued to strike Ms. Collier (at least three times) and she died. He undressed her body and bit her on her left breast. Although he confessed to having sexual intercourse with her body, the Autopsy Report Form presents no findings supporting that fact.

11. Location of the Fatality

The fatality took place approximately one kilometer north of the University of Lethbridge main campus near the Bull Trail Park South pathway. Photographs taken shortly after the fatality show that the site is near the Oldman River and appears largely grassy with only a few standing trees. As such, it does not appear to be hidden from view, but at the time of the fatality, there were no other individuals in the immediate area and that would have been apparent to the offender.

12. Confluence of Factors

The fatality was due to the unfortunate confluence of a number of factors:

- an adolescent male with a preoccupation with sexual matters,
- who suffered from an FASD disorder in which he was impulsive, easily frustrated, unpredictable and had no effective control management system,
- who was alone with a physically unimposing, unsuspecting and trusting young female,
- who had little personal experience in dealing with this adolescent male or FASD individuals generally in one on one encounters or outings,
- who was with this male in a location away from public view and activity, and
- where there happened to be a manageable object capable of instantly subduing the unsuspecting female.

It was a “perfect storm” of factors, the risk - although not the predictability – of which is somewhat obvious in retrospect.

Recommendations for the Prevention of Similar Deaths:

Caution

At the outset, it should be noted that it is difficult to predict the likelihood of injury or death as a consequence of a criminal offence. This is particularly the case where the offender has no previous criminal record and has shown no marked propensity to engage in criminal behavior. Although the individual who caused the fatality suffered from FASD (and other disabilities) and such sufferers are likely to be impulsive and lack effective behavior management controls, there was no evidence before the Inquiry that such individuals have a greater propensity to be violent

toward others than do non-FASD individuals in the general population. Violent criminal behavior is almost always an aberration, and while FASD sufferers frequently display aberrant behavior, such behavior, if at all criminal, is most likely to manifest itself in petty and non-violent crimes. Thus, and because of the limitations in the scope of a fatality inquiry, the recommendations in this report are directed to reduction of the risk of injury or death in circumstances similar to that of the fatality. It would be an error, however, to interpret any of the recommendations in this report as, in any way, profiling FASD individuals as being prone to violence towards others.

Even if all of the recommendations had been implemented before November, 2002, there is simply no assurance that the fatality would have been avoided since, as with most violent criminal acts, its incidence and the perpetrator were unpredictable.

Notwithstanding the limitation of the overall scope of this fatality inquiry to the circumstances of the fatality in question, in the broader context, the recommendations that follow may have some application to careworkers, generally, dealing with unpredictable and impulsive individuals not necessarily diagnosed as suffering from FASD.

Specific Recommendations

It is acknowledged that the following recommendations arise from the fatality which is the subject of this report and that the fatality occurred in 2002. Some, or parts of these recommendations were part of the policies and practices of the care facility in which the offender was resident and with whom the deceased was employed.

With the exception of the review of current legislation, it is not known whether policies and procedures of group homes and other residential facilities have already advanced beyond the scope and detail of these recommendations.

A. Careworker Formal Education and Training

1. Careworkers should have:
 - (i) proven specific education and training to ensure that they are familiar with the psychology and behavioral problems of the individuals under their care,
 - (ii) complete and unrestricted access to all current records (at least one year) concerning the behavior of the individuals under their care,
 - (iii) access to relevant professional assessments (or summaries thereof) of the individuals under their care,
 - (iv) familiarity, and be willing to comply, with the care policies of the agency/facility responsible for the specific individuals under their care, and
 - (v) familiarity, and be willing to comply, with the careworker safety policies of the agency/facility responsible for the specific individuals under their care.
2. Careworkers entrusted with the care of individuals should be physically capable of handling those individuals.
3. Careworkers entrusted with the care of individuals should have access to professional continuing education concerning the habits, behavior and care of such individuals.

B. Group Home Policies and Practices

4. Group homes should require the careworkers to accurately record all aberrant behavior incidents of the residents:

- (i) as part of daily summaries summarizing the daily activities of each resident,
- (ii) in an incident report that contains a detailed account of the aberrant behavior incident, the consequences of that behavior, the action taken to deal with it, and the recommendations, if any, to minimize the risk of its reoccurrence (including an identification of circumstances or prior behavior which might trigger its reoccurrence), and
- (iii) in a cumulative single report pertaining to that resident cross-referenced to the incident reports for that resident and containing the writer's assessment of any physical risks to the resident, other residents, careworkers, and member of the public, and the collective recommendations for the avoidance or management of that risk.

5. Group homes should maintain copies of the professional assessments of each resident and require the careworkers to be familiar with the contents or summaries thereof (which summaries should identify potential risks and strategies in dealing with the resident).

6. A careworker entrusted with the care of a resident should be required to read and sign off as having read the daily reports, the cumulative single report and the professional assessments (or summaries thereof) of that resident.

7. At any time, a careworker should only be assigned to the care of a resident that the careworker can physically manage at that time.

8. A careworker working alone with a resident exhibiting a sexual preoccupation or a propensity for aberrant sexual behavior should be of the same sex as that resident.

9. On a periodic basis or whenever there is a marked increase in the aberrant behavior of a resident, the relevant careworker and group home supervisors should meet to discuss risk avoidance or management strategies concerning that resident and such strategies should be recorded in writing and communicated to all staff likely to interact with that resident.

C. Careworker Safety

10. Careworker personal safety should be the subject of group home policies developed in consultation with qualified professional psychologists and workplace safety experts. Such policies should address:

- (i) identification of risks with respect to residents, situations and sites,
- (ii) careworker attire and grooming issues creating or facilitating personal safety risks,
- (iii) aberrant behavior de-escalation and management strategies,
- (iv) safe practices (e.g. do not turn your back, safe proximity, readiness, use of toys and objects), and
- (v) physical intervention and personal prevention techniques.

11. Careworkers should be required to complete and periodically update physical training courses and programs that teach personal safety strategies and responses.

D. Legislation

It is noted that, pursuant to section 40.1(1) of the *Occupational Health and Safety Act*, R.S.A. 200, c. 0-2, as amended by S.A. 2002, c. 31, s.6, the Occupational Health and Safety Council (the Council) may make a code of rules (an "OHS code"):

(a) respecting specific health and safety matters for or in connection with occupations and work sites, including

- (i) reporting requirements and the maintenance and preservation of documents reported,*
- (ii) medical and health requirements,*
- (iii) joint work site health and safety committees,*
- (iv) the making available of codes of practice and other information and documents required by an adopted code, and*
- (v) the instruction, supervision and qualifications of specified persons.*

It is also noted that an OHS code; specifically, *Occupational Health and Safety Code 2006* was made by the Council on October 23, 2006 and was adopted and came into force on February 1, 2007 (pursuant to Alberta Reg. 288/2006). While that code addresses matters of work site hazards and working alone precautions, it is clear that the thrust of the code is directed to industrial work sites and occupations where physical danger is an inherent risk (e.g. construction, mining, oil and gas, and chemical industries). The safety precautions mandated by the code are detailed and impressive.

The code does not encompass the safety of careworkers dealing with unpredictable and potentially violent individuals.

12. The Council, in consultation with relevant qualified professionals (e.g. psychologists, psychiatrists, personal safety trainers) should consider the propriety and potential effectiveness of a code that:

- a. establishes health and safety warnings, precautions, risk avoidance and risk management requirements for facilities housing unpredictable and potentially violent individuals, and
- b. requires group homes to develop policies and ensure the training of careworkers in accordance with the code,

13. Occupational Health and Safety investigators investigating group home accidents and injuries (unrelated to hazardous work site conditions) should have training or some experience in the management and care of typical group home residents and the personal safety of their careworkers.

Further Recommendations

The Inquiry received testimony from a number of individuals, and various parties to the Inquiry made recommendations concerning the employment of male caregivers and the inadequacy of funding for the residential care of FASD youth. Indeed, the two were linked: the suggestion being that inadequate funding made it difficult to employ male caregivers. The recommendations in this report have not been subjected to a cost analysis. Similarly, the myriad of issues that arise in connection with the allocation of financial resources and the availability of careworkers of either sex have not been addressed. These matters are outside the scope of this Inquiry.

Finally, almost all of the professionals (i.e. physicians and psychologists) who testified before the Inquiry encouraged a broader public awareness of the dangers and potential adverse consequences of alcohol consumption during pregnancy. This was also emphasized in the reports of other investigations of this fatality that were brought to the attention of the Inquiry. While the value of eliminating or reducing the incidence of FASD is undoubted (for many reasons beyond the risk of criminal behavior), the consideration of the effectiveness of such a

campaign in minimizing the risk of a similar fatality or safety of a careworker is simply beyond the scope of this Inquiry and the nature of the evidence received in this Inquiry. As well, the emphasis of these recommendations is towards the personal safety of careworkers, a matter that will always be an issue notwithstanding the reduction in the incidence of FASD in the general population.