



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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Provincial Court House at Siksika Nation, near the town of Gleichen, in the Province of Alberta, on the 30th day of July, 2007, (and by adjournment on the day of), before The Honourable Marlene L. Graham, a Provincial Court Judge, into the death of D.K.L.B., 15 years (Name in Full) (Age) of Siksika Nation, Gleichen, Alberta (Residence) and the following findings were made:

Date and Time of Death: January 2, 2006, between 4:30 a.m. and 6:30 a.m.

Place: Siksika Nation, Gleichen, Alberta

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

Hanging

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

Suicide

Circumstances under which Death occurred:

See attached pages 4 to 13

Recommendations for the prevention of similar deaths:

See attached pages 19 to 21

1. Description and Scope of the Inquiry

D.K.L.B. (“D”), a 15 year old Aboriginal teenager, was discovered in the basement of her foster home on Siksika Nation, in an unresponsive state, hanging from the crossbeams of the ceiling, by a rope around her neck. Siksika Emergency Medical Services (“Siksika EMS”) attended and declared her to be deceased, after which Gleichen RCMP attended to investigate. Her body was transferred to the Medical Examiner’s office for Southern Alberta in Calgary. An external examination and a toxicology test were performed. There was no autopsy.

The Fatality Review Board was notified of D’s death by Children’s Services. It recommended to the Minister of Justice that a Public Fatality Inquiry be conducted by a Provincial Court Judge. This Fatality Inquiry is a mandatory one under Section 33(3) of the *Fatality Inquiries Act* (“*the Act*”) as D, at the time of her death, was under the guardianship of a Director under the *Child Youth and Family Enhancement Act*, namely the Director of Siksika Family Services.

Mr. Allan Shewchuk, QC, was appointed Inquiry Counsel. Mr. Nick Parker, Counsel to the Director of Alberta Children and Youth Services, was given status to appear on its behalf. No other persons applied for standing at the Inquiry. A Publication Ban, as required by Section 126.2(1) of the *Child Youth and Family Enhancement Act*, applying to information that would identify D and her guardian, was confirmed on the record as applying to the Inquiry.

Under the Act, the purpose of a Fatality Inquiry is to determine the identity of the deceased; the date, time and place of death; the circumstances under which the death occurred; the cause of death and the manner of death. While the Inquiry Judge may not make any findings of legal responsibility or any conclusions of law, the Judge’s report may contain recommendations as to the prevention of similar deaths.

By consent, an Exhibit Binder containing 41 records and documents was admitted into evidence under Section 40 of *the Act*. These exhibits were referenced by one or more of the ten witnesses called to testify at the Inquiry. The witnesses were:

1. Constable Kelly D. McCoy of the Gleichen RCMP, who described the photos and Investigative Reports of Constable Harris and Constable Fortney, who attended the scene;
2. Lesley Danielle Black, an Emergency Measures Technician with Siksika EMS, who described the results of the attendance by EMS;
3. G.R.G., Foster Mother; *
4. A.W.E., Foster Sister; *
5. C.D.C., sister; *
* all of the above three witnesses gave evidence about D in the month before her death and at the time of her death
6. Rhonda Starlight, Case Worker with Siksika Family Services, who spoke about D’s history with Siksika Family Services and about the investigation she conducted after D’s death;

7. Clifford Douglas Many Heads, Director of Siksika Family Services, who spoke about D's history while in care;
8. S.E., D's recent boyfriend, who spoke about the circumstances of their breakup and it's affect on D;
9. Allan Campbell, Mental Health Therapist with Siksika Mental Health, who spoke about Aboriginal youth suicide and the Siksika Trauma Response Protocol he prepared as a result of the suicides of D and other young people, and;
10. Dr. Sam William Andrews, Assistant Chief Medical Examiner in Calgary, Alberta, who described the investigation of D's death at the Medical Examiners Office and the resulting reports.

2. D's History

2.1. Summary

D was born May 14, 1990 to N.B., an Aboriginal mother originally from the Siksika Nation and to P.W., a Caucasian father. Although the Certificate of Medical Examiner indicates her date of birth as May 15, 1990, I accept as more accurate, the Record of Live Birth indicating a birth date of May 14, 1990.

Within three days of her birth, D was placed in the care of Siksika Family Services by way of a Temporary Custody Agreement, as her mother was uncertain that she could care for her. The mother came from a dysfunctional family, had grown up in the Child Welfare System herself, and had unresolved emotional issues. She was also a chronic abuser of drugs and alcohol, who demonstrated general instability and unreliability and was never able to assume care of D. Likewise, D's father, whose relationship with her mother was marked by drinking and domestic disputes which lead to their separation, also was never able to take an active role in D's life. Although D did meet both of her parents and there was some contact over the years, generally, she remained angry and disappointed with them.

D lived her entire life in care under Siksika Family Services. The Order of Permanent Guardianship was issued November 25, 1991. She lived in a total of three foster homes with extended family, and in addition, there were three unsuccessful adoption attempts made while she was under the age of six. All of the placements were on or near Siksika Nation. Thus, D's early years were marked by instability until she was placed with her second foster mother, being her maternal aunt, Y.B. ("Y"), in 1996, where she remained for almost 10 years until she moved to the home of her third foster mother, G.R.G. ("G"), on December 7, 2005, approximately three weeks before her death. G was the former foster mother of both Y and D's own mother. D referred to G as her "grandmother".

Due to the fact D was in care, there are a number of records in existence outlining the history of her short life, including Children Service's Documents, being Information Consolidations for each year she was in care up to and including December 7, 2005; a Detailed File Review, dated April 21, 2006; Contact Notes made by the Case Workers of Siksika Family Services from October 1996 to December 2005; the Investigation Report into the death of D completed by Rhonda Starlight of Siksika Family Services; and nine Psychological Therapy

Progress Reports for 1996, 2002, 2003, 2004 with the final report dated February 6, 2005. A review of the said records and reports was helpful in obtaining a summary of D's history and an understanding of her life.

2.2. Initial Foster Placement

D's first placement was with a foster family where she called the parents, "grandma" and "grandpa", and with whom she lived before and after each failed adoption attempt, until she went to live with Y. By all reports, this was a stable, loving and supportive home with the exception of the alleged sexual abuse of D by the older son of the foster parents (addressed later in the report). While the foster parents were never willing to either adopt D or apply for permanent guardianship, they were very close to her and wanted to continue to care for her until a permanent home was found. It appears that the inability of both the foster parents and D to separate from one another contributed to the lack of success in the adoption attempts.

2.3. Adoption Attempts

D was placed with prospective adoptive parents in 1992, 1993 and 1995. By my reading of the reports, it appears that the first adoption attempt was very short lived due to issues between the parents themselves. The second and third attempts were not successful as the families were never able to overcome the transitional behavioural problems exhibited by D, who did not want to bond with the new families, as mentioned above.

2.4. Second Foster Placement

On March 18, 1996, just before turning six years of age, D was placed with Y, where she lived along with Y's two children and her own younger sister for nearly 10 years. Overall, it appears that this was a good home for D and she flourished for the most part.

Although there were ongoing conflicts with the other children, particularly with her sister, the entire family attended counselling to better understand D's emotional problems. She was found to be helpful and cooperative in the home, and was described as liking school.

She was supported and encouraged in all of her activities. D had many talents and it appears that to anything she turned her hand, she excelled. For example, she entered the 1996 Mutton Busting Contest at the Siksika Rodeo and scored the highest of all competitors, receiving an award in recognition of this feat. She was also an award winning Pow-Wow dancer and was named Siksika Indian Princess for the year 2003. She made her own dance costumes by hand. She attended church and Catechism classes and had her Communion in 2002. Just before her death, in December 2005, D and her foster sister sang together in a Karaoke contest at the Siksika Family Services Christmas party in December 2005, where they won a \$50.00 money prize for first place.

Her photographs show that she was a very cute child and a nice looking teenage girl. She was said to take pride in her appearance. In hearing her described by witnesses and reading the reports, I find that D was intelligent, talented and capable of having a promising future. She had personality and a sense of humor. Her weaknesses were her emotional

oversensitivity, weak self esteem, the abandonment/loss issues she struggled with, and the effects of sexual abuse on her behaviour with men, all of which were ongoing from time to time throughout her life. That she did as well as she did until her untimely death, is due in no small measure, I am sure, to the love and good parenting provided by Y.

2.5. Psychological Reports

The Therapy Progress Reports prepared by Chartered Psychologist, Magdalena Amestica, for 1996, 2002, 2003, 2004 and early 2005, outline the reasons D was in therapy at those times and give good insight in to her emotional and behavioural issues. She was initially referred due to maladaptive behaviours in the first foster home which worsened with the failed adoption attempts.

The initial Therapy Report in August of 1996 covered a two year period during which it was reported that D disclosed to the last prospective adoptive family, when she was five years of age, that she had been sexually abused by the adult son of the first foster parents. It appears that little was done in the way of an investigation, and the case was closed.

Ms. Amestica described D's disclosure as involving "...a long standing, severe, repeated, intense and unusual kind of adult-child sexual interference". Although the investigation as such was closed, D was treated in therapy for the alleged sexual abuse, with the use of a number of techniques. D was described as managing to express her negative and intense feelings. In particular, she expressed anger and sadness over the fact she felt the foster mother had favoured her son over D, and that by talking to the detectives, she had angered her foster parents. (page 2, Therapy Report, August 1996)

Beginning in 2002 and continuing until early 2005, from time to time, D was involved in counselling around sibling rivalry with her own sister and her cousin/foster sister, poor personal boundaries when interacting with older males and male peer friends, and emotional problems consisting of crying spells of an intense nature.

In reviewing the last two Therapy Progress Reports dated July 15, 2004 and February 6, 2005, it appears that D attended 16 sessions after the initial re-referral in February of 2002. In the July 15, 2004 report, at page 2, paragraph 2, Ms. Amestica makes this observation:

(underlined for emphasis)

"With regard to relationships in general, it has been proven that D's over-response to others' attitudes, actions, and feelings is caused by being oversensitive, very vulnerable to others' instigation, highly responsive, and easily hurt emotionally. She simply cannot accept any sign of disapproval, any kind of judgment or criticism, without feeling hurt, reacting angrily, and becoming aggressive in words and/or behaviours..."

Furthermore, at page 2, paragraph 3, she states that:

“In therapy D has been assisted to become aware of and acknowledge illogical ideas such as that criticism from peers or adults means she is worthless and no one likes her, that it is proof of her inadequacy, and a major attack on her. She was firmly confronted with her tendency to expect total consideration and acceptance from others...”

At page 3, paragraph 2, Ms. Amestica also commented that D expressed a wish to continue coming to the sessions because, in D’s words, “...you [therapist] are the only one [with whom] I can talk about everything...”.

As well, when presented with the idea of terminating therapy, D apparently “emotionally objected” to the suggestion. It was therefore the recommendation of Ms. Amestica that a meeting be set up with Ms. Medicine Shield, the Case Worker, to discuss the future course of therapy which was recommended to be every other week in frequency.

I note that the next report, which is called A Closing Summary, dated February 6, 2005, indicates that D attended only one therapy session after the July 15, 2004 Report, that being on August 11, 2004, after which the provision of services was terminated, upon the approval of Ms. Medicine Shield. No reason was given for the termination.

In concluding her Closing Summary, Ms. Amestica stated as follows at page 2:

“This complex adolescent’s main issues were identified as oversensitivity and overreactivity; relational problems with peers, especially female peers, adults in positions of authority, and relatives; boundary problems with consequent sexualized behaviours; starting of substance usage, namely alcohol; an intense need for respect, approval, recognition, consideration and acceptance”.

Further at page 2, Ms. Amestica made the following observations:

“It is this therapist’s impression that D will need extra support in the future to learn healthier ways to express her angry feelings which in turn will make it easier for her to form rewarding interpersonal relationships. It is predicted that difficulties may become more pronounced in later developmental stages in regard to sexuality issues. In addition, although it should not be assumed that a victimized child is destined for difficulty, it is felt that all measures ought to be taken at her current foster home and school to openly and regularly discuss even mild problems which arise, as a means to avoid the building of difficulties that may become insurmountable obstacles for an adolescent who has shown severe difficulties in dealing with stress”.

In conclusion, Ms. Amestica recommended the reinstatement of therapy as follows:

“Finally, the recommendation for D, especially after that last informal conversation with (name omitted) indicating she had been displaying somewhat sexualized activities, is that she reinstate therapy once per month on an individual basis”.

No further counselling or therapy was provided for D and no explanation was given for not following Ms. Amestica's above referenced recommendation, aside from an entry in the Case Worker's notes subsequent to the above referenced Closing Summary, to the effect that "... while Ms. Amestica was a good therapist, she was not good for D". No rationale was given, nor is there evidence of any other professional opinion to support this conclusion and the subsequent decision to end the counselling.

2.6. Events of 2005

Of significance, in relation to the lack of ongoing counselling, is the fact that in May of 2005, Y informed Ms. Medicine Shield, that due to D's deteriorating behaviour involving fights with her sister and cousin, drinking and staying out at night, and failing to abide by house rules etc., that she could no longer keep D in her home. Thus, a plan was made to have D enter a group home at the end of June 2005, once the school term had finished.

When the time came for D to move, Y decided to keep D in her home, as she reported that D's behaviour had improved.

Subsequently, during the summer of 2005, D began a relationship with 18 year old S.E. ("S") which extended until shortly before her death.

In the fall of 2005, D was enrolled in Grade 10 at Siksika Nation High School, where she was receiving marks well above the class average in most of her subjects. While she was functioning at school, D was continuing to have conflicts with her younger sister, her foster sister and with others in Y's household, particularly with Y and particularly over the issue of D's relationship with S.

Y took the position that as D was underage at 15 years, she should not be in a relationship with an older boy, namely S, who was then 18 years of age. Y apparently let it be known that she "would have charges laid" against S should the relationship continue. This was conveyed to S by D, which caused S to decide that the two of them should end their relationship. His rationale was that the problems with the family would be avoided and he would avoid getting into trouble and possibly going to jail. S told D of his decision in mid December 2005.

S's decision was very upsetting to D who was very attached to S. She did not want to accept his decision. S said she cried after he told her of his decision and they didn't talk for a couple of days, although they did begin talking again by telephone. During these discussions, she kept asking him to get back together with her. He did not see her again until New Years Day, 2006.

Through the spring, summer, fall and early winter of 2005 when these major issues were occurring, no counselling for D was provided.

2.7. Third Foster Placement

G had previously notified the Case Worker that she would like to have D come to stay with her in an attempt to try to work with D, before the option of a group home was tried. This led to D's move to G's home on December 7, 2005. The move was viewed by all as very positive, in that D loved her "grandmother" G, had visited G's home frequently over her life and was thereby able to remove herself from the tensions in Y's home. However, D's emotional state and demeanour were mixed in the days leading up to her suicide on January 2, 2006.

D did talk about the situation with S to G, who affirmed Y's prohibition on seeing S, but gave D the option of talking to him on the telephone.

D's 20 year old natural sister, C.D.C. ("C"), and her 17 year old foster sister, A.W.E. ("A"), were aware of D's threats to commit suicide and her actions in this regard in the last few days before her actual suicide. Both of them were also aware that D thought that she was expecting S's baby. C advised that D had come to visit her in Strathmore in December 2005 when she disclosed this belief. C offered to care for the baby, but insisted that D must finish her schooling and improve her behavior, as she had heard rumors that D was seen drinking or drunk.

Apparently, D never was pregnant as was confirmed in a medical exam at the Rockyview Hospital in Calgary, on or about December 30 or 31, 2005, which fact was deeply disappointing to D.

On or about December 30, 2005, while still in Calgary, A said that D called S and said that S was going to break up with her. She cried and did not sleep at all that night. The next day, they travelled back to the Reserve. After another phone call to S, A said that D cried all the way home. Once home, she kicked off her shoes and acted really mad over the breakup. A described how D took a razor or a knife and was seen to be preparing to cut her wrists. A took the weapon and hid it, telling her not to do it and about how many people she would hurt. D replied that she "couldn't take it anymore", but she did not take any further steps.

A testified that while she had concerns about D, she didn't believe D would actually follow through with her stated intentions, both on December 30th and on January 1st. A's explanation for not telling G or any other adult was that she didn't want to get in trouble with D for telling on her about the suicide threats.

3. Immediate Circumstances of Death

D and A were at home at G's residence on January 1, 2006, New Years Day. G attended a dinner at the home of nearby relatives. Unbeknownst to G, the girls drove her vehicle to visit S at his home. According to S, the visit took place between 7:30 p.m. and 8:00 p.m. on January 1, 2006, during which D talked to S of her desire to get back together with him. S was unwilling to do so and explained to her that it was better for both of them if they did not, so each of them could avoid further problems. He described her as being upset. A telephone

call was received from C, who told the girls to get back home with G's car as quickly as possible. Before they left, S told D that she could telephone him later, if she wanted.

It was disclosed by A after D's death, that upon their return to G's residence, D told A that she intended to kill herself and said "there would be nobody around to stop her". She went up to her bedroom in an agitated state, upset over the breakup.

However, later on, D was described by G and A as either being upstairs in her bedroom listening to music, watching TV downstairs or talking on the phone. G saw nothing out of the ordinary in D's behavior in that she was seen laughing and talking with A. At approximately 11:00 p.m., D asked G's permission to watch a movie. G agreed, and D expressed her love for G which was reciprocated. At that point, A was finishing watching a program on TV and stated that she would be finished soon and D could then watch the TV. D was seen to go back upstairs to her bedroom. That was the last time that either G or A saw D alive.

A reported that she finished watching her program and then went up to her own room. She did not check on D and assumed that D had fallen asleep in her room. Likewise, G fell asleep in the chair in the living room and did not awaken until approximately 6:20 a.m. on January 2, 2006, when she heard a beeping sound which she initially thought was a fire alarm.

Initially, G checked upstairs for the source of the beeping sound and then went downstairs to the basement, where she discovered the sound was coming from a cordless telephone on the floor. She then found D's body hanging from the crossbeams in the ceiling by a rope around her neck. Shocked and panic stricken, G ran upstairs to awaken A and then called the ambulance via 911.

In the meantime, A took a pair of scissors and cut down D's body. She said D's body "fell really hard".

Lesley Black, with Siksika EMS, advised that EMS was dispatched to the home at 6:52 a.m. on January 2, 2006, to respond to a cardiac or respiratory arrest as the result of hanging. Upon arriving at the residence, they found G and A, very distressed and emotional, upstairs in the living room. They told Black they had found D's body between 6:30 a.m. and 6:45 a.m. and that she was still and cold.

EMS was directed downstairs where they found D lying on her back on the floor. Part of the rope was still hanging around her neck as well as the other portion on the ceiling joists. A note and pen were found under her body. An overturned chair, cordless phone, and another note were found close by. As D's body was cold and still to the touch, showing obvious lividity and rigor mortis, which indicated that she was already dead, no resuscitation attempts were made, in accordance with EMS protocols.

Siksika EMS then called the Gleichen RCMP at 6:57 a.m. Constables Fortney and Harris attended at 7:15 a.m. and conducted their investigation, including the taking of photographs

and interviews, and the gathering of evidence. D's body was then removed from the basement and taken to the RCMP detachment in Gleichen.

4. Date and Time of Death

The Certificate of Medical Examiner does not provide a time of death and Dr. Andrews said the file did not contain a specific time of death. Thus, I must look to the other evidence to determine this question.

S had two telephone conversations with D after her visit to his home on January 1, 2006, both focused on D's wish to get back together with him. During both conversations she was crying and upset, according to S. The first call was later on January 1, 2006 during which S told her that she could call back. The second and final call, which S said lasted about one-half hour, likely occurred at approximately 4:00 a.m.. S described D as saying "Well I don't feel like living no more; nothing's worth living no more". He said he told her it was not good to talk like that and he believed that she was "bluffing". However, after she told him that "I love you, I will always be in your heart" and "Goodbye", S says he "heard a chair" and believed that she was in the process of killing herself. He said this happened at 4:30 a.m. (early on January 2, 2006).

He immediately phoned the D.C. residence, located near G's residence and spoke with 13 year old A.D.C., D's relative, who assured him she would go immediately and check on D's welfare. For quite some time, S found the telephone lines at G's residence and the other residence to be busy. When S was finally able to get through to A.D.C, she assured him that D was fine and that there was nothing to worry about. S states that he tried to telephone G's residence again and found the line busy and believed that the parties were again talking on the phone. He then went to sleep, believing that D was alright.

Based on S's evidence and the evidence that A cut down D's body from the ceiling joists between approximately 6:30 a.m. and 6:45 a.m., when she was found to be stiff and cold, I conclude that D died sometime between 4:30 a.m. and 6:45 a.m. on January 2, 2006. I believe that it is much more likely that she died closer to 4:30 a.m. and thus was dead when found by G.

5. Manner of Death

The evidence of the over turned chair and the beeping cordless telephone, both found in proximity to D's body, together with the fact she was found with a rope around her neck hanging from the ceiling joists, supports the conclusion that she hung herself by kicking away the chair while she was talking on the phone to S.

This death by suicide is further corroborated by the notes, totaling eight in number, which were found either by her body or in her bedroom, along with the evidence of S, A and C about D's very recent stated intention to kill herself.

The notes found near her body were a sheet of paper with a number of questions to be put to someone (probably S) about his feelings for her and the other sheet of paper contained these words:

“I did this because I couldn’t live my life with everyone yelling always mad at me. Tell S I love him and don’t put this on S because it’s not his fault none of it and don’t hate him. Tell C to carry my grave theres a list upstairs in my room of who I want on my honourary the ones with dashes are the ones who I (want) to carry my grave. Love D”.

In fact, a three page list of names was found in her room entitled “Best Friends and Good Friends”. Another note was in these words; “Shyt man things are really fucked up rite now like Chee--I lost my baby S broke with me everyone is made at me”. The other writings are in the nature of love letters, which by their tenor and content were meant for S, I presume.

The verbal statements by D, the notes she wrote, and the apparent hiding of the phones in the house, close in time to her suicide, are indicators that D engaged in some planning of her suicide, at least in the immediate hours preceding her death.

6. Cause of Death

Dr. Craig Litwin, a Forensic Pathologist, then of the Office of the Chief Medical Examiner in Calgary, Alberta, performed the medical investigation of D’s death and provided the Certificate of Medical Examiner, made an Exhibit on the Inquiry.

In this case, an external examination was found to be sufficient to determine the cause and manner of death without the need for a full autopsy which would have included an internal examination.

An external examination involves an examination of the external surfaces of the body, documenting the characteristics of the deceased and any injuries that are seen. In this case, the external examination revealed a normal 15 year old girl in terms of physical characteristics. The rope, measuring .5 centimeters in diameter and wrapped once around D’s neck, was found to have caused an abrasion or mark that went all the way around her neck and up the right side at the back of her head.

D’s body was tested for the presence of any drugs or alcohol in her system. The Toxicology Report completed by Dr. Peter Singer was negative for both.

In the final analysis, it was Dr. Litwin’s opinion that the cause of death was hanging and that the injuries found around D’s neck, as well as all the information from the scene investigation, were consistent with a suicidal hanging.

I concur with this opinion.

7. Investigation by Siksika Family Services and opinions of Rhonda Starlight and Clifford Many Heads

Siksika Family Services is delegated by the Province of Alberta to administer children's services, including protective services, under the *Child Youth and Family Enhancement Act*.

Ms. Rhonda Starlight, social worker and case worker with Siksika Family Services, conducted the investigation into D's death for the Ministry of Children and Youth Services as was required when there was a fatality of a child in care. In doing so, she had access to the detailed file review documents and all other documentation on D's file.

While D's case worker was Ms. Rhonda Medicine Shield, Ms. Starlight did see D informally from time to time in the office. She described her as happy, easy to talk to and quick to laugh. She last saw her on December 15, 2005 at the Siksika Family Services Christmas Party, where D was observed to be in a happy mood and was the winner of a Karaoke contest with A.

Ms. Starlight reported that her review of D's file showed that D became angry in May of 2005 while living at Y's foster home, over her belief that Y was treating her sister with favoritism, and because D's natural mother had been allowed to stay at Y's home. It was proposed that D move to a Group Home at the end of June when school was done. By the end of June, D's behavior had apparently improved and Y didn't want D to move, so D remained in Y's home. Ms. Starlight reported that in the fall of 2005, D was doing well in school and had no issues. It was Ms. Starlight's opinion that Ms. Medicine Shield had approved the move from Y's home to G's home in December 2005, as the issues with D's sister continued and because D dearly loved G and viewed her as her grandmother.

In reviewing D's entire file and records, Ms. Starlight was of the opinion that there was no indication of any significant problems brewing in D's life, and that the workers had no knowledge of any previous suicidal intentions. As to the historical alleged sexual abuse of D while in her initial foster placement, Ms. Starlight did not believe it was a problem for D at this stage, as D never raised the matter, according to Ms. Starlight. She was of the view that there were no systemic problems in relation to how D had been dealt with over the years while in care. She did not believe anything should have been done differently in how D's case was handled.

While Ms. Starlight acknowledged that there were several suicides involving young females on the Reserve in the fall of 2005, and that D would have known about these suicides, it was Ms. Starlight's opinion that there was no connection between D's suicide and those suicides. Her view was that the cause of the suicide was D's feelings of rejection over the breakup with her boyfriend, S.

Mr. Clifford Many Heads, the Director of Siksika Family Services since 1986, testified that after reviewing D's file, he also concluded that he had no concerns about how the department or the case workers had handled D's file. His assessment of D's history was that she "...had had a lot of issues that she went through". He pointed out that she had gone through "quite a few placements until we finally got her settled in the mid – in the late 90's". He

expressed that he felt that she had grown up with a lot of “maybe being abandoned and moving”. He went on to say that it was hard to say “whether that (moving and being abandoned) was a real factor in what happened in the end”, for the reason that “the Psychologist had spent a number of years working with D and she kept having issues”. He felt that the Department had provided all the resources that they could to address D’s needs.

Mr. Many Heads mentioned that he also saw D at the annual Christmas Party and observed that she was interacting with others and seemed very happy. He said that he asked her how she was doing, to which she responded that she was “doing good”.

When asked about whether there was any system in place at Siksika Family Services to monitor the type of behavior D was beginning to exhibit, i.e.: using alcohol and starting a relationship with an older boy, he replied that it was the intention now “to try and partner with other existing service areas on the Reserve, such as Justice, Health and the Schools to come up with a preventative process or protocol”. He also advised that the Ministry had provided suicide training for the staff of Siksika Family Services in June of 2007.

8. Aboriginal Suicide and Siksika Trauma Response Protocol

A Backgrounder document entitled “Suicide Among Aboriginal People in Canada” prepared by the National Aboriginal Health Organization, which I accessed on the Internet (www.naho.ca/english/newsReleases/04_04_2008BG.pdf), indicated that the overall suicide rate within Aboriginal communities is about twice the rate for the general Canadian population. It noted that young people are particularly at risk, with over one-third of all deaths attributed to suicide. It also noted that on-reserve First Nations youth between the ages of 10 and 29 are five to six times more likely to die of suicide than their peers in the rest of Canada. Furthermore, that while there has been a decline in Canada’s national suicide rate, it reported that Aboriginal communities do not appear to be experiencing a similar decline. In fact, it claimed that the problem amongst Aboriginal Peoples is thought to be greater than what the numbers indicate because the statistics do not include off-reserve and non-status First Nations people and Métis people.

I was provided with a document prepared by Yvonne Olivier, Mental Health Therapist/Coordinator at Siksika Mental Health, dated March 2007 which indicated that the records of the Siksika EMS for 2005 included 36 calls re: attempted suicide and 3 calls where suicide had occurred. All of the suicides involved youths and two of those cases were of young females who had hung themselves. The three suicides occurred within one or two months of one another, with a fourth occurring at the beginning of 2006 (believed to be that of D). Because of the proximity in time of all of these suicides, there was a cause for concern as the pattern was an indication that a suicide cluster may be occurring.

These multiple youth suicides in the Siksika community were the catalyst for the Chief and Council of Siksika Nation to ratify a policy of making youth and their programs a top priority according to Alan Campbell, with a MA in Psychology, working as a Mental Health Therapist with Siksika Mental Health. Mr. Campbell was hired for his position partly in response to this policy position for the purpose for developing a Trauma Response Model,

similar to a Trauma Response Model/Protocol that he had helped to develop the previous year at the Siksika Nation High School while employed there as a counselor.

Thus, the Siksika Trauma Response Protocol (“the Protocol”) was developed by Mr. Campbell, to address traumas, primarily those which were suicide related, based on a multi-disciplinary cooperative approach. The intent was to bring various Siksika Nation service areas together, including Justice, Education and Family Services, as well as the Elders of the community, to focus on intervention, including an emphasis on recognizing and responding to signs of risk and threat before a suicide occurs.

It was Mr. Campbell’s opinion that amongst the three aspects of trauma response, namely prevention, intervention and postvention (reaction to a crisis), it was intervention that was the least organized and the least intensive, not just on Siksika but, generally speaking. Also, he identified the need for the Siksika Nation to be more proactive than reactive in dealing with the issue of suicide.

Mr. Campbell described the Protocol he developed as being based on the widely accepted Traumatic Event Systems (TES) Model, developed by Mr. Kevin Cameron, an American expert who had been hired by the Alberta Government to develop a trauma response to the 1999 Taber School shooting.

Mr. Campbell conveyed a strong commitment to the strategy and collaborative method set out in the Protocol which he felt made sense in a traditional, cultural sense for the people of the Siksika Nation, because they were originally, a communal people.

When questioned by me as to possible explanations why the young people who knew of D’s threats of suicide did not take them seriously, his view was that while every suicide is different and multiple reasons underlie why a person resorts to suicide, he was not surprised by the reaction of those individuals who did not take the threats seriously, which reaction he felt was a rampant problem on the Reserve.

Mr. Campbell’s explanation for this non-reaction is a result of what he called the “intergenerational transmission of trauma”. He explained that factors such as cultural genocide, residential schools, drug and alcohol abuse, inadequate parenting causing attachment issues, to name a few, contribute to an insensitivity to trauma in Aboriginal People.

Mr. Campbell also confirmed for me that if someone is threatening suicide and has made an attempt before, that these actions are indicators of a serious attempt to complete the suicide. These actions would be viewed as primary areas of concern in a suicide risk assessment.

He also confirmed that over three days in June, 2007, a number of professionals from Siksika Nation were trained in the TES Model with a result that Siksika Nation then had an appropriate body of multi-disciplinary professionals trained to implement formal threat/risk assessment and trauma response for Siksika Nation.

Mr. Campbell's final recommendations on the Inquiry, were threefold; firstly, that the Siksika Tribal Manager and the Siksika Chief and Council support the development and implementation of the Siksika Trauma Response Protocol; secondly, that the same leaders mandate the participation and formal agreement of relevant service areas and their respective managers; and thirdly, that the leadership support the creation of a Coordinator of Trauma Response position to oversee the Protocol.

At the time evidence was called at the within Inquiry on July 30, 2007, I was advised that the Protocol was in the early stages of development, with more detail work to be done to complete the content of the Protocol. A recent letter update, dated January 16, 2009, advises that the Protocol is still in an implementation stage and that there has been minimal progress made in finalizing this implementation.

I am further advised that while not much has been happening formally, the network of various services on Siksika is continuing to work on the matter, particularly in the face of further suicides on the reserve which have prompted further discussion. I am also informed that an individual has been hired by the Siksika School Board, who is keen to have the Protocol run out of the school at Siksika, which is relevant with respect to youth at risk for suicide. Also, there is some suggestion that a search is in place for a person to coordinate the final implementation of the Protocol.

9. Other Suicide Prevention Resources

While I did not conduct a thorough survey of other suicide prevention resources and initiatives in Alberta and Canada, I did discover that there are several agencies and programs focused on youth suicide. Within the Alberta Government, there is a Cross-Ministry initiative called the Aboriginal Youth Suicide Prevention Strategy, which sponsored an education awareness and training grant program in March of 2007 for grants of up to \$5,000.00, of which the Siksika Board of Education – Crowfoot School appears to have been a recipient. Action plans to combat youth suicide have been developed in a few pilot sites on reserves. This program is part of the Alberta Mental Health Board.

Provincially, in a document outlining the “Children’s Mental Health Plan for Alberta: Three Year Action Plan (2008-2011)”, reference is again made to the Aboriginal Youth Suicide Prevention Program, as part of the Three Year Action Plan to support a coordinated and corroborative approach to optimizing the mental health and well being of infants, children and youth, up to 24 years of age, as well as their families.

Also, in 2006, Alberta Health and Wellness announced a 38.9 million dollar commitment over three years to mental health projects for Alberta’s children and youth. Of that, 12 million dollars was designated to support three suicide prevention initiatives, all of which relate directly to specific goals and objectives of “A Call to Action”. The Alberta Suicide Prevention Strategy was launched in September 2006 for the purpose of reducing suicide, suicidal behavior and the effects of suicide in Alberta over 10 years.

Within the Calgary and Area Child and Family Services Authority, there are several agencies that can be called upon for information and help including the Telecare Calgary Suicide and Crisis Information, the C.M.H.A. Suicide Services Intervention and the Distress Centre's Teen Line.

There is also the Alberta Centre for Injury Control and Research, the Canadian Mental Health Association and the Canadian Association for Suicide Prevention. There are also local crisis centres and crisis lines in many communities throughout Alberta.

Nationally, the Centre for Suicide Prevention provides information workshops and training, to an array of participants, as well as conducting research.

The World Health Organization in 2003 declared September 10th as World Suicide Prevention Day, which appears to be recognized in the Province of Alberta by many agencies and in some schools.

My point in highlighting some of the many agencies and government programs which address suicide and youth suicide, is to show that resources already exist which potentially could be very helpful to any initiatives undertaken on Siksika Nation.

10. Other Findings and Conclusions

Overall, Siksika Family Services did it's best to provide for D's needs during her short life. It endeavored to find a permanent placement for D soon after her first foster family indicated an unwillingness to adopt her. This was eventually achieved in 1995. As well, it responded to her needs, concerns and complaints, providing resources including psychotherapy up to and including February 2005.

However, the last Psychological Report on D stated that she was over-sensitive and over-reactive and recommended continued regular individual counselling during a vulnerable time in her development. The context of D's life at that time was that she was observed to be exhibiting inappropriate sexual behaviors with older men, starting to drink and not come home, fighting with her sister and foster brother, and wanting to move residences, including the option of a group home.

It is unfortunate that individual personal counselling was not continued for D as recommended, particularly in light of the behaviours being exhibited by D in her attempt to establish relationships with the opposite sex.

The loss of the relationship with her boyfriend, with whom she was deeply attached, and her disappointment in finding out that she was not expecting his child, appear to be the triggering events leading up to her suicide. These events together with the many other losses and family conflicts in her life, caused her overwhelming pain and the feeling that life wasn't worth living.

While she had demonstrated that she was capable of advocating for herself by communicating her needs, etc. to her case worker or other adults, in the case of her suicidal thoughts, she did not disclose these thoughts and feelings to older adults. Instead, she only made her suicide intentions known to her 17 year old foster sister, her 18 year old boyfriend and her 20 year old sister.

While those individuals told her not to talk that way, none of them really took her seriously and did not call for help, even though the threats took place over a couple of days. It is unfortunate that they apparently did not know enough about the warning signs of suicide to take her seriously and to get professional help for her.

It will never be known if she had had ongoing counselling, whether it would have made a difference and helped her through the painful period she was experiencing. As well, it will never be known if professional intervention would have prevented her from taking her life, in the end.

D was in a good home, with people who cared for her. Drugs and alcohol were not a factor, and the sexual abuse she had experienced, was dated. Nevertheless, she clearly became overwhelmed with her feelings about the break up of her relationship and the knowledge she was not expecting a baby, which sent her into crisis, without the benefit of any professional help or intervention.

Her weakness was her emotional oversensitivity, her weak self esteem and her abandonment/loss issues. She lacked the life experience and understanding to know that her intense feelings would not last forever. She sought relief from her pain through suicide.

11. Recommendations

1. Given the high incidence of youth suicide in First Nations communities which also has been experienced on Siksika Nation in recent years, and given the policy adopted by Siksika Nation Chief and Council to make youth suicide prevention a priority; and whereas the Siksika Trauma Response Protocol (“the Protocol”) was developed and eventually approved by the said Chief and Council in response to this priority issue but which Protocol has not been fully implemented, I recommend the following:
 - a) That Siksika Nation Chief and Council forthwith undertake a Review of the Protocol to assess:
 - 1) whether the Protocol adequately focuses on youth suicide prevention;
 - 2) what obstacles to implementation exist; and
 - 3) whether to support the implementation of the existing Protocol, or alternatively, a revised Protocol, or the utilization of other existing programs and services in place of the Protocol.

- b) That the Review should survey existing services and programs locally, provincially and federally, such as the Children's Mental Health Plan and the Aboriginal Youth Suicide Prevention Strategy, to determine the advisability of integrating and synchronizing the Protocol with already existing initiatives and programs on youth suicide and mental health.
 - c) That the Siksika Nation community organizations and agencies, which were identified as participants in the multi-disciplinary Protocol, be consulted as to their support for the Protocol in its present form and about any recommended changes.
 - d) That the Chief and Council set specific time lines for the completion of the Review of the Protocol and for the specific steps to be taken to either implement the Protocol in its present form or alternatively, to implement an amended Protocol or some other program or service.
 - e) That the Chief and Council, the service areas of the local government and the local community organizations, renew and redouble their efforts to address the current lack of progress on this crucial issue of youth suicide prevention on Siksika Nation.
2. Given that the most proximate factor in relation to D's suicide was the lack of effective action taken by the young people surrounding her in response to her stated intention to take her own life, I recommend:
- a) That the Siksika Nation find an effective means, either as part of the Protocol, as part of another program or service in the school or broader community, or as a standalone initiative, to raise awareness amongst its people generally, and its young people specifically, about the classic symptoms exhibited by suicidal persons, of the need to take these suicide threats seriously, and about how and where to obtain effective help for such persons.
 - b) That the Siksika School Division along with all schools in Alberta that are not currently doing so, seriously consider observing World Suicide Prevention Day on September 10th of each and every year, in such a way as to provide a meaningful learning opportunity for students and their families around the issues of suicide identified in subparagraph 2a) above.
3. Where it is the expert opinion and the recommendation of a professional mental health therapist that ongoing counselling is needed for a child in care, such as was recommended for D, I recommend that a Director of Child and Family Services, in this case the Director of Siksika Family Services, adopt a policy that:
- a) The professional recommendations are acted upon as prescribed.

- b) Where the recommendation is not supported by the case worker or other decision maker(s) within the child welfare system, then a second opinion about the need for ongoing counselling is obtained before a final decision to discontinue such counselling is made.
4. Where a child in care within the child welfare system has been professionally assessed as emotionally vulnerable, a policy should be adopted whereby the child is professionally monitored at regular intervals i.e. at identifiable developmental stages, especially where there are indications that the child is engaging in risky behaviours. This is particularly relevant in the case of aboriginal youths, who are at high risk for suicide.
 5. That Siksika Nation Chief and Council, and all other levels of government, review the recommendations contained in the Fatality Inquiry Report of Provincial Court Judge L. S. Mandamin, as he then was, dated July 27, 2007, for comprehensive changes in aboriginal communities and for actions of all levels of government relative to aboriginal youth suicide, with a view to implementing his recommendations wherever possible.
 6. While Alberta Justice has been maintaining a database of Fatality Inquiry Reports on its website since 2005, which Reports and Recommendations can be accessed by the public according to date, name and cause of death, there is no system in place to follow up on whether or not Recommendations are acted upon by any of the parties involved and if so, in what manner. Thus, I recommend that:
 - a) Alberta Justice consider instituting a method to follow up on the response taken, if any, to Recommendations in Fatality Inquiry Reports, such that this information could be provided as a relevant resource to judges hearing Fatality Inquiries and preparing their reports and recommendations in prospective cases with similar facts or circumstances.

DATED May 6, 2009 ,
 at Calgary , Alberta.

Original signed by

*The Honourable Marlene L. Graham
 A Judge of the Provincial Court of Alberta*