RELEASE DATE: July 22, 2004

Manitoba

THE PROVINCIAL COURT OF MANITOBA

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

AND IN THE MATTER OF: **SUSAN CAPELIA REDHEAD**

APPEARANCES:

Mr. T.J. Preston, for the Crown
Mr. J.R. Norman Boudreau, for Sarah Wood and Shamattawa First Nation
Mr. Issie D. Frost and Mr. Alan Ladyka, for Department of Family Services and Department of Justice
Mr. Michael Thomson, for Winnipeg Child and Family Services
Mr. Jeffrey F. Harris, for Awasis Agency of Northern Manitoba
Mr. Randal T. Smith, Q.C., for First Nations and Inuit Health Branch
Mr. Mark G. Mason, for the Royal Canadian Mounted Police

Manitoba

THE FATALITY INQUIRIES ACT
SCHEDULE ATTACHED TO PROVINCIAL JUDGE'S REPORT

RESPECTING THE DEATH OF: SUSAN CAPELIA REDHEAD

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HOLDING OF INQUEST

[1] Susan Redhead was 15 years old when she committed suicide at the home of her mother and stepfather in Shamattawa on February 20th, 2000. She had been discharged from the care of the Awasis Agency of Northern Manitoba (Awasis) approximately six weeks prior to her death. At the time of her death her stepfather also resided in the home. He had recently been released from custody after being convicted on charges of sexually abusing both Susan and her sister. Susan was also known to be a high risk for suicide and had been receiving mental health services while in agency care.

[2] On November 10th, 2000, an Inquest was called by the Chief Medical Examiner of the Province of Manitoba pursuant to section 19(2) of ***The Fatality Inquiries Act*** to address the following:

(1) to determine the circumstances and events leading to the death of Susan Redhead;

(2) to determine whether, given her difficulties and history, Susan received appropriate child protection and child welfare services, particularly after her discharge from care in January of 2000;

(3) to determine the circumstances under which the individual convicted of sexually abusing Susan was released from incarceration without an order prohibiting contact with his victim;

(4) to determine the availability of access and appropriate mental health services for youth in First Nations communities;

(5) to increase awareness of the need to protect children from known sexual offenders; and

(6) to determine what may be done to prevent similar deaths in the future.

LEGISLATIVE AUTHORITY

[3] Sections 19(2), 25 and 26(1) of ***The Fatality Inquiries Act*** are the authority for a Provincial Court Judge to hold an inquest with respect to the death and are as follows:

> **CME to direct holding of an inquest**
> 19(2) Where the chief medical examiner determines under subsection (1) that an inquest ought to be held, the chief medical examiner shall direct a provincial judge to hold an inquest.
>
> **Ministerial direction for inquest**
> 25 The minister may direct a provincial judge to conduct an inquest with respect to a death to which this Act applies.
>
> **Provincial judge to hold inquest**
> 26(1) Where a direction is given by the chief medical examiner under section 19 or by the minister under section 25, a provincial judge shall conduct an inquest.

[4] The duties of the provincial judge at an inquest are set out in section 33(1). After completion of an inquest, the presiding provincial judge:

(1) shall make and send a written report of the inquest to the Minister setting forth when, where and by what means the deceased person died, the cause of death, the name of the deceased person, if known, and the material circumstances of the death;

(2) shall, upon the request of the Minister, send to the Minister the notes or transcript of the evidence taken at the inquest;

(3) shall send a copy of the report to the Medical Examiner who examined the body of the deceased person; and

(4) may recommend changes in the programs, policies or practices of the Government and the relevant public agencies or institutions or in the laws of the province where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood

of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest.

[5] The Inquest regarding the February 20th, 2000, death of Susan Redhead was held over a period of 37 days:

- on November 5th, 6th, 7th, 8th, 9th, 13th, 14th, 15th, 16th, 19th, 20th, 2001, at the City of Thompson, in Manitoba;
- on November 21st, 2001, at Shamattawa, in Manitoba;
- on November 22nd, 28th, 29th, 2001, at the City of Thompson, in Manitoba;
- on February 4th, 6th, 7th, 8th, 11th, 12th, 2002, at the City of Winnipeg, in Manitoba;
- on May 6th, 7th, 8th, 9th, 13th, 14th, 15th, 21st, 22nd, 23rd, 24th, 2002, at the City of Winnipeg, in Manitoba;
- on June 28th, 2002, at the City of Winnipeg, in Manitoba;
- on September 6th, 2002, at the City of Winnipeg, in Manitoba; and
- on September 9th, 10th, 11th, 2002, at the City of Thompson, in Manitoba.

[6] When the Inquest commenced on November 5th, 2001, Mr. Boudreau withdrew as counsel for Sarah Wood and the Shamattawa First Nation. Chief Eli Miles was present and was invited to attend the proceedings on behalf of his community. Other than to give evidence on November 16th, 2001, he did not attend further. Sarah Wood was not present on the first day although she was aware Mr. Boudreau was withdrawing. Ms. Wood was invited to sit in on the proceedings. She gave evidence on November 13th, 2001. Other than that, she did not attend.

[7] A total of 59 witnesses were called.

FEBRUARY 20, 2000

[8] In the early hours of February 20th, 2000, Susan Redhead hanged herself in a bedroom of her mother's home with a coaxial cable meant to support a baby's hammock. She had been in the company of three young men earlier in the evening and Susan had been sniffing. The four spent time at Susan's mother's home where they talked and played music. Susan's mother, Sarah Wood, was in the home and told them to get out so that the music would be stopped because she was trying to sleep. During the time the young men were there, Susan was apparently upset and had been talking about an incident several days earlier when she had stabbed her stepfather, John Wood, with a knife. She had also been upset when she was speaking to her mother earlier that night about her stepfather not wanting to come home while Susan was in the home. She knew her mother wanted John in the home. Michael John Wood had been convicted in February of 1999 of sexually assaulting Susan and her sister and had been sentenced to a year in jail as a result of that.

[9] After the three young men left, Susan did not leave. Shortly after, her sister C. stopped by the house, having just been released from the R.C.M.P. cells. Susan had at first wanted her to stay the night because she did not like to be alone in the house with just her mother. She changed her mind, however, and told C. to go on home where her own people would be waiting for her (C. did not live with her mother and stepfather). John Wood was not in the home at the time as he was apparently in Thompson receiving medical attention to the hand injured by Susan.

[10] Shortly after C. left sometime around 4:00 a.m., Sarah Wood got up to check to see if the door was locked. As she walked by the room she saw a figure sitting in the room. She turned on a light and saw the ligature around the neck of the person on the bed. She said she thought at first that it was her daughter C. who had committed suicide because C. had attempted to do so on a number of

previous occasions. It was not until she looked closer that she realized that, in fact, it was Susan. She ran next door to get help and the people there contacted the R.C.M.P. who attended within minutes.

SUSAN REDHEAD: FAMILY HISTORY

NOTE: There are confidentiality requirements under ***The Child and Family Services Act***. In order to protect the privacy of the siblings of Susan Redhead, I am simply going to refer to them by initials.

Mother: Sarah Norah Thomas Redhead (Wood)
Date of Birth: November 30, 1960

Father: Patrick Eugene Redhead
Date of Birth: June 30, 1960
Date of Death: November 24, 1990

Step-Father: Michael John Wood
Date of Birth: July 3, 1964

Siblings: C.M. (father Patrick Redhead)
Date of Birth: May 21, 1981

S.J. (father Patrick Redhead)
Date of Birth: September 24, 1983

S.J. (father Patrick Redhead)
Date of Birth: March 27, 1986
Guardian: Cornelius Redhead (paternal uncle)

N.V. (father Patrick Redhead)
Date of Birth: March 3, 1988

C.I. (father Patrick Redhead)
Date of Birth: October 10, 1990
Guardians: Victoria (aunt) and Hezekiah Miles

R.V. Wood (father Michael John Wood)
Date of Birth: October 9, 1993
Guardians: Jean and Garry Unrau

R.B. Wood (father Michael John Wood)
Date of Birth: November 23, 1994

Miscarried infant
Gender: Unknown
October 4, 1995

M.K. Wood (father Michael John Wood)
Date of Birth: November 5, 1996

SUSAN REDHEAD: PERSONAL HISTORY

The history which follows is that of Susan Redhead. It is noted, however, that all of her siblings grew up in the same milieu. They were the subject of apprehensions, neglect, allegations of abuse and placed in and out of the community in various homes. It would appear that at no time did this family ever live with everybody in the same place at the same time. To understand the nature of the family, Susan's history, which follows, is multiplied by the experiences of her brothers and sisters.

August 17, 1984	Susan Redhead is born.
November, 1984	Mother abandons Susan to go drinking. At the age of three months Susan is placed in a foster home.
December, 1984	Susan is returned to her mother on the recommendation of the local child care committee.
November 24, 1990	Patrick Redhead, Susan's father, dies.
May 16, 1992	N. and Susan are placed with their aunt, Margaret Koostachin.
September 18, 1992	Margaret Koostachin asks that the children in her home be placed in care. They are placed in Shamattawa foster homes. Sarah Redhead signs a Voluntary Placement Agreement (VPA) acknowledging she needs alcohol treatment.
October 8, 1992	Susan is sent to a Thompson foster home.
October 9, 1992	Susan is sent to a Cross Lake foster home.

March, 1993	Cross Lake foster parent reports Susan stabbed her brother in an incident in the home.
July 8, 1993	The family is in Thompson and Susan's VPA is terminated.
August 5, 1993	Susan and N. are picked up for shoplifting nail polish. The police find mother highly intoxicated and a party going on in the home which was full of intoxicated people. The children were apprehended.
October 18, 1993	A one-year temporary order of guardianship was signed to Awasis Agency for C., N. and Susan.
November 1, 1993	N. and Susan go to the local group home in Shamattawa.
November, 1993	Susan makes a disclosure with respect to sexual assault by L.T. and A.M.
March, 1993	The worker notes that mother does not visit Susan and N. even though they are in the same community.
May 19, 1993	Susan is referred for a psychiatric assessment which was recommended by the Director of the group home. They thought Susan needed additional support from the worker and therapy outside Shamattawa because of inappropriate behaviour, sniffing and being AWOL from the group home and school. There was also a concern that she might be suicidal. A psychologist at Norway House saw her for one visit. Thought she was sad and depressed, not suicidal.
June, 1994	Susan, C. and N. are apprehended as they arrive in Shamattawa from Thompson. They had ten containers of nail polish and hairspray in their bags. Sarah and John Wood had been too drunk to be allowed on the plane.
September, 1994	Sarah promises to stay sober and work at reuniting family. She was pregnant with her eighth child at the time. Susan and C. returned to the home on September 19th.

September 24, 1994	Sarah Redhead is intoxicated and had been lodged in the R.C.M.P. cells. Chief and Council were advised but they indicated they were committed to helping the parents stick to their plan.
January 5, 1995	C. goes to the Agency re abuse. The cuts and bruises on her body substantiated her complaint. R.C.M.P. attend the house where there is a large drinking party underway. C. discloses neglect and physical abuse of all of the children. Susan also discloses the abuse. C. and Susan are placed in the group home.
March 19, 1995	In making temporary orders on Susan and C. the judge notes the need for long-term planning with respect to the girls.
May 13, 1995	Crown stays charges against L.T. for sexual assault following an interview with Susan at the court location. Susan's worker makes a complaint about the Crown Attorney's handling of the situation when Susan was at court.
September 28, 1995	C., Susan, N. and R.B. are taken to a receiving home by the Chief of Shamattawa who was also their uncle. The Agency notes the need for long-term treatment and the need for the children to remain in care until their parents make major changes. At that time, the Agency notes that the parents appear uninterested in caring for their children and were unfit to be parents. John and Sarah Wood move to Oxford House at this time.
November 20, 1995	Susan is placed in a foster home operated by relatives out of the receiving home in which she was living at the time.
December 4, 1995	Susan is noted as going AWOL and the foster family notifies the Agency on January 2nd, 1996 that Susan had been gone since December 29th. It is noted then that Susan's VPA is renewed to March 29th, 1996.

1995-1996	In this school year there were problems with Susan's attendance because of sniffing. The plan for her to receive substance abuse treatment appears to have been abandoned but there is no note as to why that would be the case.
July 1996 to May of 1997	There are no notes of Susan's location or situation on the Awasis file.
May 8, 1997	Susan discloses sexual assault by Roderick Thomas. He was eventually convicted and received nine months plus a two-year supervised probation order. He had broken into Susan's residence and sexually assaulted her. It is noted that he actually was sentenced on the break and enter with intent to commit sexual assault, rather than on the sexual assault.
1996 to 1997	There is no record of Agency involvement with Susan or her parents during that period of the school year.
September 17, 1997	Winnipeg Police bring Susan and N. to the Winnipeg CFS After Hours Emergency Service. They had been hanging around the bus depot and were very dirty. They had been sniffing with their brother and got lost in downtown Winnipeg. They were afraid they would get beaten up by Sarah Redhead (Wood) when they returned. The girls were placed in an emergency placement where they appeared quite happy and asked if they could have baths.
September 18, 1997	Sarah Redhead (Wood) is interviewed and denies that she has a problem with alcohol. She does admit that she hits or shakes the girls when she is angry with them. Susan and N. began crying when told that they would be returning home. Winnipeg Child and Family Services recognize there are problems but decide that Sarah Redhead (Wood) should be given the opportunity to address her problems as she presented as being willing to do so. They note if there were future concerns the children should be apprehended.
October 5, 1997	After Hours Emergency workers got a call and attended at the Redhead home where they found Sarah Redhead and John Wood both quite

	intoxicated and arguing. John Wood was taken by police to be lodged IPDA and Susan was left in the home.
October 6, 1997	Workers spoke to Susan who did not want to come into care so safety planning was done with Susan. Later that day, in dealing with Sarah Redhead and John Wood, Winnipeg Child and Family Services indicated that they would be apprehending the children because of the unwillingness of the parents to seek and complete treatment.
October 14, 1997	Susan and N. had gone AWOL over the weekend and were found at Sarah Redhead's home.
November 6, 1997	Susan ran away from school and was admitted to the Crisis Stabilization Unit (CSU).
November 12, 1997	Susan enters Kirkos House. The report from CSU indicated that Susan had been suicidal and that there was a family history of suicide.
November 28, 1997	Winnipeg CFS receives a six-month temporary order of guardianship on Susan, N. and R.B.
December 6, 1997	Susan assaulted a resident at Kirkos House and went AWOL. She was charged and taken to the Manitoba Youth Centre and returned to Kirkos House on December 8th.
February 26, 1998	Susan disclosed a sexual assault in Shamattawa in 1997 by F.T. She also disclosed an assault by three boys who urinated on her while they were all living in a group home in Shamattawa during 1996.
May 17, 1998	Staff are told that Susan is apprehensive about living with John Wood and preferred to reside with an uncle when they were talking about planning for where she would go after Kirkos House. A decision was also made to have her assessed for possible FAS/FAE.
May 19, 1998	Susan's sister, C., had attempted suicide and had been rushed to Thompson Hospital. She was later transferred to the Psych Unit at the Health Sciences Centre in Winnipeg.

May 26, 1998	A one-year VPA was signed to continue Susan's placement at Kirkos House.
June 9, 1998	Worker completed a report of an abused child to Manitoba Family Services and Housing concerning Susan's recent disclosure of sexual abuse by John Wood.
June 15, 1998	Susan is admitted to a psychiatric ward after attempting suicide. She was discharged back to Kirkos House on June 25th.
August 28, 1998	Susan was admitted to a hospital psychiatric ward after threatening to commit suicide.
August 29, 1998	Susan was discharged from Winnipeg CFS and placed with the Awasis Agency under a VPA despite Sarah Redhead's history and the serious allegations against John Wood.
September 19, 1998	The Agency was notified that Susan was experiencing increasing difficulties with episodes of suicidal ideation and attempted suicide. Susan wanted a visit with her siblings.
September 20, 1998	Susan made further disclosures of suicidal ideation related to her stepfather's sexual assaults.
September 23, 1998	Susan had a visit at Kirkos House by Sarah Redhead, C. Redhead and John Wood. Concern was expressed that John Wood was visiting, given the disclosure Susan had made about his sexual assaults.
September 27, 1998	Susan is suicidal and had physically and verbally assaulted the staff.
October 14, 1998	Further suicidal ideation and she was found lying on her bed crying with an extension cord in her hand. She was transported to the Crisis Stabilization Unit, staying there until October 16th.
October 20, 1998	Susan elaborated on her disclosure of sexual abuse to her therapist, a clinical psychologist.

October 26, 1998	Staff report further suicidal ideation because of the unsettledness of her future.
November 4, 1998	Suicidal ideation expressed prior to a meeting which was scheduled with her Awasis worker the next day.
November 5, 1998	No one from Awasis attends the scheduled discharge planning meeting.
November 11, 1998	Susan was found in her room with a plastic garbage bag over her head. She denied attempting suicide but she had learned that a friend in Shamattawa had died a week earlier.
November 12, 1998	Kirkos House staff call Awasis Agency to express their concern about not hearing anything from the Agency. Susan was described as being in a constant state of attempting suicide simply because she had no idea what the plans were for her future. She barricaded herself in her bedroom and assistance had to be sought to get the door open.
November 13, 1998	Awasis was called again on November 13th and discussed sibling visits but agreed Susan should not be returning to Shamattawa because she continued to feel afraid about being in the same community as the men who had assaulted her. Susan was prevented from attempting suicide later that day and placed in the Crisis Stabilization Unit.
November 19, 1998	Susan's discharge report showed that she had been charged with mischief with respect to damaging some property at Kirkos House. She was dealt with by alternative measures of community service and an essay. She was placed in a foster home run by a Kirkos House unit supervisor.
January 18, 1999	Foster mother called the worker quite concerned because Susan was threatening to kill herself. The foster mother was concerned that she could not get Susan to contract herself to keep herself safe. There had been difficulties ever since Susan had returned from a Christmas visit in Shamattawa. It is noted that the Awasis file contained no notes about the visit.

	The home-based Crisis Intervention Service placed a support worker in the foster home to help keep Susan safe.
February 23, 1999	Michael John Wood was convicted of two counts of sexual assault, two counts of sexual interference and two charges of failing to comply with a recognizance. The sexual assault and interference charges related to Susan and her sister C. He was sentenced to one year of incarceration and one year's probation on the sexual assault charges, five months concurrent on the sexual interference charges and one month on each failure to comply charge consecutive and concurrent with the one-year sentence. He was released from jail in October of 1999.
May 31, 1999	An update showed that Susan occasionally went AWOL from placement. Home Based Crisis Resolution Services from Ma Mawi Chi Itata Agency were used to support the placement stresses. Noted was Susan's visit in Shamattawa with her mother, having had no contact with her for two years (no notes of this visit were found in the Awasis file material). There had been a recent suicide attempt by her sister C., and a friend had succeeded in committing suicide as well. Susan described her visit home as difficult because her mother was making disparaging remarks about her biological father, accusing him of physically abusing the children when they were younger. Susan, however, still wanted to return to Shamattawa and it was noted that a return would require regular home visits to ensure that things were going smoothly. There was nothing recorded to indicate that mother's past history of abuse, neglect and alcoholism had changed in any fashion so as to make her a fit and safe parent for her children. There was no discussion of how Susan's suicide attempts and depression would be dealt with by a parent who had a history of not being able to provide even basic elements of care.
July 16, 1999	Susan takes a planned trip to Shamattawa. She was placed in a relative's home during her visit but did not stay there the first two nights. She was drinking at her grandparents' home and told R.C.M.P. that she

	was living with her mother. Susan's grandmother advised that Sarah Redhead (Wood) was in Fort Severn.
July 27, 1999	Susan lodged in R.C.M.P. cells as she was sniffing.
July 30, 1999	Susan was AWOL from her second foster home and was sniffing and drinking. She hid from the R.C.M.P. and Band Constables.
August 2, 1999	Susan was brought to the nursing station after spending the previous night in R.C.M.P. holding cells as the R.C.M.P. had found her in the bush with a noose around her neck. She was very unstable and continued to state her intention to kill herself. As a result, Susan was medivaced to a psychiatric facility in Winnipeg where she remained until August 17th, 1999.
August 17, 1999	Susan is discharged from hospital with a diagnosis of chronic depression.
September 1, 1999	Susan's foster mother wrote to the Awasis worker indicating that Susan was taking an anti-depressant medication that had begun to show some positive changes in her sleep patterns.
September 13, 1999	Susan's foster father called Youth Emergency Crisis Stabilization Service after finding a noose set up in Susan's closet and a knife in her bedroom. CSU beds were full so a home-based crisis intervention worker took Susan to the Pediatric Hospital Emergency. Susan was returned home from the hospital emergency department.
November 4, 1999	Susan admitted to the Crisis Stabilization Unit after her foster mother had found a knife in her bed and had difficulty getting it away from Susan. Ten days later Susan attempted suicide by overdose. She was checked at a local hospital and was returned to the foster home. Upon awakening she told the foster mother she would hang herself. The foster mother asked the Mobile Crisis Team for assistance in transporting her back to hospital.

November 16, 1999 — The foster mother called the Mobile Crisis Team again as Susan had appeared in the bedroom door with a cord tied tightly around her neck. Susan said she was feeling very badly and was thinking about the sexual assault by her stepfather as he had been released from jail three weeks earlier and she had been notified of this. Susan entered the Crisis Stabilization Unit for two days to keep her safe and to give respite for the foster family. She was discharged on November 18th.

December 3, 1999 — The foster mother had written and called the Awasis worker to organize some planning for Susan, because they could no longer look after her in the foster home after December 3rd, 1999. December 3rd came and went without any planning having been done.

December 7, 1999 — Susan went AWOL from the foster home. She was apparently staying with various family members who were either residing in or visiting Winnipeg. She was not receiving her anti-depressant medication at that time.

December 15, 1999 — Foster mother faxed a very detailed letter to both the Shamattawa and the Thompson offices of Awasis outlining her concerns for Susan and the concerns about the lack of planning that had been done. The foster mother was clear that Susan acknowledged that she could not live with her mother and remain safe and healthy.

December 17, 1999 — Susan returned to Shamattawa. She was placed in a foster home.

December 22, 1999 — Susan is moved to her aunt Margaret Koostachin's home. The former foster mother complained that Susan was non-compliant with house rules. Her aunt had the same complaint.

January 6, 2000 — Susan's mother renewed her VPA and terminated it on the same date. The case plan noted that Susan wanted to go home and that in the event that Susan needed assistance her mother was advised to "seek help at the Healing Centre" in Shamattawa. There is

	no information contained in Agency files as to whether there was a monitoring plan in place or an assessment of whether Sarah Redhead could provide the care that Susan needed. There was also nothing noted as to John Wood's presence in the community and if he was there, where he was living.
February 18, 2000	Susan was taken to the nursing station by her sister, C. She had resumed sniffing in January after returning to the community and was concerned over hair loss and intermittent upper abdominal pain. Doctor suggested different shampoo and told her to come back on February 20th, Monday, for further testing.
February 20, 2000	Susan Redhead hanged herself in her mother's home during the early hours of February 20th, 2000.

[11] From the time Susan went AWOL from the Wall foster home on December 7th, 1999 until her death on February 20th, 2000, there is but sketchy information on what happened in her life. What is known/was revealed during the Inquest is:

(1) A detailed letter of concern was faxed by Jackie Wall on December 15th, 1999 to both Shamattawa and Thompson offices of Awasis;

(2) Susan did arrive in Shamattawa on December 17th, 1999;

(3) She was in two foster homes before going to live with her mother and John Wood approximately December 29th, 1999;

(4) The VPA was renewed and terminated by Sarah Wood January 6th, 2000, apparently to cover payment;

(5) Susan was present but did not speak to the worker about her wishes at the time the VPA was terminated. Apparently, she was not asked. The worker's evidence was (Volume 5, page 72):

Q: What did Susan tell you?

A: She didn't say anything.

Q: Did you ask Susan what she wanted?

A: She never talks to me whenever I want to talk to her.

Q: So, Susan did not speak to you during that meeting that you had?

A: No, she didn't.

Q: Was Susan sniffed up that day, do you think?

A: I don't know.

Volume 6, page 8, referring to Susan:

When she was in Shamattawa she never responds when I talk to her.

(6) Susan may or may not have been "bothered" sexually by John Wood during the time she lived with her mother and John Wood. According to the evidence she apparently made references to her friends that suggested it might be the case, ending one conversation with the comment to the effect that "If I'm pregnant it's not my fault." (Susan was not pregnant at the time of her death.)

(7) There was an incident where Susan cut John Wood with a knife. It was not formally reported to the police. John Wood had been sent to hospital in Thompson as a result. He was expected imminently but was not in the community when Susan died.

(8) We know Susan was lodged in cells at the R.C.M.P. Detachment on:

28/12/1999 at 12:35 a.m.
29/12/1999 at 9:00 p.m.
9/1/2000 at 9:42 p.m.

10/1/2000 at 6:13 p.m.
13/1/2000 at 9:30 p.m.
22/1/2000 at 9:06 p.m.
23/01/2000 at 10:25 p.m.
16/02/2000 at 10:32 p.m.

These were all because she had been sniffing. This last one is also the date that she cut John Wood's thumb.

[12] Dr. Medd's notes on the chart during the February 18th, 2000 visit say she had told him that she had last sniffed approximately three days before that date.

THOMPSON CHILD AND FAMILY SERVICES

[13] Susan Redhead was apprehended on August 5th, 1993, after she and her sister N. were caught shoplifting in Thompson. Thompson Child and Family Services (Thompson CFS) placed the girls in foster care. They then proceeded to take information and interviewed the parents. They also liaised with Awasis workers, including Christine Fenner, following the directives in the Provincial Programs Standards manual. Section 421, in particular, requires a child and family service agency to invite the particular aboriginal child care agency (in this case Awasis) in planning for the children. The Thompson CFS social worker entered into a contract with Sarah Redhead and John Wood with respect to long-term planning for the children. This is a planning tool to involve the parents in setting out the long-term needs for the children.

[14] With Christine Fenner's involvement, Awasis requested that Thompson CFS seek a one-year temporary order of guardianship on N., Susan and C. That order was given on October 18th, 1993. C. went back to Shamattawa but Susan stayed with the foster family in Thompson until November when she was placed in the group home in Shamattawa. It appears that all of the involvement of Thompson CFS was documented as required.

Recommendations:

[15] There are no specific recommendations to be made as far as the involvement of Thompson CFS. Their involvement in the scheme of things with Susan Redhead can be described, perhaps, as fleeting but, by standards for child welfare, appropriate.

WINNIPEG CHILD AND FAMILY SERVICES

[16] Winnipeg Child and Family Services Agency (Winnipeg CFS) was included in this review because at different points in time they had responsibility for the care of Susan Redhead. I quote from the submission made by Winnipeg CFS counsel, Mr. Thomson, because there is a fairly straightforward summary in his submission.

[17] Winnipeg CFS ceased to have any involvement with Susan approximately 18 months prior to her death when a court order was made under section 28 of ***The Child and Family Services Act*** (the "Act") on August 28th, 1998.

[18] Winnipeg CFS involvement with Susan was relatively straightforward and the sequence of that involvement is as follows:

October 6, 1997	Susan is apprehended along with her sister N. Her three siblings had been apprehended three days earlier.
October 14, 1997	Awasis is served with notices by Winnipeg.
November 17, 1997	Approximately six weeks after Susan is apprehended and after an assessment of her special needs is completed, she is admitted to a residential treatment facility, Kirkos House.
November 20, 1997	Winnipeg CFS is granted a six-month temporary order of guardianship with respect to Susan.
December, 1997	Susan begins to attend for therapy with Dr. De Luca.

April 19, 1998	Sarah Redhead and John Wood complete a treatment program at Pritchard House which Winnipeg CFS had requested they attend.
May 26, 1998	Winnipeg CFS enters into a voluntary placement agreement with Sarah Redhead (Wood).
June, 1998	Sarah Redhead and John Wood "relapse" and return to live in Shamattawa First Nation. From this point Winnipeg CFS is reliant upon Awasis for assessment information regarding Sarah Redhead and John Wood. In the same month Winnipeg reports details of Susan's disclosure regarding John Wood to Awasis, the directorate and Winnipeg Police Service. There are also notations of suicidal ideation on June 9th, 1998 and June 16th, 1998. The June 9th, 1998 matter was at the same time as the disclosure with respect to John Wood. This information was passed on to Awasis.
July 14, 1998	Awasis case plan re care of Susan on a section 28 transfer.
July 23, 1998	Contract entered into by Awasis and Sarah Redhead and John Wood.
July 28, 1998	Letter from Awasis counsel (Helen Zeufle) confirming section 28 transfer, and enclosing the above-noted case plan and contract.
August 28, 1998	Court order made under section 28 of the Act (after initial child protection court docket appearances July 8th, 1998, July 29th, 1998, August 21st, 1998 adjournments for service of Awasis documents) (Exhibit 121).

Recommendations:

[19] It would appear from a review of the evidence led at this Inquest that the Winnipeg CFS was in compliance with:

(1) ***The Child and Family Services Act*** and Regulations;

(2) the program standards; and

(3) generally accepted social work practice.

[20] There are no specific recommendations to be made with respect to how Winnipeg CFS handled their involvement with Susan Redhead.

AWASIS AGENCY OF NORTHERN MANITOBA

[21] This Agency is mandated under ***The Child and Family Services Act***. It was established in 1983 and at the time served 25 reserve communities in Northern Manitoba. A number of the First Nation communities have now established their own Child and Family Services and at this time there are now 12 First Nation communities under the care of the Awasis Agency.

[22] Shamattawa is a community located approximately 365 kilometers northeast of Thompson and 750 kilometers northeast of Winnipeg. It is a relatively new community, settled in the 1950's when the York Factory Indian Band split into three groups. One group settled at the junction of the Gods and Echoing Rivers. This is the community of Shamattawa. Shamattawa is a Cree community and has a population of approximately 1,100 people. According to evidence given by Sergeant Shelly Dupont, who was the NCO in charge at the detachment in Shamattawa between June 20th, 1999 and June 25th, 2001, there were approximately 866 people living in Shamattawa. Of that number, there were, in 2001, 456 people under the age of 18 and of that 456 people 389 were under the age of 12.

[23] Her evidence also disclosed that there are 161 houses on the reserve and approximately 40 of those houses have no sewer or running water systems (Volume 2, page 57). During the 2001 census year there were approximately, on average, eight individuals living in each residence in Shamattawa. Many homes are poorly maintained, poorly furnished and are usually heated by wood heat. Some of these buildings have nothing more than a 45-gallon drum that acts as a wood stove.

[24] There is little in the way of business in this community and most of the population are supported by social assistance.

[25] This has been and continues to be a community which has deep-rooted problems with alcohol and solvent abuse, sexual abuse, family breakdown and dysfunction, neglect and violence. Many in the community, including very young children, sniff solvents. There is a high rate of suicide and attempted suicide. A high percentage of the children in the community have been in care or in and out of care. One of the difficulties that engenders is that by the very nature of the community, there are very few healthy homes in which to place children. As a result, many have had to be placed out of the community.

[26] At the start of this Inquest, Awasis (the Agency) took responsibility for failing Susan Redhead while she was in their care. The Agency's philosophy behind the focus on reunification of families is one that is understandable given the history of Shamattawa, and it is not inappropriate. Unfortunately, that focus can sometimes lead to tunnel vision to the detriment of many members of a family.

[27] This case is a sad commentary of how that focus can go terribly wrong. The history of Susan Redhead's life given earlier speaks eloquently to that.

[28] Hindsight is, of course, 20/20. But there were any number of signs over the almost 16 years that Child Welfare had been involved with Susan Redhead and her family that this family was unlikely to be amenable to what others - the Agency, the community and, indeed, the Redhead family - wanted for them.

[29] Adding to the difficulties inherent in dealing with totally dysfunctional, chaotic, neglectful, abusive and rejecting parents (a description which would appear to apply to Sarah and both her husbands in *seriatim*) is the lack of available skilled, competent, trained workers in the community of Shamattawa to make an effective intervention with this family.

[30] Evidence at this Inquest clearly showed a number of problems in the provision of service. There were problems in administration, communication (consultation and support for the workers), training of workers, their knowledge and appreciation of the system requirements, the need to comply with ***The Child and Family Services Act***, program standards and accepted social work practice. The problems existed with upper management and the impact widened as it filtered down to those who were expected to provide effective and appropriate service to children and families in need. There was a clearly stated philosophical goal of family unification without the concomitant acknowledgement that the goal may not always be reached.

[31] One worker in giving evidence described the philosophy of the Agency as: "To avoid permanency planning". If you as a worker were not able to unify the family, to help them be healthy, you are left to feel (sic) "you're incompetent" (Volume 8, page 43).

[32] Another worker when asked about support from the Agency said: "I feel like all alone" (sic) (Volume 6, page 36) and went on to describe a situation where she tried to consult because she needed help…"there was no discussion" (Volume 6, page 37).

[33] A further factor to be taken into account is the interaction between the Agency and the Chief and Council and the Local Child Care Committee (LCCC) who actually hired the workers. The Agency screens the applicants, the LCCC interviews and offers the job. Awasis then does background checks and, subject to their agreement (because they pay the salary), the worker is hired. The LCCC expects to be involved to some extent in the planning. One of the concerns expressed by a worker was that a number of years ago the chairperson of the LCCC, a person who was on various committees at different times, was allegedly acting sexually inappropriately. When the worker brought that up with the Agency "…I was told to mind my own business basically" (Volume 8, page 15).

[34] David Monias became Executive Director of Awasis Agency on October 2nd, 2000. He indicated in his evidence that since he became Executive Director he has conducted a broad review of policy and procedures in the Agency itself. He agreed that "in the past, we have put these people in positions of management without the appropriate training…basically you would give them a title and you expect them to function as such" (Volume 27, page 7).

Recommendations

[35] It may well be that as a result of that review some of the recommendations made here may already be underway. Nevertheless, these are my recommendations:

(1) *The Awasis Agency must review existing practices, policies and procedures.*

Evidence taken at the Inquest showed workers who were uncertain of procedure, responsibility and lines of communication, and who had a general feeling of a lack of support. Identifiable guidelines are required as well as (perhaps more importantly) immediate and effective, actual support.

(2) *Take immediate steps to develop a strategy with the Provincial Directorate to provide competency-based training for Awasis Agency's local child care workers in Shamattawa.*

The training must be culturally appropriate and attuned to local circumstances. Specific areas which need to be included are:

(a) *personal health and wellness;*

(b) *suicide recognition and prevention;*

(c) *alcohol and solvent abuse treatment;*

(d) *recognizing and understanding problems related to FAS/FAE;*

(e) *crisis intervention management;*

(f) *a discussion of* ***The Child and Family Services Act****;*

(g) *the Regulations; and*

(h) *accepted social work practice.*

(3) *Develop a long-term training scheme which regularly reviews and updates the skills and knowledge of the front line service providers.*

(4) *Create a defined and understandable line of communication to the Agency for support and consultation.*

(5) *Put job descriptions in writing so as to provide parameters that will both set out and allow the worker to give a clear explanation of the kind of help Awasis can give so that the client as well as the worker understands Awasis is not just there to do the client's bidding.*

(6) *The job description should be included as part of the tripartite contract signed when the worker is hired so that Chief and Council, the Agency and the worker all know the role and responsibilities of the worker.*

(7) *There should be regular reviews/evaluations of the worker, at the very least, on an annual basis but also on a more informal basis to discuss problems and give suggestions and receive feedback.*

(8) *One of the things that can be discussed in terms of dealing with the feedback is that if a worker and a client cannot communicate, there should be a consideration of switching workers or finding someone who the client will speak to as a go-between. Realistically, the fact*

that a client may be better able to speak to somebody else should not be a source of embarrassment but, rather, an acknowledgement that some personalities match better with one person than another.

(9) *Look at establishing a "buddy system" for local workers*

Where workers work in isolation, particularly when there is a stressful situation, it is imperative that they have someone to talk to who can relate to the particular situation. This does not necessarily have to be in person; it can be by telephone, but that kind of outlet is an important one to provide support and prevent premature burnout.

(10) *There should be provision for regular review of each case with the Agency supervisor.*

(11) *Each entry on the running log should be initialled or signed by the maker.*

In this particular case, somebody went back and wrote the case worker's name on each notation. The maker of the notes, in giving her evidence, agreed that the notes were, in fact, her handwriting but the signature purporting to be hers was not, in fact, hers.

(12) *Each client contact should be documented on the file.*

(13) *Quarterly summaries should give a snapshot of the situation and should identify progress or lack thereof and set goals.*

(14) *When files are transferred to a new worker there should be a summary snapshot of the file prepared.*

(15) *When files are closed, there should be a closing summary on the file identifying why the file is closed and the planning done which allows closure of the file.*

(16) *Files should be kept in a secure location but be accessible when needed.*

Organization of the files is very important. In the case of the Inquest, whatever paperwork that apparently existed in Shamattawa was taken to the Thompson office. In getting documents for the Inquest, many records appeared to be missing. There were gaps in the information and a few items, for example, a letter dated December 15th, 1999 with a notation dated December 17th, 1999 on the back of that letter, were provided to Court a few days before the Inquest began. It had apparently been in a "pile of stuff" in the director of operations' office and/or other documents were in wrong files.

(17) *Supervisors must be trained to know how to supervise.*

In the case notes of March 30th, 1999, it reflects "she needs to come to the office and let the worker know what help we can offer her". Child welfare is proactive and it should not be left up to the client to identify their needs. Often the reason they are in trouble is that they cannot objectively define what the problems are. Supervisors who are trained properly to provide supervision can help identify what steps the worker should take rather than waiting on the client.

(18) *A Voluntary Placement Agreement (VPA) should never be used if a parent is unfit.*

(19) *A VPA should never be used where a child is in need of protection.*

(20) *A VPA should be reviewed and approved by the operations manager at the time it comes into being and when it is terminated.*

(21) *A better way must be found of securing the VPA.*

Currently one copy of the agreement is handwritten and the parties sign it, but the parents are required to sign two blank pieces of paper which are then apparently sent with the handwritten agreement to Thompson where it is typed and a typed agreement is sent back to Shamattawa. It is understandable that parents might be suspicious when they are required to sign two blank copies of agreements.

(22) *VPA's must not be allowed to expire before they are reviewed or renewed.*

(23) *Prior to a child being released from the Agency, a home safety assessment must be made.*

(24) *A discharge safety plan reviewed by the operations manager before the release of a child from Agency care should be in place and documented.*

(25) *There should be a regular review of the Child Welfare Mandate with the workers.*

For instance, section 7 of ***The Child and Family Services Act*** *under Declaration of Principles says:*

> *7 Declaration of Principles*
> *Families are entitled to receive preventative and supportive services directed to the preserving of the family unit.*

7(1) Duties of Agencies
There is provision:

> *"According to standards established by the director and subject to the authority of the director every Agency shall:*
>
> *(a) work with other human service systems to resolve problems in the social and community environment likely to place children and families at risk;*
>
> *(b) provide family counseling, guidance and other services to families for the prevention of circumstances requiring the placement of children in protective care or in treatment programs;"*

In giving evidence, for instance, one of the workers knew that Keewatin Tribal Council or Medical Services would help arrange to do something in the community on suicide prevention but did not ask for that help.

(26) *It is recommended that the Agency consider having a native elder at the Agency for staff to talk to.*

(27) *There should be regular lines of communication with the Chief and Council.*

This is particularly important as Shamattawa has a high turnover in the make-up of Chief and Council who are elected according to band custom.

(28) *Based on the above recommendations, it is of <u>critical importance</u> that adequate funding for professional training and development be built into the funding provided to a child care agency.*

(29) *There should not only be funding provided to the Agency for training itself, but there should be provision to access provincial programs which have the expertise and are already in place to provide the kind of training required.*

(30) *There must be a rationalization of the method of funding to the Agency in order to allow for services to families and prevention programs.*

(31) *When an Awasis child welfare ward returns to a First Nation, the R.C.M.P., the nursing station and mental health worker should be advised by the Child Welfare Agency.*

(32) *Hiring standards – The Child and Family Services Directorate should institute minimum practice requirements for all Child Welfare workers through regulation or policy.*

(33) *Awasis child care workers should be equipped with telephones so that they can be located when the R.C.M.P. or nursing station need to get in touch with them when they have a problem with a child.*

(34) *The appropriate federal, provincial, First Nations representatives and Awasis Agency should combine their resources to study the issue of funding a receiving/group home in Shamattawa.*

(35) *Each First Nation should have access to a family counsellor or family therapist specifically to work exclusively with families since families are the building blocks to society.*

Family therapy <u>might</u> have made a difference in how Susan Redhead's life developed if it had been available and in use virtually from the time of her birth.

(36) *The Child and Family Services Directorate should institute <u>minimum</u> practice requirements for all child welfare workers through regulation or policy.*

Competency-based training, which includes a cultural and diversity workshop, addictions intervention, sexual abuse and suicide

intervention and prevention modules and FAS/FAE training, should be mandatory for all child welfare workers as soon as practicable.

(37) *The Provincial Placement Desk should circulate to all agencies an annual report of the kind of programs and services with which they have been dealing.*

The agencies have a responsibility to ensure that information is disseminated to not only their staff but to the communities in which they work so both line workers and clients will be better informed about available services.

(38) *Those responsible for running Awasis Agency of Northern Manitoba should read transcripts of the evidence taken at this Inquest.*

They will then have a real understanding of the workers' perceptions of the roles, responsibilities and administrative requirements, not to mention the problems and frustrations of the job.

MANITOBA JUSTICE

Prosecutions

[36] Although Susan herself had minor involvement in the justice system (she was charged for damage she did at Kirkos House), she was also lodged at R.C.M.P. cells in Shamattawa on numerous occasions due to intoxication but no actual charges came from that. Her major contact with the system was as a victim of sexual assaults. She disclosed a sexual assault in 1993 to a worker. The assault had taken place when she was eight years old. By the time the matter went to court in 1995 she was almost 11 years old.

[37] A word should be said here with respect to the conditions under which courts operate in Shamattawa and indeed similarly in other remote communities

in the North. Space is a large factor and in Shamattawa the courtroom area and the halls outside of it are very close quarters. There are a lot of people moving around and there is no privacy available for the Crown to interview its witnesses and/or defence counsel to speak to their clients and witnesses. Generally speaking, the dockets are a substantial size and as a result it is difficult as well for the Crown to have a great deal of time to speak to witnesses. In a situation like this it is a terrifying matter for a young girl who is attending court and knows she will have to testify against an older person, and that she will have to see somebody that has hurt her. She will also have to testify in English which is not her first language.

[38] In one of the complaints made by Susan that went to court, the Crown spoke with Susan and made a determination that she would not be a credible witness given what she was saying to him on the date of court which was inconsistent in some aspects with the statement that she had given to police. He also did not feel that she would communicate on the witness stand and doubted that she could be sworn. His assessment on a variety of things, including these, was that there was not a likelihood that the prosecution could succeed and as a result there was a stay of proceedings entered.

[39] On another occasion, as a result of a disclosure, Roderick Saunders Thomas was arrested for break enter with intent to commit an indictable offence, sexual interference, and sexual assault. Susan was the victim in this case again. The matter was set for trial on March 18th, 1998. Susan was present, having been flown in from Winnipeg. The accused could not be transported (he was in custody) and the matter was remanded to Thompson on March 19th, 1998 to set another trial date. As a result of a plea bargain the sexual interference and sexual assault charges were stayed. Roderick Thomas plead guilty to break enter with intent to commit an indictable offence (that being the sexual assault). As a result of that, he received a sentence of nine months' imprisonment and two years' supervised probation to follow. In the probation order there was no order for no contact or communication with Susan Redhead. The Crown had assessed

that since Susan was in a residential treatment centre in Winnipeg and Roderick Thomas had indicated no plan to return to Shamattawa, it was unlikely their paths would meet and therefore no “no contact” clause was required.

[40] Susan also made a complaint against her stepfather, John Wood, with respect to having sexually molested her. He was arrested and charged with sexual interference against Susan and sexual assault against her older sister. He was released by consent on November 17th, 1998. The conditions of his recognizance were for him to reside in Oxford House and have no contact with Susan or her sister. A trial date had been set for April 26th, 1999 in Shamattawa.

[41] When he was charged with four breaches of that recognizance he was remanded into custody in February, 1999 in Thompson. The matter was adjourned until February 23rd, 1999, at which point he plead guilty to a charge of sexual interference against Susan and to a charge of sexual assault against her sister. He received a sentence of one year in jail for the sexual assault charge and a concurrent five months in jail on the sexual interference charge to be followed by one year of supervised probation. There was no order of non-contact with Susan or her sister included in that probation order. While Susan may have been still in Winnipeg at the time, her sister was living in Shamattawa.

[42] It is noted that the recognizance that John Wood was on specified “no contact or communication with C. Redhead and Susan Redhead and no contact with females under the age of 18 unless under the direct supervision of a responsible adult”.

[43] At the time of her death, there were two other investigations in process with respect to two other males whom Susan had made disclosures about having sexually molested her.

[44] In all, by the time Susan Redhead was 15 years old, she had allegedly been sexually molested by at least five different men – some of whom were relatives. It says something about the personality of this young girl, who had little

support from home, that she had the strength to make the disclosures at all and, terrified though she may have been, was prepared to go to court.

Recommendations:

(1) *When a person is about to be sentenced, the Crown should review the recognizance.*

If there are conditions on the recognizance such as a no contact or communication clause, the Crown should advise the court of the conditions. That may or may not result in those conditions being included on a probation order but at least they will have been brought to the attention of the court for its consideration as part of the sentence.

(2) *The Crown has a policy directive which had an initial date of February 19th, 1999. That directive was to have Crown counsel make all reasonable efforts to have a victim impact statement made for the court.*

This policy should be reviewed, in particular with respect to the method of implementing the policy in remote communities where there appear to be logistical and manpower problems in obtaining them for court purposes.

(3) *Logistics and manpower may be a problem but if the victim is there, their view should be put forward by the Crown (if the victim cannot by reason of language or youth).*

(4) *The Crown should attempt to identify a local person who can translate where the complainant is more comfortable in speaking in their own language to make sure their voice is heard.*

(5) *The Crown should consider a policy of routinely asking for a "no contact or communication order" to protect victims of sexual assault, especially where there are young children involved, no matter where the accused and complainant currently live – ours is a mobile society.*

(6) *The issue of use of a screen for child witnesses should be revisited immediately.*

There may have to be some creative thinking done as to how a screen may be accomplished. It may be different from one community to another depending on the set-up of the court. But, everything should be done to minimize the terror and trauma of a young witness testifying. This is an area where practical assistance can be given.

(7) *When child witnesses are being interviewed an adult should be present for their support. If the adult is intrusive or insists on answering for the child, it should be made known to the adult not to answer for the child.*

If a problem is foreseen it may be appropriate to try to identify a resource in the community, i.e., a police officer, a worker or a teacher, who relates with the child and can be used as support for the child in an interview situation when they do go to court.

(8) *A child victim support program should be developed and implemented in remote communities with particular attention to language and cultural difficulties as well as the limitations of court facilities in remote communities.*

(9) *Crown attorneys should request "no contact" orders in all cases where an accused who has been convicted of a sexual assault has as part of their sentence a period of probation unless there are special circumstances which make such an order unnecessary or would create a hardship for the victim. Those circumstances, where they exist, should be on the record.*

(10) *When a sexual offender is to be released from custody, Corrections should advise of the pending release of the offender and where he plans to live to the Child and Family Services in the jurisdiction of the place where the offender intends to live and/or his home community if that is the same place, and where the victim resides.*

(11) *Written notification to the police force where the charge originated should be sent to that police force immediately upon conviction.*

(12) *The police force in the community to which the sexual offender is to be released should be notified of his intention to live in that community prior to his being released.*

(13) *The Crown must advise the victim or the guardian, or both if it is age appropriate for the victim, immediately of a disposition and the reason for it.*

With respect to the Roderick Thomas matter, Susan and her escort sat in the airport in Thompson for a whole day. They returned to Winnipeg on the 19th of March but did not receive notification until April 13th that, in fact, the accused had plead guilty on the 19th of March.

(14) *The Department of Justice should fund more staff for the Crown office in Thompson.*

Preparation of cases takes more than reading a file, particularly in sexual assault cases or matters where there is an identified victim who has been greatly impacted.

Probation Services

[45] John Michael Wood was released from Headingley Correctional Institution (HCI) on October 24th, 1999. At the time he was released from HCI arrangements had been made and he had been provided a letter giving him an appointment to meet with the probation officer in Shamattawa on October 26th, 1999 at 3:00 p.m. At that time, Probation Services attended to Shamattawa from Tuesday through Thursday every two weeks. It is during this time that offenders were to be reporting in Shamattawa. It is noted in this case as well that Corrections had also made an appointment for John Michael Wood to see the National Native Alcohol and Drug Abuse Program (NNADAP) worker in Shamattawa.

[46] Information from the Corrections officer shows that the material, which included the probation order, the police report and the assessment of John Michael Wood done at Headingley, was faxed to the Thompson office of Probation Services on September 19th, 1999, in advance of Mr. Wood's release. The probation officer in her evidence indicated that she did not recall receiving any of the material which had been faxed. She indicated that the only information she had was a copy of the probation order. She had had a phone conversation with the Corrections officer from Headingley about the making of the initial appointment with Mr. Wood. She indicated that the faxed material must have gone missing from the file because she did not have it and it did not show on the file.

[47] Mr. Wood did not show up for his appointment on October 26th. The probation officer said she looked for him in the community and through community contacts such as Band Council members and the R.C.M.P. She found or was given an address in Thompson. She indicates that she wrote a letter to him in Thompson in November or December of 1999 telling him to get in touch with the Thompson office to set up an appointment. That letter is not on file; it is also missing. Mr. Wood apparently never received the letter because it was apparently returned to the office. However, the returned letter was not filed as indicated above; the letter never made it to the file.

[48] On April 6th, the probation officer sent a letter to Mr. Wood to General Delivery, in Shamattawa, for an appointment on April 26th, 2000, at 10:30 a.m. Apparently, she had been advised by a source in the community that Mr. Wood was in Shamattawa.

[49] Of concern with respect to the process here is the fact that apparently the probation officer did not have the circumstances of the offences and did only get the probation order from the court office. No police circumstances of the offences came from the Crown and the probation officer did not request them. The evidence is that there should have been a risk assessment received from Headingley (which is not necessarily forwarded on every case) but the probation officer indicates should be. However, she indicated that she did not get the material in this particular case.

[50] The question was then put that if she had all of the information from the police report, the risk assessment, etc. with respect to the fact that this man was convicted of sexual offences against his stepchildren, would he have been considered to be an immediate danger to the community? The probation officer gave the answer yes. <u>According to Policy 776, Probation Services' policy with respect to failure to comply with a court order, if there is an immediate danger posed to the community and the individual is considered to be high risk in that fashion, a breach should be laid.</u> In this case, the probation officer indicated <u>a</u>

breach still would not be laid because policy sets out that even if a person is at high risk they must miss two consecutive appointments before a breach should be initiated.

[51] By the time Mr. Wood did meet with the probation officer on April 26th, it was five months after he had been released from HCI. At this time, the probation officer still indicates that she had not received the police report re the circumstances of the offences (Volume 11, page 35): "when I met with John I did not know who his victims were".

[52] It is also in evidence that when he attended the April 26th appointment, Sarah Wood accompanied him and the probation officer had to ask her to leave so that she could talk to Mr. Wood because Mrs. Wood answered for Mr. Wood otherwise.

[53] The probation officer indicated that she saw Mr. Wood once a month for the next couple of months although there is no notation of that on the probation file. She saw him until he was involved in an incident where he was charged with assaulting his wife and received a period of jail time. So the file shows a risk assessment done in October of 2000 when he was released and he was on the second probation order. But the probation officer indicates that she did not do one on the first probation order. It was required that one be done but she indicated she must have overlooked it.

[54] There are many gaps and deficiencies in what has just been described but there is also another side to the picture. At the time John Michael Wood was released from HCI in October of 1999, the probation officer was responsible for covering Shamattawa, some of Thompson, as well as Pikwitonei and Thicket Portage. In Shamattawa alone, the average case load varied between 80 and 100 individuals at any particular time. The probation officer indicated that she had taken a two-week training course on counseling sexual offenders in December of 1999 and January of 2000. She also indicated that between February, 2000 and May of 2000, she ran 12 sessions on domestic violence in

Shamattawa on the evenings that she was in the community for the three days. The rest of the time, however, on a caseload described by her as being mostly all high risk cases, the maximum amount of work was simply monitoring people. There was not a lot of time to do more than that.

Recommendations:

(1) *It is absolutely vital for Probation Services to receive from the Correctional Institution the correct address to which a person is going upon release from custody.*

In this case, on a one-year probation order, the first interview with the individual was some five months after he was released. That cuts into any time benefit for counseling that might have been available on the one-year probation order.

(2) *Police departments of origin should be advised by Probation Services of any probation order in place for a sexual offender.*

(3) *Record keeping.*

No police reports were received with respect to the circumstances of the offences. The probation officer should have requested them. It is difficult to start treatment when you do not have the background information other than what comes from the offender.

(4) *A primary risk assessment should be done on every file.*

(5) *Corrections/Probation should review the instrument used to calculate low/medium/high risk sexual offenders.*

(6) *Breaches of probation by sex offenders should be initiated immediately by Probation Services and prosecuted by the Department of Justice, that is, after the first breach.*

(7) *When a file is closed or transferred, according to Policy 370, all handwritten notes are to be removed.*

However, it is my recommendation that no handwritten notes be destroyed unless there is a summary of contact on file which clearly identifies it as a summary of contact.

(8) *A full-time probation officer is needed in Shamattawa.*

It is my understanding from Ernie Konrad (the area director in Thompson) that as of September, 2002 the probation officer goes into Shamattawa every second week for four days. There is a caseload now of 70 to 100 people but it is the only caseload for which that probation officer is responsible.

It is also our understanding that as Garden Hill now has a full-time probation officer living in the community, as vacancies become available, there is consideration being given to having a probation officer who lives in the community of Shamattawa as well. That is also apparently being addressed or considered in St. Theresa Point and Oxford House. It is noted that there are no new resources with respect to this but as vacancies become available the resource pool is looking at being shifted in this fashion.

LOCAL MEDICAL SERVICES/NURSING STATION

[55] At the time of the Inquest, physician services to Shamattawa were approximately seven days per month. Dr. Thomas Medd gave evidence that he has been going into Shamattawa since 1985 and although he has a psychiatric practice in The Pas he continues to do two days a month in Shamattawa providing general medical services. Another doctor attends to Shamattawa approximately five days a month. It became abundantly clear during the hearing

of the evidence that better service to the community would entail more physician coverage as well as another nursing position.

[56] It would appear that due to the high volume of work involved there is a lack of communication and appreciation of community resources. There is little interaction between the doctor and the local community except for the presenting medical problem.

[57] The nursing staff have more contact with the community because they live in the community but at the same time they are primarily oriented to dealing with the next patient. The nurses basically appear to do all of the liaison in terms of referring people on their own initiative or by request from the doctor.

[58] An example that is disturbing in terms of the lack of communication was given in evidence by Dr. Medd when he was asked whether there was a protocol for sexual assault victims and his answer (Volume 1, pages 21-22) "I think--you know, I'm not sure of the written protocol. I do think that there, there is a protocol at the station when I think about it, but it is pragmatic to, to a large degree". At page 25: "Do you or does the nursing station have a suicide prevention protocol?" Answer: "Well, there is no formal protocol for suicide prevention, that I am aware of." And in looking at what community resources are available, the doctor indicated that he was of the opinion that there were several workers who work for NNADAP (in fact, there was only one (at the time of the Inquest)). In dealing with Brighter Future Initiatives (BFI) and his knowledge of them, his answer at page 24 was: "Very limited other than that it's a Federal program. I think there may have been some difficulties having some meaningful impact but beyond that I can't say too much…there would be others who are in a better position to comment on that than me."

[59] And in relation to the Building Healthy Communities program he indicated that he was not as familiar with that one as he was with the BFI program.

Recommendations

(1) *Nurses and doctors who are hired to work in First Nations should be provided with specific workshops on suicide prevention and identification skills as part of the initial employment process.*

(2) *Protocols or written policies should be established and reviewed on a regular basis with respect to solvent abuse, sexual abuse, suicide prevention and section 18 of* ***The Child and Family Services Act*** *(when a child is in need of protection).*

(3) *Workshops in those areas should be conducted on a scheduled basis for both staff at the nursing station and the community.*

With respect to suicide prevention, recognizing sexual abuse, solvent abuse and child protection, it is important to have regularly scheduled things because if these are done on an ad hoc basis they rarely seem to come to fruition (I am aware that sometimes these might not proceed as scheduled due to weather or a death in the community which often result in cancellation).

(4) *Doctors and nurses at the nursing station should review on a regular basis their knowledge of what resources are in the community both for the purpose of knowing who to refer people to as well as being able to liaise with resources to provide information in terms of public health issues to the community.*

(5) *There should be a binder maintained at the nursing station which contains the name of each community resource and a small "blurb" which describes the function and who the contact person is.*

This would also be of practical use for the R.C.M.P. to have, but such duplication in a small community should not be necessary. It

should, however, be accessible to both, as well as other community service providers.

(6) *There should be more outreach to the community. For example, going into the school, using the local radio station.*

(7) *Better notation should be made on the charts.*

For example, John Wood attended the nursing station on February 16th, 2000, with respect to a bad laceration. He was referred to a surgeon in Thompson. He would have not been medivaced out but flown out on a regular flight. However, there was no note on the file as to whether he actually went or not.

(8) *A method should be developed for follow-up information to the nursing station when patients are sent out.*

There are sometimes no reports returned and as a result staff at the nursing station do not know whether the individual is back in the community unless they come to the nursing station for some reason.

(9) *There should be a written hospital protocol that a case summary on discharge should follow a child.*

If the child is not returning to the original living situation, the case summary on discharge should go to the alternate caregiver but also to the original referee.

(10) *The case summary should also follow the child to the nursing station in the community when the child returns home.*

(11) *Any suicide ideation disclosed at the nursing station should result in a referral to Child Welfare.*

(12) *Charts should be computerized.*

That way when someone is sent out of the community, say, to Children's Hospital, the nursing station can easily be notified electronically as to where the person is discharged to and when.

(13) *There should be a form of some sort on the chart aside from the ongoing written details which simply could be checked off when a referral, for example, is made to NNADAP so that it doesn't have to be repeated through the notes every time but is easily accessible if staff wants to find out if a referral has ever been made.*

(14) *There should be a clinical therapist in the community. It need not necessarily be the same person but the coverage should be full-time.*

(15) *Dr. Medd related that as a psychiatrist he is unable to provide ongoing counseling to people with major mental disabilities and his function is that of primarily medication management.*

It is recommended that the possibility of a video hookup be instituted such as the one described by Dr. Keith Hildahl (Volume 24). The in-person counseling could then be followed up with face-to-face counseling via video hookup between personal visits to the community.

(16) *In order to do some of what has been set out in the recommendations with respect to workshops, there is a need for four nurses in the community (Shamattawa): one to do public health; one to do the schools with emphasis on nutrition and parental teaching; and the other two to work on the floor at the nursing station.*

One of the mandates of the nurses is to promote public health but practically and historically speaking the emphasis has simply been on crisis and trauma.

(17) *It is recommended that there be three or four, preferably four, NNADAP workers in Shamattawa.*

So many people get referred to NNADAP that the one worker who is there usually burns out very quickly and as a result there is a large turnover in that position with no continuity of a provision of service.

(18) *A liaison of one person from Awasis and one person from the nursing station should be set up so that when people are brought for treatment the nursing station knows who the guardian is (there have been occasions when the nursing station has sent children out, i.e., medivaced them, with the wrong escort because they did not know who the guardian was).*

(19) *On each medical file there should be an identification of the family members.*

In this case, it is notable that the physician did not know that Susan Redhead was the stepdaughter of John Wood. As a result, when he saw them two days apart he had no idea that the one might be connected to the other.

(20) *Doctors should get into the habit of generally asking what the individual situation is.*

It may provide some insight into the presenting problem as well as whether or not there is something under the surface that should be the result of a referral to an Agency for help. In Shamattawa this is particularly key because of the dysfunction of so much of the

community. It is necessary to look at the person as a whole, not just as the presenting medical problem.

(21) *Where a child is noted to have been sniffing or staff is aware that there has been some abuse or suspected abuse it should not just be noted on the file but referred to the appropriate agency.*

For example, on Susan Redhead's chart it is noted: "April 22, 1994 there for a check-up, had been sniffing". There was no referral for treatment.

As another example, on January 19th , 1995: Susan was brought in by an Awasis worker. There was an indication that she had been beaten by her mother with a shoe. No referral was made to the R.C.M.P. (While it might be assumed that Awasis has a responsibility to report such things, and in fact they do, it is not duplication. It would provide medical evidence to the R.C.M.P. in their investigation as there were obvious signs of the assault.)

Again, in October, 1995: Susan was brought in by Awasis because she was losing her hair. It was suspected that this was with respect to the fact that she was sniffing at night according to her foster parent. There was no referral for treatment.

Yet again, in November, 1995: Susan was brought in by a member of the community smelling of gas. She indicated that she had fallen on a stick in the bush. There was no referral for treatment or to Awasis.

(22) *A policy should be put in place for nursing staff to monitor those who do not show up for medical and/or counseling appointments with the therapist.*

(23) *When a referral is made to a resource such as a clinical therapist, children under the age of 18 should not simply be told that the resource is there if they have a problem and need to talk to somebody. An appointment should be made for them and they should be actively encouraged to keep the appointment.*

(24) *When a referral has been made there should be a "Bring Forward" (BF) system in place for staff at the nursing station to make a call to follow up to see whether or not the person has actually gone to the resource.*

This, of course, would not be necessary if the person comes in to the nursing station before that time and tells the staff whether or not they have actually gone. It can just be noted on the chart.

(25) *When the child is one who is involved with a child welfare agency, the clinical therapist or psychologist should report clinical findings and recommendations to the agency.*

There is provision for doing so on the consent form. There should be a more explicit procedure to ensure it is done.

(26) *When patients are referred out of the community such as those who go for mental health issues (approximately 50 a year), part of the referral should contain a request for not only a report but also a note that the individual has been asked to contact the nursing station upon their return to set up after-care or follow-up as required.*

(27) *In-service training should include familiarization with the function and the role of the child advocate's office.*

This may be of some assistance when there is a difference of opinion between the nursing station and the community as to

whether or not a child should be sent out for treatment. This is important because there can be negotiation, rather than confrontation with threats of forcing medical staff out of the community via Band Council Resolution (BCR).

(28) *When a complaint is made to the regional office with respect to a staff member at the nursing station, the regional office should provide a copy of that letter to the medical staff involved and ask for a response.*

Evidence was given that a chart was requested by the regional office after a complaint but not a response from the medical staff involved.

(29) *Where there is a complaint with respect to the staff at the nursing station, a mediation process should be put in place to resolve concerns.*

This may help circumvent the always present threat of being BCR'd out of the community.

National Native Alcohol and Drug Abuse Program (NNADAP)

[60] The objectives of NNADAP are to support First Nations and Inuit communities to reduce the high levels of alcohol and other substance abuse, and to build the capacity and provide support for individuals and families in pre- and post-treatment.

[61] NNADAP workers are hired by Chief and Council. High expectations are put on NNADAP workers by community leaders and they expect a full range of services. Generally, NNADAP workers do more prevention and maintenance but they are expected to do assessments and referrals and after-care that they are not equipped or trained to do. Each community decides for themselves who the person is going to be as a NNADAP worker and they are the only ones that have

anything to say about what qualifications their people need to be a NNADAP worker. Some communities have very high turnovers of NNADAP workers because of each community's political situation which turns over workers with every new Chief and Council and others have high turnover by virtue of the fact that they are overwhelmed and burn out.

[62] Training for NNADAP workers and Community Health Representatives (CHR) is coordinated through the Aboriginal Training for Health and Human Services Program which is run out of the Manitoba Keewatinowi Okimakanak Inc. (MKO) in Thompson. Approximately $170,000 a year is given to the Aboriginal Education for Health and Human Services (AEHHS). There is a conflict whereby AEHHS wants to develop, and has developed, programs that are academically transferable. The conflict occurs where a number of the NNADAP workers who want and need training do not meet the requirements to take the type of training that the program is trying to achieve through the University of Manitoba because they do not have the academic background. That creates tension between the person in the community hired by the community to do a particular job and the ability of that person to access training that will, in fact, help them do their job on the front line in the community. At the present time, there is not a standard for what a NNADAP worker is. As a result, the training for NNADAP workers is unsatisfactory at the present time.

[63] It should be noted, however, that there has been movement to examine the AEHHS and the Manitoba Community Wellness Working Group mandates and as a result in March of 2003 a draft entitled "Joint Capacity Building Strategy for First Nations Community Health and Human Service Workers" was submitted to the Assembly of Manitoba Chiefs and First Nations Inuit Health Branch in an effort to make some move towards rationalizing a continuum of training opportunities for NNADAP, CHR, BFI and BHC workers.

[64] NNADAP workers are also responsible for the referral and accessing of individuals for treatment in residential centres outside of the community. In Manitoba, the federal government funds:

- Whisky Jack Treatment Centre;
- Peguis Alcare Treatment Centre;
- Nelson House Medicine Lodge;
- Pritchard House in Winnipeg (family program);
- (formerly) Virginia Fontaine Treatment Centre; and
- fee-for-service for some clients at the St. Norbert Foundation.

[65] It is noted that there are gaps in that there is no resource for alcohol abusers 12 years of age and under and there is no place for adult solvent abusers.

Recommendations:

(1) *The federal government should review their treatment programs with a view to including treatment geared to alcohol abusers under age 12 and adult solvent abusers.*

(2) *Consideration should be given to developing an outreach program at Whisky Jack Treatment Centre.*

(3) *Competency-based training modules should be mandatory for NNADAP workers.*

MENTAL HEALTH SERVICES

[66] Mental health service in Manitoba is a hydra-headed creature. A myriad of resources exist within the rubric of “mental health”. This Inquest heard from a number of these resources with a view “to determine the availability of access and appropriate mental health services for youth in First Nations communities” (Terms of Reference No. 4 in the Calling of the Inquest).

[67] A note here: The reference is to "youth in First Nations communities". Specifically, this Inquest looked at Shamattawa where the death of Susan Capelia Redhead took place, a community in which historically and currently youth suicide is a matter of utmost and ongoing concern. While this Inquest focused on Shamattawa, youth suicide in the community is not unique to this First Nation. Statistics cited by Manitoba doctors Wilkie, Macdonald and Hildahl in a paper titled "Community Case Study: Suicide Cluster in a Small Manitoba Community" published in the Canadian Journal of Psychiatry in 1998, show that:

> Suicide rates vary across different cultural groups. This suicide rate in aboriginal Canadians in Manitoba is 2.3 times the provincial average; among aboriginal adolescents aged 15 to 19 years the rate is nearly seven times higher. The most striking difference is among 15 to 19 year old females, with aboriginal females committing suicide 23.4 times more frequently than non-aboriginals.

While those statistics may or may not be precisely accurate today, they are illustrative of what is a significant concern: youth suicide.

[68] Many of the recommendations made may apply to a greater or lesser extent in other First Nation communities, as they share common institutional programs on reserve and access to mental health systems off reserve.

[69] At the present time, mental health services are insured services and, therefore, available to all Manitobans including citizens who live on First Nations. With very rare exceptions, a citizen who lives on a First Nation has to leave their community to access mental health services in Manitoba.

[70] On reserve, mental health falls between the cracks. The Northern Medical Unit, which is a university program established in 1970 and is covered by the Faculty of Medicine Department of Community Health Sciences, used to provide itinerant psychiatrists to communities across Manitoba.

[71] The program was initially established in an effort to stabilize physician resources in Churchill but quickly became a university outreach program for First Nation and other aboriginal communities in Manitoba and Inuit hamlets in what is

now Nunavut. The program grew because historically there had been challenges in recruiting and retaining health professionals in remote First Nations communities. The Northern Medical Unit fills the need because there is a gap.

[72] Where the Northern Medical Unit used to provide itinerant psychiatrists, they now have itinerant consultants to the Percy E. Moore Hospital, the Norway House Hospital and the Churchill Health Centre. There are no longer itinerant psychiatry services to any other aboriginal communities.

[73] The change occurred in the 1990's when it appears that the federal government moved to favour the natural support of community-based mental health initiatives (BFI/BHC).

[74] The role of itinerant psychiatrist, when there were such beings, would be to fly in on a regular basis to remote communities. They would be able to provide capacity-building within the community and do formal or informal education work. They would liaise with community-based staff whether they were nurses or visiting physicians or community health workers. They also had linkages to secondary and tertiary care, i.e., access to hospital beds or specialty psychiatric services not available in the community.

[75] The itinerant psychiatrist also was available for program development and program support, i.e., identifying patterns of illness and disability in communities and how best to resolve them with the university programs and university resources.

[76] The benefit of having itinerant psychiatrists go into remote communities is, first of all, that they come to know the community and become familiar with the culture and geography of the community. It is hard for people in the south to imagine what it is like in a particular community. Unless you go into the community, you cannot get a real feel for what the conditions are that people are facing. By doing so, and meeting the people, not just the leaders, there is an ability to help design services which are congruent to a particular community.

[77] It is not necessary for the psychiatrist to necessarily go in on a frequent basis. Two of the doctors who gave evidence, Dr. Keith Hildahl and Dr. Bruce Martin, indicated that it might be sufficient for a psychiatrist to go in two or three times a year. If you then marry the personal visits each year with telephone consultations and/or video conferencing, support is available very quickly. More importantly, the fact that there has been previous face-to-face contact makes the distance conferencing much more comfortable, particularly for the person in a remote community.

[78] Another benefit of the itinerant psychiatrist attending a remote community is that people who might not otherwise seek help for fear that they may have to leave the community and their family behind to get that help may be prepared to accept the help they need if they are reassured that they will not be sent away from home.

[79] Needless to say, the cost of providing psychiatric services on site in the community coupled with the ongoing support through television or video is very much cheaper than sending people out of their communities to be treated in Winnipeg or elsewhere with all the attendant costs of looking after somebody who is away from home.

[80] Anecdotal evidence also suggests that when people are sent out of the communities they tend to stay longer in the hospital or treatment program they may be in than they might otherwise.

[81] It is also difficult once somebody has been taken out of the community and “treated” and is to be sent back into the community because:

(1) The situation at home in the community is probably no different than it was prior to the young person being sent away for treatment. The result is, of course, that with nothing changed, whatever gains had been made while the person was out of the community are

likely quickly undone once they simply go back into the same milieu; and

(2) There can be trouble moving children back into these communities. They frequently are in a lot more trouble before they get moved out of the community, and if they have mental health needs the communities don't want them back because of the trouble that had been caused. They also simply do not have the resources to deal with them coming back into the community.

[82] Dr. Hildahl made the observation "The lack of capacity in these communities is staggering."

[83] The program which used to operate out of the Northern Medical Unit would be that a very seasoned psychiatrist went into the communities and they would take residents or trainees in psychiatric programs with them. Eventually that resident, when he was finished his program, would become the itinerant psychiatrist and would in his turn then mentor a junior person. This allowed for a continuum of service which was knowledgeable about the uniqueness of a particular community.

[84] It should be noted that the Northern Medical Unit provides itinerant psychiatry services to the eight Inuit hamlets they are responsible for in Nunavut and were asked to expand their psychiatry itinerant services into the central Arctic. The funding for the program is covered entirely by the Government of Nunavut.

[85] Registered psychiatric nurses are now working on a full-time basis in many of the Arctic communities as a priority for enhanced primary health care staffing.

[86] The nursing curriculum has a strong focus on suicide, cluster suicide, adolescent suicide, solvent abuse and crisis intervention. The clinicians who

teach that to the northern nurses are specifically physicians and psychiatrists who travel into the community so they know the realities of the situation.

[87] A psychiatric nurse is equipped to understand what might be side effects of psychiatric medication and what might not be side effects. They will know what might indicate a need for emergency discontinuation of the medication and what might not. They will know what might indicate a clear need for the provision of a PRN medication (one that has to be administered as the need is indicated), and what would not be indicated. They are able to provide continuity for the biological treatments and to the monitor the side effects but also look at counselling and psychological aspects as well as the social aspects.

[88] The visiting psychiatrist is available by phone to the nurse in the community if there are difficulties or issues. There can be meaningful consultation between the two professionals who are conversant with the issues even though the psychiatrist may be in Winnipeg or some other centre a long distance away from the community.

[89] As indicated earlier in this report, in the 1990's the federal government moved to community-based, community-directed and community-paced programs of BFI and BHC.

[90] Prior to 1994, mental health services were provided for in much the same fashion as currently are provided by general practitioners, pediatricians, dentists, etc. Then itinerant psychiatrists attended in First Nation communities on a regular basis. In the early 1990's, the focus of the provision of mental health services underwent a shift to providing for community-based services. Brighter Future Initiatives (BFI) came first. This was designed as a community development program which had six components: community mental health, child development, solvent abuse, injury prevention, healthy babies and parenting.

[91] The programs were designed at a national level and then as they came into the regions, First Nations were to have a big part to play in the development at the community level and implementation of the programs. They were to be community-based/community-directed/community-paced. Each community was recognized to have different capabilities and needs.

[92] The Chief and Council are responsible for hiring BFI workers. Although the money comes from the Government of Canada, there is no control over who is hired, what qualifications are required and what the function of the job is. The hiring and direction of the BFI worker comes from Chief and Council.

[93] The funding for BFI is based on recommendations by Justice Thomas Berger called the Modified Berger Formula: 65% is distributed based on a per capita on reserve population; 10% is distributed on isolation; 25% is core-based where that money is distributed equally to each of the 61 bands. BFI's annual budget in Manitoba is $5.5 million.

[94] One of the concerns raised by all of the front line workers who gave evidence at this Inquest is that while they are hired and given a title, there is a lack of direction from Chief and Council as to the components of their job and, equally, a lack of training and the ability of Chief and Council to endorse/fund their attendance at training sessions.

[95] Many workers do not push that too hard because they do not know what their funding allocation is.

[96] Building Healthy Communities (BHC) is a program that came in, in 1994, which was to cover two areas:

(1) Mental health/counselling or training mental health and crisis management related to mental health, critical incidents stress debriefing.

(2) The second component was to be solvent abuse intervention, prevention and education.

[97] The same method of hiring operates with the BHC program as with BFI. The same problem in terms of accountability and frustration on the field level exists.

[98] The BHC mandate, however, differs from the BFI in that there is no obligation or requirement for Chief and Council to hire anyone. The moneys can be allocated to a position or activities but it is left up to the Chief and Council to decide how that money should be best used in that area.

[99] In funding, it breaks down to $4.5 million for mental heath and $1 million for solvent abuse, about $5.5 million in total for Manitoba.

[100] The BHC/BFI programs provide a certain amount of benefit to the communities, but in Shamattawa in particular the workers are well-meaning but ill-equipped. They do not know clearly what is expected of them and have not the training or support to feel the necessary degree of competence or confidence to do the job where they work in a small community. This is complicated by the fact that many people know them, their background and their level of training.

[101] The First Nations Community Wellness Diploma, which is a university-accredited course (delivered since 1996), is funded from the BFI and BHC program funding. This diploma and program provides skills in wellness and mental health to give people an understanding of the issues and strategies on how to address problems. It is delivered in module format to allow some flexibility.

[102] Problems arise in that this course is not compulsory. It is in the total discretion of the community whether they think the people who work in these positions should take the program or not.

[103] Another complicating factor is that to get into this program one must meet the University of Manitoba minimum standards which is a Grade 12 or the mature student requirements.

[104] Many communities prefer to hire from within the community. The difficulty is that some of the people who work in these positions would not qualify for the admissions standards. A Director of Health at Keewatin Tribal Council indicated that with the latter group they used the method called “professional development” to train these workers. He stated: “We overlook their formal education and we train them in the area of mental health on the premise that ‘the best counsellor there is, is usually a friend’.” (Volume 15, page 9).

[105] One of the other difficulties with respect to the appropriate training for BHC/BFI workers is that if the Chief and Council do not buy into a program that is offered, then no one attends. This happened with an FAE/FAS workshop in November of 2000. Red River Community College had a 13-week program condensed into a five-day workshop at the request of federal program managers and delivered it in Winnipeg. This was on assessment skills and strategies because workers were asking for information as they were dealing with issues that they did not know how to deal with. There were 62 participants from various tribal councils and it was very well received. No one from Shamattawa attended.

[106] In November, 2001, a workshop on basic skills for community wellness workers was put on. A clinical psychologist from Saskatoon was hired and he went into six of the seven tribal councils and delivered four-day workshops on basic skills. One hundred and nineteen workers attended. Nobody attended from Shamattawa.

[107] The above two examples simply underline the fact that it is up to the commitment of the community itself and its leadership to determine and support the training it requires of its community workers.

[108] Another difficulty that arises with the BFI/BHC programs is that although the federal government funds these programs, they take a hands-off approach once the money has passed to the First Nation. There is no real provision for auditing or evaluating the strengths or weaknesses of these programs. Mr. Doug Mercer, who is the Regional Coordinator of BFI and BHC, Manitoba Region of the First Nations and Inuit Health Branch, gave evidence that where he thought there might be a problem and requested an audit, he was likely to actually get an audit done on one of about every ten requests that he made.

NON-INSURED HEALTH BENEFITS (NIHB)

[109] First Nations people are entitled to these benefits in addition to the services that they are entitled to as provincial citizens. Benefits are such things as pharmacy transportation, optical, dental and mental health. The mental health benefit is entitled "Interim Program Directive for Mental Health Services" (dated 1994). It is intended to be a crisis intervention, short-term therapy mandated service and it is delivered through three different methods. That is, where there are contribution agreements with tribal councils or First Nations the money is essentially given to the organization and that organization administers the service on behalf of the department, or there are mental health therapist contracts wherein mental health therapists go into the First Nations communities on an itinerant basis for "x" number of days a month as the need requires. There is also a fee-for-service arrangement that is basically client-driven. This is the kind of service that Susan Redhead received when she was living in placement in Winnipeg and was having sessions with a clinical psychologist in Winnipeg.

[110] Non-insured health directive funding by the federal government to First Nations communities in the year 2000 was $3.2 million in Manitoba alone.

Recommendations

(1) *The First Nations and Inuit Health Branch and the Department of Health of the Province of Manitoba, must collaborate with the First*

Nations and all service providers in the community (in this case, Shamattawa) to develop a coordinated approach to ensure the community is provided with sufficient mental health services to meet the needs of the community.

(2) *Regular meetings should be scheduled, at a minimum once a year, among the First Nations and Inuit Health Branch, First Nations and others who are providing funding or services to discuss who is doing what, how much, and where things are going in terms of what is being put into a community, and what is needed to ensure that programs are congruent to the needs of the community.*

An example of a program that changed over the years in Shamattawa is the Leonard Miles Memorial Centre. In 1979 this centre was established to be a drop-in centre where workers in Shamattawa would be trained to take over the development and operation of the centre, develop local leadership in Shamattawa, facilitate the re-entry into the Shamattawa community of children who have been treated for lead poisoning in Winnipeg or other locations so that they do not resume solvent-sniffing behaviours upon their return to Shamattawa, promote a healthy lifestyle activity in Shamattawa, and reawaken the sense of identity and culture in the community of Shamattawa, thereby increasing the pride, independence and responsibility.

Programs were to be developed to fulfill the objectives of the agreement. Funding for this particular centre and the program was over and above any other funding. No other community got this extra funding. The funding for this program was a separate line on the budget of $110,000 a year. The community was not required to develop a plan each year to trigger the funding. No evidence of the successes or progress or problems dealt with was given at the

Inquest. Witnesses who were from the community appeared to know little about any programs that went on there. When the Court party toured the building on a day we heard evidence in Shamattawa, it appeared to be functioning as a drop-in centre and canteen. In early 2004, a federal Labour Affairs Officer concurred with the Chief and Council who had condemned the building shortly before the Officer's visit.

(3) *In order to achieve a coordinated approach, jurisdictional differences need to be parked at the door.*

Any real attempt at a solution must involve the blurring of jurisdictional barriers in order for anything to be accomplished, for example, Medical Officers of Health (MOH). Each one of the twelve Regional Health Authorities has an MOH who is overseen by the Chief Medical Officer of Health. They have specific rules and responsibilities under ***The Public Health Act*** *but they don't normally go on reserve. They do have the authority to do so. This has been something of contention because, for example, if an individual on reserve is bitten by a dog or a rabid animal or the animal is suspected of being rabid, the only person who can issue the release of the rabies vaccine is the Medical Officer of Health. The federal program medical officer does not have that authority, yet it is a plain vaccine. So there is a necessity to have communication, and there is an interim directive with the Province on access to Medical Officer of Health coverage.*

Another area of cross-jurisdictional issues is in the treatment of diabetes. Both the Province and the federal government run diabetes programs. There has been movement in this area, however, to coordinate the provision of services to diabetics.

(4) *The participants must be those who are in a position to actually make decisions.*

Much evidence was given during the course of the Inquest that there have been various and sundry attempts to bring together people from different service areas. Discussions take place, but rarely are the people involved in a position to effect change. This is not a new problem. The concept of integration of all levels of leadership and jurisdictional responsibility holders coming together for an integrated model has been written about and spoken in many places including the Royal Commission on Aboriginal Peoples. Failure to integrate these three jurisdictions has negatively impacted on the provision of mental health services, and will continue to do so without the participation of those who are high enough in the scheme of things to take the responsibility of making decisions.

(5) *There is a need for networking and coalition building.*

The Vice-President for the Burntwood Regional Health Authority, Mr. Ed Azure, has had contact with an organization servicing a mirror community, Pikangikum, in Ontario. He was invited as an observer of a governmental working group comprised of local, regional and federal authorities and departments that are working across jurisdictions and interdepartmentally to address the situation in Pikangikum. He would be a useful resource for the cross-jurisdictional issues.

(6) *First Nations and Inuit Health Branch should review the organizational structure of the Department.*

Non-insured health benefits are covered in one directorate. Brighter Future Initiatives/Building Healthy Communities (BFI/BHC),

the community-based mental health programs, and the nursing station programs each report to separate directorates (see Exhibit 133). Reporting is vertical through managers to the Directors in each area. The result is that not only do people working in one directorate not always know the programs in other directorates, but when a problem is identified at the line level, it goes upward. If the problem is one that does not catch the priorities of the management, it may never get to the point of being discussed with the directors who have the ability to make decisions to implement needed changes.

(7) *Any programming must be of a long-term nature.*

Year-to-year contracts are short-term as there is no sense that there is a true investment in achieving any long-term outcomes. Changes in behaviours which have developed over many years are simply not amenable to short-term "fixes". Building capacity in a community or communities is a matter of a step at a time and requires a long-term commitment.

(8) *End stage treatment is expensive. Emphasis from all levels of government should include proaction and prevention.*

By doing so, eventually the investment will minimize the need for costly intensive treatment.

(9) *The whole issue of reopening the Shamattawa Healing Centre and providing the appropriate funding to ensure that the centre is able to deliver on an ongoing basis, addictions treatment and after-care, emergency shelter for children and programming aimed at strengthening the family unit, should be re-visited by those participants who apparently believed it was workable in the first place.*

Involvement in planning for the long term is needed, not just the money to get the program to the starting line.

(10) *After a series of community consultation sessions in 1998 and 1999, there was a determination in Shamattawa that a community-based, community-directed healing strategy was required with support and guidance from outside agencies/government departments.*

The project was called "Niwaskahikan" (colloquially known as the "Healing Centre"). Excepts from the "Building a Healthy Shamattawa" committee describe the basis upon which the proposal was founded:

> *Our history shows that we have not benefited from short-term programs parachuted in from the outside. We only want to work with organizations who are prepared to help us build our own capacity to create a better life for ourselves…*
>
> *…Shamattawa has been a troubled community almost from the beginning. Outsiders have been responding to Shamattawa as if it were in crisis. Shamattawa is not in a state of crisis; it is, rather, in a state of chronic long-term dysfunction, which has become the social norm. The social norm, "just the way things are here", is more resistant to change than any crisis…*
>
> *…It is our belief that the community has not been helped by parachuted short-term programs and consultants. We need help of sufficient duration and commitment to develop our own capacity to create a better life for ourselves.*

It had the goal of building a duplex. Parenting and home management techniques were to be taught during the day and during the night the duplex was to be used as a shelter for intoxicated children who were not able to be managed at home. This would also mean that those children would not be held in the R.C.M.P. cells.

The funding partners and/or participants were the Shamattawa Health Committee, Indian and Northern affairs Canada (INAC), Medical Services Branch (now FNIHB), the Children and Youth Secretariat for the Province of Manitoba, Keewatin Tribal Council (MKO), Awasis Agency, National Crime Prevention Program, Aboriginal Healing Foundation, and Canada Mortgage and Housing Corporation (provided $200,000 toward the construction of the duplex).

Once constructed, the Healing Centre ran for about six months before the funds ran out. There were problems around the use to which the building was put. At a meeting with INAC, FNIHB found that the Healing Centre was being used as an emergency receiving home for children in need of protection. The Regional Director for FNIHB indicated to the Regional Director of INAC that that was their responsibility, not FNIHB's, if it was being used as a Child and Family Services emergency receiving home and that INAC should be looking at other federal funding and then work with the Province on it.

(11) *A very real problem was that long-range planning (which would include bringing professionals in to teach and train) on a budget that was seen as having no assurance for further funding after 12 months or so was difficult to impossible.*

(12) *Community development must be a priority.*

But any programming must start where the community is at. Otherwise it is, and will be seen as, just another program driven by people from the south, who have little or no appreciation of the realities of the community or communities involved. A previous federal employee with the then Medical Services Branch described being told "Health Canada wanted me to promote nutrition.

Somebody who doesn't care whether they live or die don't (sic) care whether they're eating peas and carrots or potato chips." (Volume 14, page 30). Dr. Martin in his evidence expressed it succinctly: "We have to respect the wisdom and the knowledge of the community and how some of these concerns might be addressed and not just put in place the experiences of our own non-aboriginal culture and what might be successful" (Volume 31, page 58).

(13) *An itinerant psychiatric program should be instituted in consultation with First Nation communities to provide psychiatric services on-site in First Nations communities.*

This is not to replace the community-based programs of BFI and BHC, but to provide a professional component of mental health services, which has not been available in the communities for quite some years now. Evidence from both Dr. Martin of the Northern Medical Unit and Dr. Hildahl of the Manitoba Adolescent Treatment Centre suggest that providing treatment in the community would not only allow people to live at home rather than being sent out of the community, but would, in doing so, be cost effective.

(14) *Psychiatric nurses should be recruited and placed in every nursing station in remote communities.*

One in each community would be best, but it might be necessary to place one on a full-time basis in larger communities and/or in communities with demonstrated high need (such as Shamattawa), and serve smaller communities on a half-time basis. This is to supplement, not replace, current nursing staff.

(15) *The Manitoba Adolescent Treatment Centre (MATC) should be approached to develop a training program for those who work with child and adolescent mental health issues in First Nations.*

MATC was asked to develop, and developed, a curriculum for a training program for community-based mental health workers in the north so that people would not have to travel too far from community and family to take it. They developed cultural competency modules, modules around psychiatric medications, developing family resiliency, etc. Instructors were hired to take the teaching to the north with four or five-day centralized teaching. They hoped to continue doing this program with funding out of Manitoba Health. They also provided training for people working for rural Regional Health Authorities delivering child and adolescent mental health services. MATC took the contract and developed the curriculum, but partnered with Manitoba Health. Dr. Hildahl was of the opinion, based on the service delivery models, that it would not be a large stretch to take the material and develop it for First Nations communities.

(16) *First Nations and Inuit Health Branch (FNIHB) should do an evaluation of the BFI/BHC programs.*

As indicated above, workers are not entirely sure of their roles and expectations. They know what their salaries are, but not what dollars are committed to allow them to do programs or take training. (Approximately $11 million dollars in funding is distributed each year by the Manitoba Region of FNIHB to support BFI/BHC programs in Manitoba.)

(17) *The terms of reference of the programs, developed at a national level, are very generic and need to be translated into language that*

help identify pragmatic parameters that give the workers a better idea of the framework within which they are expected to work.

A generic description of a national program will translate differently in different parts of the country. Regional branches of FNIHB should be able to work with different First Nations in their area to identify program needs.

(18) *Recognition and support should be given to traditional healing methods.*

(19) *Support should be given to encourage and maintain elder and family camping programs.*

(20) *Regional managers should be in a position to work with, but not interfere with, the leadership of First Nations communities such as Shamattawa.*

They should perform the role of consultant to help facilitate a way to meet the goals of the BFI/BHC programs. Evidence given at the Inquest indicates that once the funding is given, FNIHB has a "hands off" approach.

(21) *Manitoba Health and the Regional Health Authorities should collaborate to study the feasibility of a crisis stabilization unit in Thompson and The Pas, which should include a mobile crisis intervention team which can go into a community on short notice.*

(22) *The MacDonald Youth Services Crisis Stabilization Unit should be advertised throughout the province on an annual basis in the mental health community.*

(23) *The "Kids Help Phone" should be advertised and posted in schools, community centres, nursing stations and R.C.M.P. detachments.*

This is a Canadian toll-free 24-hour national bilingual telephone counselling service for children and youth (telephone number: 1-800-668-6868).

(24) *In the same places as listed in the previous paragraph, the youth suicide prevention website should be posted (www.youthsuicide.ca).*

END NOTE

[111] The circumstances of Susan Redhead's life and death can only be described as tragic. From birth, neglect and abuse began to shape the person she would become. It was clear from the evidence that she very much wanted the love and supportive environment of her family. It was equally clear that her family could not provide the nurturing environment that she and her siblings not only needed but to which they were entitled.

[112] Gordon Favelle, Director of Mental Health for the Manitoba Department of Health, described "the two best predictors of suicide, is (sic) hopelessness and helplessness. And if we find ways of addressing that, then we're going to reduce suicide." (Volume19, page 85). Susan did receive care from people along the way who cared for her. She received excellent care at St. Norbert Foundation's (now the Behavioural Health Foundation) Kirkos House. When she needed more individual help, the Walls took her into their home and family and did as much or more than anyone could expect. But the ongoing suicidal ideations and attempts became too much. Given the instability which was part of her life from beginning to end, along with the sexual abuse and use of solvents, the hopelessness and helplessness to which Mr. Favelle referred appears to have overshadowed Susan's life. Some people will commit suicide. In the end, given her life and the history of attempts at suicide, it is, perhaps, unsurprising that Susan took her own life on February 20th, 2000.

[113] I respectfully submit my recommendations and conclude this Report this 19th day of July, 2004, at the City of Winnipeg, in Manitoba.

"K. M. Curtis"

K. Mary Curtis, Provincial Judge

Manitoba

THE FATALITY INQUIRIES ACT
SCHEDULE ATTACHED TO PROVINCIAL JUDGE'S REPORT

RESPECTING THE DEATH OF: SUSAN CAPELIA REDHEAD

EXHIBIT LIST

Exhibit No.	Description
1	Boudreau withdrawal letter
2	C.M.E. letter
3	John Wood chart
4	Susan Redhead chart
5	D Division Memo 045
6	Typed notes of J. L. Jennenne
7	Glaspey memo to H.S.C. dated February 22, 2000
8	Computer printouts re lodging
9	R.C.M.P. statistics to Awasis re sniffing and suicide
10	Dupont letter to Awasis dated April 26, 2000
11	Dupont letter and proposal dated June 7, 2000
12	Transcript of Susan Redhead complaint 98-01-29
13	Monthly policing reports dated October, 1999
14	Youths in R.C.M.P. cells dated 08-18-00
15	High Risk Youths dated 08-18-00

Exhibit No.	Description
16	Dupont letter to Passler dated 1-10-01
17	R.C.M.P. fax to Winnipeg Child and Family Services
18	Awasis Agency file – Susan Redhead (binder)
19	C.M.E. Report
20	Wall letter dated December 15, 1999
21	Thelma Bland memo re December 17, 1999
22	Fax to Thelma Bland dated June 28, 2001
23	Joanne Redhead letter from Thelma Bland dated September 24, 1998
24	Thelma Bland memos dated June 29, 1998
25	Thelma Bland handwritten memo to Carla Taylor date May, 1999
26	Foster Placement Request form dated November 17, 1995
27	Thelma Bland letter to Joanne Redhead dated August 26, 1998
28	Original Awasis Agency file on Susan Redhead
29	Original Awasis Agency family file on Redhead
30	VPA Renewal dated January 6, 2000
31	VPA Termination dated January 6, 2000
32	Wall fax to Joanne Redhead dated December 15, 1999
33	Discharge Summary Report dated February 28, 2000
34	Children in Care dated September 28, 1995
35	VPA dated October 15, 1995 and Case Plan
36	Children in Care document dated January 2, 1996
37	Renewal of VPA dated January 8, 1996

Exhibit No.	Description
38	Termination of VPA dated January 31, 1996
39	Awasis Agency of Northern Mt. A.C.M. Case Planning Guide dated November 6, 1997
40	Wall letter dated September 9, 1998
41	VPA Susan Redhead dated August 29, 1998
42	Fax to Joanne Redhead re CSU dated October 14, 1998
43	Undated A.C.M. Planning Guide
44	Child Care Instruction Sheet
45	Joanne Redhead memo re Sarah Wood dated March 30, 1999
46	Special Needs Calculation Chart
47	Child Care Instructions May 18th and July 7, 1999
48	Susan Redhead VPA dated May 30, 1999
49	Wall letter dated July 5, 1999
50	Memo re Susan Redhead in Shamattawa dated July 18, 1999
51	AWOL memo dated July 30, 1999
52	Health Sciences Centre Admission dated August 3, 1999
53	Fax from Wall re clothing dated September 1, 1999
54	Wall letter dated November 25, 1999
55	Memo (Joanne Redhead) dated December 17, 1999
56	Child Care Instruction Sheet dated December 28, 1999
57	Change of Placement for Susan Redhead dated January 12, 2000
58	Change of Placement for Susan Redhead dated January 6, 2000
59	Void – Flight Arrangement dated December 16, 1999

Exhibit No.	Description
60	Termination of VPA dated July 8, 1993
61	Memo from Jesse Redhead dated September 17, 1998
62	Crisis Stabilization Unit dated September 16, 1998
63	Two Child Care Instruction Sheets dated 11-2-99/ 16-9-99
64	Memo to file – visit by Sara & John Wood – Kirkos House dated September 23, 1998
65	Crisis Stabilization Unit fax re Susan Redhead dated October 15, 1998
66	Letter to Robert Lafontaine, Attn: Jesse Redhead dated October 23, 1998
67	Unsigned letter – Thelma Bland dated November 6, 1998
68	Fax from Marymound Susan in Crisis dated November 17, 1998
69	Handwritten memos re Jacquie Wall as foster home dated November 9th and 13th, 1998
70	Handwritten Child Information Sheet dated November 18, 1998 (part of November 13, 1998 fax from SE Resources Development Corp)
71	Memo – 6 months VPA dated November 30, 1998
72	Child Instruction Sheet dated December 18, 1998 with effective date December 12, 1998 – home via Thompson with Jesse Redhead as escort
73	Fax MacDonald Youth Services dated January 19, 1999 – Youth Emergency Crisis Stabilization
74	Letter Jacquie Wall to Jesse Redhead re Susan Redhead dated January 21, 1999
75	Letter from Jacquie Wall dated May 13, 1999 (foster parent to Carla Taylor)
76	Fax from Thelma Bland re special needs dated July 5, 1999

Exhibit No.	Description
77	Child Care Instruction Sheet dated July 5, 1999 re travel arrangements for Susan
78	Fax from Thelma Bland – Awasis Agency Attn: Carla Redhead dated November 26, 1999
79	Children in Care dated May 3, 1995
80	Termination of VPA re Susan – Greg Fidler dated November 21, 1995
81	Child Care Instruction Sheet re VPA dated December 29, 1995
82	Susan Redhead complaint re John Wood 98-052
83	C. re John Wood 98-0602
84	Sentencing transcript re John Michael Wood dated February 23, 1999
85	Docket dated February 23, 1999
86	Policy Directive for Crown to seek Victim Impact Statements in sexual assault case dated February 19, 1999
87	Copy of Probation Order re John Wood
88	Copy of court schedule dated February, 1999
89	Docket consisting of five pages
90	Report to Child Abuse Registry
91	Appendix E – Objectives and Activities National Native Alcohol & Drug Abuse Program
92	Probation file re John Wood
93	Appointment letter re Michael John Wood
94	Fax – Corrections re Michael Wood dated September 19th
95	Failure to Comply with Court Order Policy – 776

Exhibit No.	Description
96	Case Management Policy – section 740
97	Allegation of Non-Compliance with Probation Order
98	Theory – job description
99	Cecil Miles statement
100	Thompson Child and Family Services file re Susan Redhead (binder)
101	CFS Program Standards Manual – section 421
102	Memo – Ken Cairnie dated February 15, 2001
103	Proposal from Shamattawa First Nation Funding dated December 6, 1999
104	Proposal Crime Prevention/Youth Development through Recreation and Peer – Support Demonstration Project dated February 19, 1999
105	Original Exhibit List
	All above exhibits were entered in Thompson Provincial Court February 4, 2002 – Winnipeg Court
106	Original Crown's file on Roderick Saunders Thomas
107	Copy of Sentencing Transcript of Roderick Thomas
108	Autopsy Report Form prepared by Dr. Nanassy
109	St. Norbert Foundation Reports – two volumes dated July 1, 1998 – November 18, 1998 and November 12, 1997 – June 30, 1998 (blue binders)
110	A picture of Susan and two young boys
111	Mr. Wood's Headingley file (green file)
112	Five-page Dismissal Policy No. 80-30 dated July 6, 1999 – Victim's Rights in Corrections

Exhibit No.	Description
113	Four-page Divisional Policy No. 65-20 dated February 21, 2000 – Sexual Offender Intervention
114	Seven-page Correctional Services Policy No. 55-110 dated May 16, 1996 – Case Management
115	Interim Program Directive – Mental Health Services – four pages dated March, 1994
116	Two-page letter dated August 7, 2001 to Mr. Gord Favelle from Dr. A. T. Balachandra
117	Four-page package containing confirmation of prior approval to Dr. De Luca dated June 28, 1999, two-page assessment from Dr. De Luca dated May 29, 1999 and an Informed Consent Form
118	One-page letter dated September 25, 2001 to Dr. A. T. Balachandra from Gord Favelle
119	Two volumes (two black binders) of the WCF Files/Records re Susan Redhead Inquest
120	Copies of the Affidavit of Service on Awasis Agency and Native Agency and two copies of the Petition and Notice of Hearing
121	CFS Court Disposition Summary – Winnipeg – four pages
122	Crown Attorney's file on Leonard Horace Thomas (Shamattawa)
123	Three-page proposal – Building a Healthy Shamattawa signed by Jerome Berthelette
124	Two-page letter prepared by Doug Mercer – Briefing Note Shamattawa First Nation
125	Two pages – Objectives – Health Liaison – Leonard Miles Memorial Centre
126	Two-sided letter prepared by Lorne Cochrane
127	Two pages – Indian and Northern Affairs Canada re Shamattawa First Nation "Building a Healthy Shamattawa"

Exhibit No.	Description
128	Meeting Report and Action Plan – Building a Healthy Shamattawa – four pages
129	Records of the Crisis Stabilization Unit re Susan Redhead
130	Ma Mawi Wi Chi Itata Centre Programs and Services Handbook
131	Pediatric Death Review Committee – Annual Report – 1999
132	Map of First Nation communities in Manitoba
133	Organizational chart (Directorate, Manitoba Region: First Nations and Inuit Health Branch)
134	Five-page document dated January 27, 1999 from Catherine Cook
135	Two-page document dated April 15, 2002
136	NNADP Review – NNADP Drug Abuse Program – General Review 1998
137	Curriculum Vitae for Dr. Keith Hildahl
138	Booklet titled MATC
139	Policy dated August 31, 2000 titled “Release of High Risk Sexual Offender Protocol”
140	CNAC Referrals Policy dated August 31, 2000
141	Peace Bond Application policy
142	Package titled “Manitoba Competency Based In Service Training Program”
143	Curriculum Vitae of Katherine Mallick
144	Package titled “Residential Care Priorization & Co-ordination”
145	Curriculum Vitae of Ken Cairnie
146	File copy from Phil Goodman dated November 3, 1999 – Comments from DECVA

Exhibit No.	Description
147	Two-page letter from Mark Mason to Alan Ladyka
148	One-page letter from Mark Mason to Tim Preston dated April 2, 2002
149	Curriculum Vitae of David Monias
150	Voluntary Placement Agreement – nine pages
151	Awasis Agency – File Closure Form
152	Awasis Agency – ACM Case Closing Form – two pages
153	Awasis Agency of Northern Manitoba (Case File Review) – five pages
154	Child and Family Services Programs Standards – four page – Manual (Voluntary Placement of Children) – section 250
155	Two-page memo (to all staff) from D. Monias dated November 12, 2001 re signing of VPA's
156	Blue binder titled "Awasis Agency of Northern Manitoba" (pumpkin colour)
157	Blue binder titled "Quick Reference Manual (Awasis)"
158	Binder titled "Awasis Agency of Northern Manitoba" with covering letter (Susan Redhead)
159	Three-page memo to First Nation Family (Manitoba Region) from Marilyn Kapitany date stamped March 28, 2002
160	Curriculum Vitae of Dr. William Fleisher
161	Health Sciences Centre chart (Susan Redhead) dated April 29, 2002
162	One-page letter from Dr. Robert Steinberg dated November 3, 1998
163	Booklet titled "Aboriginal Focus Programs"
164	Curriculum Vitae of Dr. Bruce Martin

Exhibit No.	Description
165	Copy of letter dated June 24, 2002 written by M. Kapitany, Regional Director General from Indian and Northern Affairs Canada
166	Quarterly Reports from Doug Mercer – 131 pages – copies
167	Copy of Referral Letter dated December 9, 1997
168	Two-page copy of letter dated December 9, 1997 written by Dr. De Luca
169	Two-page letter written by Dr. De Luca dated May 29, 1999 to Dr. Hettinga of Health Canada – copy
170	Two-page letter dated June 18, 1998 to Mr. Ron Flammand of Medical Services Branch
171	Self-Reporting Documents completed by Susan Redhead dated December 16, 1998 and January 20, 1999
172	Notes of Dr. De Luca
173	Provincial Suicide Response and Aglukark material
174	Aboriginal Education for Health & Human Services pamphlet
175	Community Health & Human Services Workers Diploma Program sheet
176	Whisky Jack Treatment Centre Inc. pamphlet
177	Résumé of Khrys Courchene

Manitoba

THE FATALITY INQUIRIES ACT
SCHEDULE ATTACHED TO PROVINCIAL JUDGE'S REPORT

RESPECTING THE DEATH OF: SUSAN CAPELIA REDHEAD

WITNESS LIST

1. **Dr. Thomas Medd**, Psychiatrist, currently practices full-time in The Pas, Manitoba; until August, 2000 employed full-time at Selkirk Mental Health Centre

2. **Constable Kelly John Glaspey**, officer with the R.C.M.P. Detachment in Shamattawa

3. **Sergeant Shelly Dale Dupont**, Operations NCO for Emerson (Red River Detachment); formerly at R.C.M.P. Detachment in Shamattawa

4. **Wanda Helman**, Registered Nurse with Medical Services Branch and nurse in charge at Shamattawa Nursing Station

5. **Thelma Barbara Bland**, Director of Operations with Awasis Agency, Thompson

6. **Joanne Redhead**, Supervisor with Awasis Agency

7. **Sean Koostachin**, Susan Redhead's cousin

8. **Sarah Nora Wood**, Susan Redhead's mother

9. **Jessie Myna Redhead**, currently Financial Administrator/Secretary at Shamattawa Education office; formerly Childcare Worker and Intake Worker with Awasis Agency

10. **Carla Michelle Taylor**, Unit Supervisor at Awasis Agency of Northern Manitoba in Shamattawa

11. **Christine H. Fenner**, Senior Child and Family Services Worker with Awasis Agency of Northern Manitoba, Unit Supervisor in Shamattawa

12. **Eddie Ernie Joseph Azure**, Vice-President of the Burntwood Regional Health Authority in Thompson

13. **Margaret Peggy Koostachin**, Sarah Wood's sister, foster parent and former Chief of Shamattawa (elected 1996 and 1998)

14. **Roy Joseph Miles**, former Chief of Shamattawa (2000-2001) and former Band Manager

15. **Eli Harvey Miles**, Chief of Shamattawa

16. **Robert Bruce Craig**, mental health therapist

17. **Breta Marie Passler**, Crown Attorney, Prosecutions Branch, Thompson

18. **Shirley Canabie**, doctor's assistant and relief clerk at Nursing Station; formerly NNADAP worker in Shamattawa

19. **Theresa Henderson**, Family Services and Housing Social Worker in Child Protection; formerly Probation Officer in Thompson

20. **Nancy Diane Thomas**, Building Healthy Communities representative in Shamattawa

21. **Cecil Miles**, Susan Redhead's friend

22. **Mervin Thomas**, Susan Redhead's cousin

23. **Crystal Marie Redhead**, Susan Redhead's older sister, eldest daughter of Sarah Wood

24. **Cheryl Noreen Martinez**, Northern Team Leader, Child Protection and Support Services, and former supervisor with Thompson Child and Family Services

25. **Laurel Dawn Gardiner**, registered nurse, school teacher and adult educator, currently employed as Income Security Reform Project Manager with Manitoba Keewatinowi Okimakanak Incorporated

26. **Emile Garson**, Director of Health at Keewatin Tribal Council in Thompson

27. **Raymond Kenneth Frank Champagne**, Crown Attorney, Department of Justice Manitoba

28. **Brenda Vanasse**, Assistant Director of Youth Services, Kirkos House, St. Norbert Foundation

29. **Shelley Marie Armstrong**, Residential Worker at Hope Centre, Winnipeg and Crisis Unit Worker, Sara Riel Incorporated; formerly Youth Treatment Worker, St. Norbert (Kirkos House)

30. **Jacqueline Louise Wall**, Clinical Case Manager with Alternative Parent Home Program, Macdonald Youth Services; Susan Redhead's foster parent post-Kirkos House

31. **Michael Pollock**, Correctional Officer, Headingley Correctional Institution; formerly Case Management Officer at Headingley Correctional Institution

32. **Dr. Peter Hettinga**, Acting Case Manager, Non-Insured Mental Health Services, First Nations and Inuit Health Branch, Non-Insured Health Benefits

33. **Loretta Bayer**, Director, Aboriginal Health Department, Manitoba Health Department – Policy

34. **Gordon Kenneth Favelle**, Director, Mental Health, and Coordinator of Youth Suicide Information Centre, Manitoba Health Department

35. **Kevin Michael O'Toole**, Supervisor, Winnipeg Child and Family Services

36. **Glen David Arthur Reid**, Prosecutions and Criminal Policy Section of Manitoba Department of Justice, formerly Crown Attorney in Thompson

37. **Douglas James Mercer**, Regional Coordinator, Brighter Futures Initiative and Building Health Communities Initiative, Manitoba Region of the First Nations and Inuit Health Branch

38. **Irvin Smith**, Native Services Coordinator, Manitoba Family Services; formerly Executive Director of Awasis Agency

39. **Randall Julius Klaprat**, Program Coordinator, Youth Emergency Crisis Stabilization Services, Winnipeg

40. **Michael Warren Kaan**, Director, Clinical Services, Marymound Inc.

41. **Peter Rogers**, Director, Professional Services Directorate, Manitoba Region of First Nations Inuit and Health Branch

42. **Clarence Nepinak**, Regional Advisor, Inuit and Indian Health Careers Program, and Regional Manager, NNADAP

43. **Dr. Vernon Keith Hildahl**, Chief Executive Officer, Manitoba Adolescent Treatment Centre

44. **Dennis Lemoine**, Manager, Investigations and Auditing, Corrections Division, Province of Manitoba, and Vice-Chair, Community Notification Advisory Committee

45. **Katherine Valerie Hallick**, Provincial Training Coordinator, Child Protection and Support Service Branch, Government of Manitoba

46. **Dr. Milton Tenenbein**, Pediatrician and Medical Toxicologist, Children's Hospital (solvent abuse)

47. **Pat Alphonso Cox**, Coordinator for Provincial Placement Desk, Child Protection and Support Services Branch

48. **Ken Cairnie**, Acting Director, Service Delivery and Compliance, Child Protection and Support Services Branch, Child and Family Services, Government of Manitoba (retired)

49. **David Allan Monias**, Executive Director, Awasis Agency of Northern Manitoba

50. **Dr. William Fleisher**, Site Medical Director for the Child and Adolescent Mental Health Program at the Health Sciences Centre and Program Head of the Child and Adolescent Psychiatry Program

51. **Dr. Catherine Louise Cook**, Regional Director of Aboriginal Services and Medical Officer of Health at Winnipeg Regional Health Authority

52. **Barbara Lavallee**, Area Director, Aboriginal Focus Program, Continuing Education Department, University of Manitoba

53. **Dr. Bruce Douglas Martin**, Director, Northern Medical Unit, Faculty of Medicine, University of Manitoba

54. **Dr. Rayleen De Luca**, Clinical Psychologist and Professor at Faculty of Psychology, University of Manitoba

55. **Martha Palmer**, Assistant Program Coordinator, Aboriginal Education for Health and Human Services (funded by Heath Canada First Nations and Inuit Health Branch in Manitoba/MKO)

56. **Susan Geady**, Clinical Mental Health Therapist (independent contract basis) with First Nations and Inuit Health Branch

57. **Steven Earl Clarke**, Director, Whisky Jack Treatment Centre, Thompson

58. **Khrystina Anerijivna Courchene**, Operations Manager, Shamattawa (Awasis Agency)

59. **Ernest Paul Konrad**, Area Director, Community and Youth Corrections, Thompson