Documenting The Decline

The Dangerous Space Between Good Intentions and Meaningful Interventions
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A Special Report published after an Investigation
in accordance with Part 4 and Part 5 of
The Advocate for Children and Youth Act

Dedicated to Honour the Memory of
CIRCLING STAR
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Preface

A note on names
The decision to identify a child or youth within a public child death report is one that requires careful reflection. Consideration must be given to the circumstances of the individual story and take into account the wishes and experiences of surviving family, especially surviving siblings. Safety implications must be thoroughly understood as well as the delicate balance between privacy rights and public interest.

In this special report, the Manitoba Advocate has anonymized the youth in question, their family, the community where the family lives, and the locally-delivered services. This decision was made because this youth had involvement under the federal Youth Criminal Justice Act (the YCJA), which expressly prohibits identifying any youth dealt with under that Act. The Advocate determined that inclusion of the justice-related information was critical to the reader’s understanding of the youth, and so, including his involvement in youth justice services required this special report to be released without any information which could identify him.

Readers will see that the youth is referred to by his Spirit Name, Circling Star. We are honoured and thankful that in their meetings with our office, Circling Star’s family gifted us their permission to use his Spirit Name.

A note on language for “dad” vs. “biological dad”
Throughout this special report, “dad” and “father” refers to the individual Circling Star identified and referred to as his father. “Biological dad” refers to the individual who is Circling Star’s biological father. This distinction has been made based on how Circling Star identified these individuals.

A note about the poster images included in this special report:
In 2012, our office along with our counterpart provincial Advocate offices in Ontario and British Columbia collaborated with the Canadian Museum for Human Rights for a campaign that reinterpreted The United Nations Convention on the Rights of the Child (UNCRC) through an Indigenous youth lens. We worked with the public education organization, The Healthy Aboriginal, based in Comox, British Columbia, who commissioned Indigenous artists from across Canada to illustrate each of the 42 Articles of the UNCRC. Promoting the rights of children and youth is foundational to our approach to children’s advocacy and we feature some of the illustrated Articles from the UNCRC on the pages of this special report. To view the complete set of child rights posters, visit our website www.manitobaadvocate.ca

A thank you to the family
The loss of a child is a weight few can truly imagine. In our work with families throughout Manitoba, we bear witness to the grief that families who have lost a child must carry as they try to recover and move forward. It has long been our commitment that we will reach out to surviving family to invite their participation in our investigations as we work to come to a full understanding of the child who has died.
and to determine whether public services in our province ought to be improved to prevent future deaths. We know the significant limitations that service files have to inform our reports, as one of our objectives is always to review services through the eyes of the child. With that as our lens, the input from family – the people who best knew and loved the child is deeply valuable and irreplaceable.

This special report is much richer and more complete because of the participation of Circling Star’s family. On three separate occasions, we sat with his family, with two of those meetings happening in Circling Star’s community. Our entire team extends its gratitude and deepest thanks to Circling Star’s family for their bravery and invaluable participation in this special report. The information and insights they shared with our office, particularly those of Circling Star’s mother, are reflected throughout this special report.
Executive Summary

Adolescence is an important time of learning and discovery. When conditions are ideal, adolescence is an exciting bridge between the wonder of childhood and the deeper wisdom that comes in later years. Adolescents are curious, nervous, eager for adventure, sometimes hesitant and unsure, and, as a group, boisterous and wonderful, reminding us to step outside of our comfort zones and keep growing. As children pass through adolescence, they need support from adults to ensure that as they explore the world and take on new experiences they are safe and developing in ways that allow them to meet their full potential.

When professionals are delivering services to children, those professionals hold an incredible privilege to ensure that the services they provide help children build skills that support and protect them as they emerge into adulthood. The best services are those that allow families to take the lead in identifying their needs. When multiple systems are involved, there must be efforts to collaborate and coordinate for smooth delivery of necessary supports. Unfortunately, not all stories reflect these ideal conditions.

Growing up, Circling Star seemed like a typical child. He was active, happy, and, according to his parents, he loved to eat. He enjoyed being outside, was taught how to hunt and fish, and one of his favourite places was being outdoors in the bush. At the age of 13, Circling Star discovered that the man who had raised him from infancy was not, in fact, his biological father. He learned this significant information by surprise from a non-family source in his community. After learning of his biological father, Circling Star ran away from home and his mother called the community Child and Family Services (CFS) office seeking support. The immediate crisis subsided, Circling Star returned home, and CFS ended their involvement. However, Circling Star’s parents shared with our office that this revelation was deeply shocking for Circling Star and one from which they felt he never fully recovered.

At the age of 14, Circling Star began high school in a new community and stepped out onto a path that began with minor acting-out, but which, over the course of the next three and a half years, declined into significant levels of risk-taking, and ultimately led to his death. Circling Star struggled in his new school. While he had ended Grade 8 with positive teacher comments and good grades, this was not his experience in high school. He struggled particularly with one of his teachers who did not recognize that Circling Star’s behaviour was a result of underlying challenges. Circling Star was regularly disciplined and suspended – sometimes for many weeks at a time – for minor infractions that began with refusing to stand for the national anthem. His behaviour and responses escalated to verbal altercations and ultimately to Circling Star attending school while intoxicated, threatening staff, and carrying a weapon.
Sometimes, when looking back on a series of events that have unfolded, we cannot help but consider what might have happened if certain decisions would have been made differently. We wonder what might have been if small changes had occurred. With the benefit of hindsight, we can see more clearly that certain events held significant influence over what was to come. We look back in time and see that those small changes might have ended with a different result. This is especially true after the death of a child.

Circling Star struggled significantly with drug and alcohol misuse in the last four years of his life. After reviewing countless documents and conducting many interviews, the specific conditions that led Circling Star to begin his substance use remain unclear. What does seem clear to us, however, is that there were many missed opportunities for the professionals in Circling Star’s life to intervene in meaningful trauma-informed ways at critical junctions of his life.

As advocates, we have the privilege to safeguard the best interests of all children. We work from a belief that all children and youth have opinions and ideas that need to be heard. When they tell us what they want and we know those choices are not in their best interests, it is our responsibility as professionals and our commitment as advocates to take the time to talk to young people about what our concerns may be. A commitment to listening and offering meaningful guidance can help children and youth talk through their ideas and grow in their understanding of the world in which they live.

Circling Star’s story is a collection of missed opportunities. It includes descriptions of the involvement of many public services that never worked together in any meaningful way and of professionals who passively interacted with a boy who was in a deepening crisis. Some of the public services did not deliver services that met minimum service requirements, some did not properly document their involvement, while others consistently documented but never intervened in any way that might have made a real difference for Circling Star.

One of the services reviewed here is school-based addiction counselling. Our investigation revealed clear evidence of the positive rapport that the counsellor was able to establish with Circling Star, and this relationship evidently had meaning for Circling Star as well, for he continued to seek out this counsellor. And yet, while the counselling sessions were well-documented and lasted for many years, there was no evidence of intervention that helped Circling Star address his drug use patterns. Despite Circling Star consistently disclosing significant issues of addiction, signs of mental illness, thoughts of suicide, and growing despair, there were few attempts by addiction services to reach out to Circling Star’s parents or to the other services involved in his life. Over more than three years of addiction counselling, Circling Star’s parents were never provided with the opportunity to be brought into the discussions so they could participate in supporting him in his significant and growing struggles. As advocates, we defend a child’s right to privacy and believe strongly that children must have private spaces where they can speak in confidence to professionals and other safe adults as they try to figure out the world. However, it is difficult to endorse a counselling approach that witnesses a child – beginning at age 13 – disclosing significant levels of drug use and sharing that he is drinking to blackout, and does not afford parents an opportunity to know the depths of hopelessness and the levels of risk their child is experiencing.
In Circling Star’s case, addiction counselling was provided as part of an agreement with the high school where he was a student. Education is a designated service under The Advocate for Children and Youth Act, as such, this special report includes an examination of the education services provided to Circling Star. What stood out when we reviewed his school files and spoke with personnel at his school, was how much Circling Star struggled when he entered high school, and how he was never successfully engaged in that environment. It is likely true that some of Circling Star’s behaviours would have made him a challenging student for school staff. Unfortunately, in Circling Star’s case, it seems the favoured strategy for addressing his behaviours was by excluding him from school through suspensions, with little attention paid to the sadness and trauma underlying this behavior that stands out for our team when we look back at the education services he was provided.

This investigation also looks at the nature of youth justice services and specifically the services available to youth in rural communities like the one in which Circling Star lived. When Circling Star was 13, he was convicted for arson. Drugs and alcohol were considered factors in the crime Circling Star committed, and the reaction of some people in the local community was severe. Circling Star’s parents shared with us that their son was not safe in the community after his role in the arson became known. Our team was informed that drivers would swerve towards him while he was walking, which increased his risk in the community. It was for this reason that Circling Star’s dad bought him a used SUV that they fixed up together; his parents wanted to keep Circling Star safer and not have him walking around by himself. Circling Star’s dad shared that he carries significant feelings of guilt because it was in this SUV that Circling Star would later die as a result of a single motor vehicle accident.

Safety was an ongoing concern for Circling Star throughout his teenage years. This special report also examines CFS supports delivered to Circling Star and his family. Throughout their involvement, the CFS agency responsible for providing services to Circling Star and his family did not provide services consistent with their mandate for child protection. This special report provides details of the interactions that the CFS agency had with Circling Star’s family and the lack of appropriate interventions on the part of CFS, including uninvestigated reports of abuse, known periods of homelessness, placing him in homes that were assessed as high risk, and then offering no supports to mitigate that risk.

Over the years, the CFS agency followed behind Circling Star, funding placements of his own choosing, even after they were deemed unsafe by the agency’s own process. While the CFS agency provides services in an area with scarce resources, there were no demonstrated attempts to provide supports to the family in the family home and prevent this child from being taken into care. We are left wondering what might have been different for this family if the focus would have been on helping to address Circling Star’s discovery of his biological parentage, and if the work with the agency might have focused on building strong and open communication within the family environment. Instead of focusing on the family dynamic, or taking on the role of case managing the growing number of public services involved in Circling Star’s life, the CFS agency provided services which were reactive to what was happening in the moment, with no demonstrated vision of a longer-term plan. Circling Star was making increasingly risky
choices and the professionals in his life who had a role – and sometimes a legal obligation to intervene – did not consistently protect him.

Overall, this special report demonstrates the importance of information sharing and coordination. Throughout their involvement, the services active in Circling Star’s life and those of his family operated in isolation from each other. There was little effort made to communicate between service providers and important information was not shared, weakening each service area and their respective plans. It is sad to look backwards and wonder what might have been different if a short burst of intensive and coordinated service could have been mobilized to support the family when Circling Star was only 13. For those of us who have the privilege to serve children, while investigations like this one can be difficult to read, it is critical that we always seek ways to improve. We have a responsibility to all families in Manitoba to identify gaps in each of our public services and then work with extreme focus to build stronger systems of support.

We are honoured to serve children, youth, young adults, and families in Manitoba. On behalf of my entire team we extend our deepest thanks to Circling Star’s family – thank you for helping us better understand your son. We hope that through his story and in his memory we honour him. For all who take the time to read this special report and reflect on its message, we encourage you to consider what role you can take in improving the lives of all children and youth in our province.

Daphne Penrose, MSW, RSW
Manitoba Advocate for Children and Youth
Methodology

The Manitoba Advocate for Children and Youth (the Advocate) is notified of all deaths of children, youth, and young adults up to age 21 in Manitoba. The Advocate holds the legal responsibility to assess each death and the discretion to further review or investigate the public services that were, or which should have been, providing support to the young person or their family.\(^1\)

The Office of the Children’s Advocate (now the Manitoba Advocate for Children and Youth) was notified of the death of Circling Star on June 24, 2016, the day he died. Following receipt of the official notification, it was determined that Circling Star’s death was in scope for review because CFS was involved with Circling Star and his family in the year before his death. As such, formal notification of the Advocate’s intent to conduct an investigation of services was sent to the CFS agency and the Southern First Nations Child and Family Services Authority (known as the “Southern First Nations Network of Care”). The investigation was assigned internally to an Investigator and a review was initiated under this office’s former legislated mandate.

The Investigators who completed this review requested, received, and subsequently reviewed many sources of information to create a complete picture of the public services received by Circling Star and his family prior to his death. The services reviewed for this investigation include those provided by:

- A CFS agency of the Southern First Nations Network of Care, which receives its mandate from the Manitoba Department of Families;
- The Addictions Foundation of Manitoba (AFM), an agency mandated by the Manitoba Department of Health, Seniors and Active Living;
- Circling Star’s High School, a secondary school under the authority of a School Division of the Manitoba Department of Education and Training, and
- Community and Youth Corrections, a division of the Manitoba Department of Justice.

Additionally, federally funded local health services in the area of mental health were included for context.

Files reviewed included the report of the medical examiner and autopsy and records under the authorities of: the Royal Canadian Mounted Police (RCMP); Department of Justice via Community and Youth Corrections; Department of Families via the CFS agency of the Southern First Nations Network of Care; Department of Health via the Addictions Foundation Manitoba (AFM); and Department of Education via Circling Star’s High School and School Division. Originals or copies of written records were reviewed by Investigators either at the organization in question’s office or at the Advocate’s office.

In addition to file reviews, one or more interviews were conducted with Circling Star’s probation officer, the CFS agency supervisor, the child protection worker, the family enhancement worker, the principal of Circling

\(^1\) See Appendix C, which provides further information about The Advocate for Children and Youth Act (ACYA). For information on the notification process and reports by the chief medical examiner to the Manitoba Advocate for Children and Youth, see The Fatality Inquiries Act, particularly s. 10(1-2).
Star’s Secondary School, Circling Star’s AFM counsellor, the mental wellness advisor of the federally funded local health service, the staff sergeant of the local RCMP detachment, and an educational consultant of the Department of Education. Interviews were conducted in person or over the phone. Hand-written notes were transcribed, becoming part of the official record of the Advocate.

In November 2017, the Advocate and staff travelled to Circling Star’s home community to spend time with his parents in order to gain a more complete understanding of Circling Star and the events of his life.

On March 15, 2018, The Advocate for Children and Youth Act (ACYA) was proclaimed and the scope of the investigation was broadened under the Advocate’s new mandate. Additional notifications were sent about the ongoing investigation and the Advocate’s intention to make this special report public. Formal notifications of the investigation and pending public special report were sent to the Manitoba Department of Health, Seniors and Active Living, the Manitoba Department of Justice and Attorney General, and to the Manitoba Department of Education and Training. An additional notification was sent to the Manitoba Department of Families that the Advocate intended to release a public special report following the investigation under section 31 of the new ACYA legislation.

Based on the broadened scope of investigation and evidence that emerged, additional file materials were reviewed and further interviews were conducted with AFM, the CFS agency, Circling Star’s school counsellor, his secondary school, and his school principal.

The Advocate and the two Deputy Advocates met with Circling Star’s mother in September 2018 to review a draft of this special report. An Elder was present to provide guidance on the process and support to Circling Star’s mother. Tobacco was offered to the Elder who assisted Circling Star’s mother through comfort care and smudging. The special report in its entirety was reviewed over seven hours. Circling Star’s mother provided additional information about the family’s perspective on services received and their memories of Circling Star. That additional information is reflected herein. During our meeting, the family gifted the Advocate their permission to use Circling Star’s Spirit Name for this public special report.

In the interest of administrative fairness, agencies that provided information for this investigation were given an opportunity to meet with the Advocate to review the findings, analysis, and recommendations specific to their service domain area in order to verify the accuracy of the information contained herein. An Elder opened these meetings and provided support throughout the discussion with each of the systems. In acknowledgement of the essential voice and value of Indigenous political leaders and governance systems, the Manitoba Advocate extended an invitation to the Grand Chief of the Southern Chiefs Organization to review this special report and its conclusions. The Advocate, members of her executive team, and an Elder from the Advocate’s office met with representation from the Grand Chief’s office prior to this special report being released to the public.

There are limitations to this investigation. The accuracy of our evidence relies on the completeness and accuracy of administrative records, the veracity of service providers in the additional information collected from them during interviews, and, when record-keeping is incomplete, the memory recall from
service providers who have been involved. While, in many cases, data was verified and cross-checked with multiple sources, this was not always possible.

There is an additional limitation imposed on the public, including staff at the Manitoba Advocate for Children and Youth by the federal Youth Criminal Justice Act (YCJA). The Advocate is prohibited from identifying any youth involved with the justice system, a system which is delivered provincially but regulated federally. Although the Manitoba Advocate is empowered by legislation to access and obtain any information from provincial systems, including the Manitoba Department of Justice, she is expressly prohibited from sharing that information with other systems or with the public until the information is anonymized. As such, when the Advocate determines an investigation will be released to the public, if that youth was involved with Justice, the Advocate must remove identifying information about the youth and their family from the special report. The alternative is to release a special report naming a youth, but removing all mention of their involvement with the Justice system.

In consultation with the family, the Advocate made the decision to release this special report using the youth’s Spirit Name, Circling Star.

With the proclamation of the Advocate’s new mandate provided by the ACYA, the Manitoba Advocate is empowered to monitor and report publicly on the level of compliance with recommendations made by the Advocate. Our office is also committed to improving public awareness and opportunities for public education. To that end, the Advocate has initiated processes whereby systems, which receive recommendations for change, will be required to report their progress to the Advocate every six months. Those updates will be analysed by our office and this analysis will be shared publicly so that Manitobans can further monitor improvements in publicly funded, child-serving systems.
Circling Star’s Story

CIRCLING STAR FROM BIRTH TO AGE 12

A Happy Youngster

According to his parents, Circling Star had a happy and playful childhood. The second of three boys in the family, he was known for his soft-spoken nature, “kind heart,” and thoughtfulness towards others. His parents spoke lovingly about their memories of Circling Star growing up in their rural community.

Circling Star looked up to his big brother. His mother told our office that when the boys were young, if you saw their oldest boy, you would always find Circling Star trailing along behind. “They loved each other,” his mom said with a smile, adding that his brothers affectionately called him “Chicano.” Circling Star’s parents described a boy who would happily wear an old jacket with a hole and give away his new one if he thought someone needed it. Circling Star was quieter than his brothers, and while there were times when his parents struggled in their relationship, they tried hard for the boys. During his childhood, Circling Star’s mother worked as a licensed practical nurse at the local health centre and at a hospital in a nearby town. His father worked in construction and other seasonal occupations which sometimes took him away from their home community.

Circling Star’s family spent a lot of time outdoors hunting and fishing. Circling Star learned these skills from his father from an early age. Circling Star’s mom said it was clear early on that he loved to hunt. She recounted a fond memory of when Circling Star, at 8 months old, was given a rib bone from a moose hunt. Circling Star gripped the foot-long rib with his little hands and gnawed away happily until it was clean, then he looked up at his mom asking for more. “He cleaned off three ribs before I told him that was all he could have,” his mom laughed. “He always loved to eat” (Interview, Circling Star’s mother, September 21, 2018).

Circling Star attended the local community school until completing Grade 8. He showed regular attendance at his elementary school and, while math proved to be one of his difficult subjects, he made regular academic progress and was well liked by others. “I think math was his favourite subject,” his mom told our office (Interview, Circling Star’s mother, September 21, 2018).

Circling Star’s cumulative education file, which was reviewed for this investigation, includes many positive comments from his teachers. In kindergarten, his teacher commented that Circling Star, “…was able to do more than required. He was a pleasure to have in class.” In Grade 5, he won an academic award. In Grade 7, Circling Star’s teacher wrote that he “…has a good attitude towards his studies. He works quietly and diligently on his assignments. He gets along well with his peers and enjoys school.” These comments continued through Grade 8, when his teacher noted that Circling Star, “…is a very pleasant young man who enjoys sports. He is still struggling with some math concepts.” Circling Star graduated from Grade 8 with final academic marks ranging from 68 to 74 percent and 93 percent in physical education. About math, his mom told us that he “…really liked math. I think it was one of his stronger classes. [Circling Star] and all the
boys always stayed and attended math classes after school” (Interview, Circling Star’s mother, September 21, 2018).

CIRCLING STAR AGE 13 YEARS

Circling Star Learns of his Biological Father

Circling Star’s family first came to the attention of a CFS agency of the Southern First Nations Network of Care on August 31, 2011, when Circling Star’s mother called to ask for help. Circling Star (age 13) had run away from home and was refusing to return. His mother told the CFS agency staff that she did not know how to manage Circling Star’s behaviour and she asked the agency to help her reach out to her son. Circling Star had recently discovered, from a non-family source, that the father he had known since birth was not his biological father. Instead, Circling Star’s biological father, who had not been involved in Circling Star’s life, was a well-known resident of his community known to the CFS agency due to a history of child protection concerns.

When Circling Star learned about the identity of his father, he reacted with anger. A counsellor in Circling Star’s life would later document: “[Circling Star] state [sic] bio dad tried to kill him when he was in his mom’s stomach. [Circling Star] hates that people think he looks/acts like his bio-dad.” Circling Star’s parents told our office during the course of this investigation that all of the subsequent difficulties that he faced were connected to this discovery, which had been shocking and difficult for him to process (Interview, Circling Star’s parents, November 16, 2017; Interview, AFM counsellor, December 5, 2017).

A week later, the CFS agency’s file notes stated that Circling Star was back home with his family and the crisis had been resolved. The CFS agency suggested the family participate in family group counselling, but the family declined. The family’s stated plan was to access federally-funded local health services and to involve Circling Star with the counsellor that came to the community. The CFS intake file was closed on November 29, 2011, without further contact made with Circling Star or his family. The family did not pursue counselling (Interview, Circling Star’s parents, November 16, 2017). Circling Star’s mom explained that their decision to not arrange counselling was because Circling Star had not wanted to go. He told his mom: “If I can’t talk to you about my anger issues, then who can I talk to?” (Interview, Circling Star’s mother, September 21, 2018).

CIRCLING STAR AGE 14 YEARS

Circling Star Enters a New School and Meets Teacher X

A year later, in September 2012, Circling Star began attending high school a 40-minute bus ride from his home community. The new school he attended was in a School Division where many students are bussed in from a number of outlying areas.

Students entering the school bring a variety of academic levels, but most have been assessed below their academic grade level. The reading range for students entering Grade 9 varies from Grade 2 to Grade 9 with
the average reading level of Grade 6 upon high school entry. Academically, the school viewed Circling Star as average among his peers (Interview, Circling Star’s principal, Secondary School, December 5, 2017 and May 17, 2018). However, although Circling Star had been described recently as “pleasant” by his Grade 8 teacher and had previously received academic achievement awards, Circling Star encountered significant struggles in his new environment.

Circling Star’s Grade 9 year from 2012-2013 was marked by repeated suspensions. His first recorded discipline referral form, which includes a checklist of possible infractions for the teacher to fill in, was sent to the principal as the year began, on September 20, 2012. The teacher who completed the form outlined that Circling Star had come to class without his books, got up in the middle of class to get his books, and would not comply with Teacher X’s directive. The teacher wrote that he instructed Circling Star to “hold on for a moment, [but Circling Star] just walked out like I didn’t exist.” When Teacher X talked to Circling Star at the end of class, Teacher X noted that Circling Star “found it funny.” Later that day, Teacher X wrote that he had observed Circling Star in the hall wearing a hat, which was not allowed according to school rules. When Teacher X called Circling Star over, Circling Star was noted to have run from him, hid the hat, and then refused to turn it over. On the discipline referral form, Teacher X described Circling Star’s behaviour as “disruptive” and a “refusal to comply with teacher instructions.”

Four days later, Teacher X had another encounter with Circling Star. On September 24, 2012, Teacher X reported via another discipline referral form that Circling Star refused to stand for O Canada, refused to take his hood off in class, and later that day refused to remove his hat. He was described by Teacher X as “rude and defiant” and was given his first one-day suspension. By September 26, 2018, Teacher X suggested that a “threat assessment be started on student.” A threat assessment is an assessment procedure that can be triggered when staff have safety concerns.

Circling Star’s mother provided additional context for why it seemed that this particular teacher in the school was so quick to single-out and discipline Circling Star. According to Circling Star’s mother, Teacher X decided before Circling Star arrived that he would get into as much trouble as his older brother. “He had already labelled him,” Circling Star’s mom told us. She shared that Circling Star’s dad rarely travels without a bandana and his boys also wore them, which the school interpreted as the family being gang-involved. “It wasn’t true,” Circling Star’s mom told our team, “but they were accused by the teacher...he already labelled him before he started” (Interview, Circling Star’s mother, September 21, 2018).

**Suspended from School, Charged with Arson**

Circling Star received his first school suspension. While out of school, he was involved in setting a fire that significantly damaged community property.

A few days later, Circling Star and a second youth confessed to the school counsellor and asked for her help in going to the Royal Canadian Mounted Police (RCMP). Circling Star and a friend were charged criminally under s.434 of the *Criminal Code: Arson-damage to property*. 
There are differing versions of the events; however, it appears that alcohol and drugs were a factor in the incident. This was Circling Star’s first recorded involvement with police. His mother shared that the fire was the result of Circling Star being “tested” by his friends and from his desire to fit in with a crowd. She noted that the boys had been smoking cannabis, that Circling Star had lit a garbage can on fire, and that the fire had quickly become out of control.

Circling Star was arrested and released into the community, bound by a recognizance. The recognizance allowed Circling Star to be in the community until his charges were dealt with, provided he abided by the conditions listed below:

- Attend Court [in November 2012] at 10:00 a.m.
- Keep the peace and be of good behaviour, which includes not causing a public disturbance, and obeying all laws and regulations and any applicable court order
- Attend court dates as ordered
- Live with his parents
- Not live at a different address unless a Judge has first granted permission
- Go to school regularly
- Not contact [name removed] or [name removed], except at school in classes, no other communication with the named individuals by telephone, e-mail, mail, or in any other way or have another person communicate with them on his behalf
- Be at his home address – 24 hour house arrest
- May be away from designated home address during curfew hours:
  - When under the direct supervision of his parents
  - In the event of a medical emergency involving him or a member of his immediate family
  - Going to school
- Come to the door of the designated home address or answer the telephone if any peace officer was to conduct a curfew check

Within three weeks of entering high school, the “pleasant student” with the “cooperative” attitude was transformed. The review of Circling Star’s school file revealed a concerning pattern over the remainder of that year, with Circling Star receiving eight suspensions for a total of 20 days removed from school. Almost all of the suspensions were initiated by one teacher, Teacher X, and supported by the principal; one other teacher suspended Circling Star for 2 days in response to Circling Star skipping class in May 2013. There were no discipline referrals from his other teachers in the file from his first year (see Appendix D: School Suspension History).
Circling Star’s school file did not record any efforts on the part of the school to mediate the escalating power struggle between Circling Star and Teacher X. All of the recorded incidents placed responsibility solely on Circling Star for the events that led up to his many suspensions, and described only the changes that were required from Circling Star to change his behaviour and attitude. This punitive approach did not reflect a commitment to trying to understand a student who was clearly struggling and the school’s approach was ultimately not effective in engaging Circling Star, in changing his behaviour, or increasing his chances of academic success. Instead, Circling Star was left to battle it out with a teacher who was authoritarian and punitive when a student did not obey his directions and who also held significant power over Circling Star’s involvement in the school.

There are many alternatives to suspensions. Manitoba Education and Training’s *Provincial Code of Conduct, Safe and Caring Schools, Appropriate Interventions and Disciplinary Consequences* (2017) outlines multiple “disciplinary consequences that emphasize positive and proactive strategies that foster student learning, as opposed to punitive and reactive strategies. Negative consequences may be necessary when other approaches to problem behaviour are unsuccessful; however, they are not effective when overused” (p. 5).

Circling Star’s behaviour escalated from arguments over standing for the anthem and wearing his hat, to swearing and allegedly using gang signs, characterized by Teacher X as intimidation, resulting in further suspensions. On Oct 10, 2012, Teacher X wrote, “recommends suspension for [Circling Star] (not sure how long he is up for).” The infraction checked on the form was, “late for class.”

On November 21, 2012, Circling Star attended school intoxicated. He received a five-day suspension from the principal and an additional five-day suspension from the superintendent. Although provincial education policy states: “Written Behaviour Intervention Plans shall be developed for students who have been suspended out of school more than twice during a given academic year” (Manitoba Education, Citizenship and Youth, 2007), there was no intervention plan found on Circling Star’s school file in the 2012-2013 year. Education policy also requires notification to the parents or guardian of the student within 24 hours of a suspension; no records were kept on Circling Star’s file of notices to his parents. Circling Star’s mother recalled two meetings that were scheduled with the school; neither of these meetings were documented by the school and it is unclear to the Advocate who may have attended in addition to Circling Star’s parents (Interview, Circling Star’s mother, September 21, 2018).

The school file contained no indication of attempts to mediate the continued conflict between Circling Star and Teacher X, no indication of any recognition that the teacher may have been acting inappropriately, and no indication of effort made to help Circling Star adjust in a more positive way to his new school. Over the course of his Grade 9 year, Circling Star achieved six credits with marks in the 50 to 60 percent range except for a class called Transitional Math, where he scored 75 percent (Circling Star, cumulative file, Secondary School).
Circling Star’s Addiction Issues Emerge and Escalate

In October 2012, Circling Star (age 14) began meeting with an Addictions Foundation of Manitoba (AFM) counsellor after a referral was made by his high school. The AFM counsellor was located within the school. In Manitoba, 43 of the 263 schools have in-school AFM services; Circling Star’s high school paid for the services of an AFM counsellor one day per week (Interview, AFM staff, December 5, 2017). Circling Star and his AFM counsellor developed an enduring counselling relationship over 36 one-on-one sessions between October 2012 and August 2015. Throughout those three years, Circling Star’s AFM counsellor documented his use of alcohol and other drugs, painting a concerning picture of the escalating addiction of a young person.

The AFM file indicates that with respect to alcohol, Circling Star was never able to maintain more than short periods of sobriety during this time. In his first AFM session in 2012, he described his alcohol use as two to three times a month including an episode of blacking out after drinking 26 ounces of whiskey five weeks earlier. By September of 2013, Circling Star disclosed that he and others drank 60 ounces in one hour. His AFM counsellor warned him of the potential for alcohol poisoning. His use of cannabis varied, but escalated from about half a gram daily in 2012 when he was 14, to 6-8 grams daily in 2015 at the age of 17. During his first session, Circling Star shared with his AFM worker that, at 14 years of age, he used cocaine and prescription drugs. While Circling Star was noted to acknowledge cocaine and prescription drugs as potentially harmful and was working to limit his use of them, he did not develop any intent to limit his use of cannabis or alcohol.

As outlined in their policy, the information that AFM gathers is not shared. Therefore, AFM never shared with Circling Star’s parents that Circling Star (age 14) was describing regular use of cannabis, episodes of alcohol use to the point of blackout, and the use of cocaine and prescription drugs. In fact, while AFM documented this decline during the three years in which they provided counselling to Circling Star, they made outside referrals for additional supports only when their concerns were related to abuse, homelessness, and mental health. Over the years of their involvement, AFM did not view Circling Star’s increasing drug and alcohol use as a protection concern, despite the regular disclosures Circling Star was making that detailed his ongoing risk and compromised safety in the community.

AFM’s policies regarding youth disclosures and obligations to report were reviewed as part of this investigation.

AFM’s position is that client engagement is a key priority, but their policy also acknowledges the important role parents and guardians play in the safe care and recovery for youth who use what AFM terms “alcohol, other drugs, and gambling” or AODG:

We recognize the high risks that youth involved with AODG face, the wishes of many parents, guardians or other youth service providers, and the reality that abstinence would be the ideal for this population. However, when a youth client does not want to quit their involvement, rather than impose external expectations and risk pushing the client away, we engage them and work to
motivate them toward less harmful choices. We encourage the involvement of parents, guardians and significant others in the youth’s lives and provide information and programs on how to understand what is going on with their young person, and how to communicate more effectively and how to cope with the difficult feelings experienced by a parent/significant other whose child may be having problems associated with AODG (p.23).

Despite their own policies about the involvement of parents, Circling Star’s AFM counsellor did not involve Circling Star’s parents in the ongoing counselling relationship notwithstanding the fact that this level of addiction at age 14 could have been interpreted as a serious threat to his health and safety. Circling Star’s parents were not aware of the extent to which Circling Star was using alcohol and other drugs. Regarding cannabis, “I knew he did,” his mother told our office, “...there was always speculation” (Interview, Circling Star’s mother, September 21, 2018). She indicated she had been unaware of the other drugs and the levels of alcohol he was using.

In line with AFM’s approach, Circling Star’s AFM file did not clearly outline treatment goals or document progress towards goals. Rather, it recorded his usage, considered what his current level of involvement was, and assessed a stage of change². Circling Star’s level of involvement was rated as harmful or dependent 23 times out of 24 ratings in the record from October 2012 to June 2015. His stage of change was most often regarded as pre-contemplative in the areas of alcohol and cannabis. As he usually had no goal to reduce his usage, particularly of cannabis, the counsellor continued building a relationship and providing information.

Circling Star’s time with the counsellor included, for example, encouragement to continue with his efforts in school, strategies to control his impulsivity, examination of the use of power in family and intimate relationships, and safety planning for the use of alcohol. As noted above, there was no involvement of Circling Star’s parents or significant others. In Winnipeg, parent programs, family therapy, and parent intervention and support are offered to family members and others who are close to the youth receiving treatment (Interview, AFM staff, May 10, 2018). AFM offers no equivalent service to Manitoba families in rural and remote locations. In addition, Circling Star’s counsellor indicated to our office that AFM is not involved with parents because AFM reports to the school, which they consider the initial source of their referral (Interview, AFM staff, December 5, 2017). Our investigation revealed that the school kept AFM apprised of when Circling Star was suspended. However, there was no evidence on either the school file or the AFM file that the AFM counsellor’s conversations with Circling Star’s school included any detail about Circling Star’s drug and alcohol use, or other concerns that were affecting his safety in the community.

The implementation of the AFM policy that restricted information sharing meant that the AFM counsellor was the only person in Circling Star’s life with the knowledge of his significant and escalating addiction issues. This was a missed opportunity to create a wider circle of care around Circling Star that could have contributed to a greater coordinated and sustained effort to support him. Having an AFM service provider in

² The stages of change approach is widely adopted by addictions agencies across Canada as a practice model for service delivery. For more information, see the Addictions Foundation of Manitoba, “Stages of change,” https://afm.mb.ca/wp-content/uploads/2013/03/Stages-of-Change5.pdf
the school was convenient for Circling Star; however, he could not access services while he was suspended or during the summer.

**A Conviction for Arson and the Start of Probation**

At some point in the court process, Circling Star pled guilty to the arson charge, which resulted in a Gladue pre-sentence report (PSR) being ordered. The Gladue PSR is a common legal practice that provides important information to judges about the individual’s Indigenous history, including the historical impacts of colonization and residential schools, for consideration prior to delivering a sentence on a conviction.

On February 27, 2013, Circling Star appeared in provincial court, was convicted, and was sentenced to a 12-month supervised probation order beginning February 27, 2013, and set to expire February 26, 2014. In his Gladue PSR, Circling Star was described as believing “he has problems with drugs and alcohol” (p. 8). He added that, “the amount of alcohol, drugs and pills being used in [my home community] does have a negative impact on me.” He also said, “seeing it all around me, all the empty baggies and beer cans, it’s hard to deal with, but I’m trying my hardest to avoid it” (p. 8). Circling Star’s mother confirmed that Circling Star was around quite a bit of drinking and occasional drug use from family and community members. She acknowledged that Circling Star’s dad has a reputation for being tough, but notwithstanding his own history of involvement with the justice system, “he’s not like that” (Interview, Circling Star’s mother, September 21, 2018).

Circling Star received one year of probation with the conditions that he:

- keep the peace;
- report to the probation officer as required;
- attend school and follow rules;
- attend and participate in addictions assessment and counselling and any or all other counselling;
- have no contact with two named youth;
- observe a curfew from 10:00 p.m. to 6:00 a.m., unless he was with his parents;
- abstain from alcohol and drugs; and
- complete 120 hours of community service.

Circling Star began meeting with his probation officer on March 4, 2013. Circling Star’s mom was initially in regular contact with the probation officer and supported efforts to have Circling Star meet his conditions. Despite his probation conditions, Circling Star’s school attendance and other imposed requirements did not improve. His probation file notes in April 2013 that Circling Star attended eight out of a possible 20 days of school. Circling Star’s school attendance remained erratic and other behaviour also appeared unchanged.

Following his sentencing, Circling Star continued seeing the school-based AFM counsellor. In April 2013, his AFM file notes that despite his court-imposed conditions, he reported daily use of 1-2 grams of cannabis, misuse of prescription medication, and drinking several times a week. There was no reporting relationship or collaboration between Circling Star’s AFM worker and his probation officer. AFM remained steadfast in
their position of not sharing any information without client permission beyond confirming attendance at AFM sessions.

During that time, according to the probation file, his living arrangements were unstable due to conflict at home between Circling Star and his parents. In early April 2013, Circling Star’s mother told the probation officer that her son was living with his maternal grandparents. However, at the end of April 2013, a family member of Circling Star said that he had been living with them for the past two months. By mid-May 2013, Circling Star had returned to living with his parents, but, by July 2013, he was again staying at the home of his grandparents. The reasons for this movement were attributed to Circling Star’s lack of willingness to follow house rules, attend school, and respect others.

By June 2013, Circling Star was talking separately to both AFM and probation services about being gang-involved. The AFM counsellor noted in her file that Circling Star said he was making “lots of money.” He admitted that his attitude was, “I’ll do what I want.” However, his outlook on life had taken a down turn. He spoke of feeling that “no one cares” about him. In his discussion of gangs, alcohol and drug use, family issues, violence, and death he seemed resigned to the outlook that, “This is reserve life.” Within his community, Circling Star talked about being called a “terrorist” for his role in the fire he started and for which he was convicted. He also spoke of not being afraid anymore and of being willing to die for the gang. He admitted to heavy alcohol use.

Circling Star’s probability to reoffend was assessed as high by probation services, and as such, on June 19, 2013, Circling Star was directed to participate in the Intensive Supervision and Support Program (ISSP) of probation services. ISSP staff have the advantage of being available at critical times such as evenings and weekends to make and receive contacts with youth. The degree to which they are engaged with the youth on their caseload varies. The requirements of Circling Star’s ISSP were: daily reporting by phone between 8 p.m. and 10 p.m., complying with a curfew from 10 p.m. to 6 a.m., and weekly in-person reports to the ISSP worker. In Circling Star’s case, his requirement for weekly in-person reports with his probation worker was altered to bi-weekly reporting, “due to distance” of the probation worker. The ISSP worker travelled to the community to meet with Circling Star (Written communication, probation officer, June 20, 2018).

**CIRCLING STAR AGE 15**

**Circling Star Struggles to Meet Conditions of Probation; His Addiction Escalates**

In August and September 2013, the ISSP worker reported that Circling Star did not call to report as required on five occasions and missed the call for curfew twice. The ISSP worker also reported Circling Star’s assurance that he was fully compliant with the court condition that he abstain from alcohol and drugs, which was in contrast to his confession to the AFM counsellor on September 12, 2013, that his drug and alcohol use had increased during the summer. When Circling Star’s probation officer discovered that the
ISSP worker was rarely having any contact with Circling Star, a different ISSP worker was assigned. By the October ISSP report, Circling Star’s non-compliance with the conditions of his probation related to school attendance and alcohol and drug abstinence were noted (Circling Star, probation file).

Circling Star’s mother participated with Circling Star in meetings with the probation officer twice over the summer. However, her involvement declined, she missed a scheduled appointment, and the probation file noted that she was not responsive to telephone messages. The probation officer recorded in her notes that Circling Star’s mother was not holding Circling Star responsible for his actions. When we spoke with Circling Star’s mother during the course of this investigation, she described one meeting when Circling Star was so upset he had to walk out to compose himself following an offensive comment made by the probation officer. Circling Star’s mother told our office that at that point, Circling Star stood up and left the meeting, and his mother, “vibrating” from her anger related to the offensive comment, chastised the probation officer stating: “You shouldn’t trigger him like that” (Interview, Circling Star’s mother, September 21, 2018). She informed our office that this was the final time she attended a meeting with the probation officer.

During the next several months, Circling Star maintained his contact with probation services and AFM. His school attendance continued to be irregular, however Circling Star reportedly shared with his counsellor that he felt his school was trying to support him (AFM file note, October 10, 2013).

In contrast to what Circling Star shared with the AFM counsellor, the ongoing conflict between him and Teacher X continued to escalate, resulting in suspensions. In September 2013, Circling Star was suspended for having brass knuckles at school. His school file included a Behaviour Intervention Plan (BIP) dated October 3, 2013, which was developed by the principal, resource teacher, counsellor, resource supervisor, school psychologist, and the AFM counsellor. Neither Circling Star, his parents, nor Teacher X were included in the planning session. “I can’t remember that they ever invited us,” Circling Star’s mother told our office (Interview, Circling Star’s mother, September 21, 2018).

The development of the BIP did not engage Circling Star, did not acknowledge or address the conflict with Teacher X, and did not seek any parental involvement. Further, the plan did not have specific and measurable objectives, did not attribute responsibility for action items, and did not include a timeline. This would have made it impossible to evaluate or measure any progress. The BIP outlined behavioural objectives the school had for Circling Star and some practices to be used in the short and long term. As outlined in the table below, the onus was on Circling Star, the child, to change the situation without assigning tasks and supports to anyone else to increase his opportunities for success. As a result, there is no indication anyone completed any of the tasks outlined below.
On October 18, 2013, Circling Star’s file notes that he attended school while intoxicated and physically shoved the principal. No further details were provided. As a result of this incident, the school suspended him immediately for five days and the superintendent imposed a further suspension of six weeks until December 16, 2013, when a re-entry meeting would be held. The school file noted that referrals to AFM and the school counsellor would occur; however, Circling Star was already involved with both services. The school counsellor did not keep a written record of her involvement with Circling Star.

During Circling Star’s suspensions, the school provided work for him to complete at home. Although the school record does not indicate any conditions for his return to school, Circling Star’s probation file indicates that Circling Star’s return to school was dependent on his completion of the assigned work. No notes of a December re-entry meeting were presented for review during this investigation. It is clear that Circling Star did not return to school until February 3, 2014, an absence of three and a half months from October 18, 2013 to February 3, 2014. There was no file documentation from the school division to indicate a further suspension.

When interviewed during this investigation, Circling Star’s parents provided additional information that was missing from the school file. They said that it was determined Circling Star would not be able to re-enter classes in December since he would have been so far behind his classmates after such a long suspension.
“We were just waiting for the second semester to start because he wouldn’t have been able to catch up” (Interview, Circling Star’s mother, September 21, 2018).

The school file included a re-entry contract dated February 3, 2014, outlining the following behaviour expectations for Circling Star:

- Regular and punctual attendance;
- Regular and consistent completion of assignments;
- Proper behaviour in accordance with classroom/school/divisional rules and policies;
- Eliminate all forms of unacceptable behaviour;
- Refrain from any sort of criminal activity that is in violation of the school’s code of conduct; and
- Commit to meet with individuals providing support services when required.

Circling Star, his mother, the principal, and the school counsellor signed this re-entry contract, which further stated:

Following our team meeting, I have informed [name of principal] that I will follow the School and Division’s Code of Conduct as it pertains to the safety of everyone else in the building. I do promise to adhere to the school’s Code of Conduct and the terms of this contract, which has been implemented to ensure the safety of all students, including me at [name of school].

Should I, [Circling Star], fail to meet any of the conditions as outlined above, then [School Division Policy] (2009), will be followed and I may be asked to withdraw from all classes and jeopardize future attempts to re-register or be put on an alternative program setting, home placement.

Circling Star’s probation officer recorded that Circling Star “continues to lack the motivation to change his situation” (Probation file, June 13, 2013). Circling Star’s period of probation officially ended in February 2014. According to his probation file, he had completed no more than 80 of the 120 mandated community service hours.³ A review of his year on probation demonstrates that the period of probation was not effective in changing Circling Star’s behaviour, and that he had not been effectively supported to fulfil the terms of his conditions. Circling Star did not live at home, he did not consistently abstain from alcohol and drugs, he did not regularly attend school and follow educational rules, and he completed an uncertain number of his assigned community service hours (Circling Star, ISSP Progress Reports). He was breached once in June 2013 by his probation officer for failing to regularly attend school and AFM counselling.

In February 2014, Circling Star’s closing summary for his probation file noted that he was motivated to complete school work and had enrolled in several classes. However, it was also noted by probation services

³ The file record includes contradictory accounts of the number of completed service hours, ranging from zero to 80.
that the family was experiencing problems and a CFS agency was involved. Unfortunately, there is no indication in the CFS agency’s records that they had involvement at this time, and no documentation of any family challenges at this time.

**Out of School and a Missed Mental Health Referral**

Following the conclusion of his probation, Circling Star continued seeing his school-based AFM counsellor. Over several weeks of meeting with the AFM counsellor, Circling Star completed the *Personal Experience Inventory* tool that AFM uses for assessment. This inventory is widely used in substance misuse treatment programs for assessing adolescent chemical dependency and psychosocial risk.4

On March 25, 2014, Circling Star’s inventory was analysed and the AFM counsellor noted concern in two areas. The inventory suggested that a psychiatric referral would be appropriate for Circling Star. It also indicated some potential for suicide.

On April 10, 2014, Circling Star was noted to have said to his AFM worker, “I have nothing to live for.” Although permissions are not required to disclose suicide risk, the AFM worker first obtained permission from both Circling Star and his mother prior to making a referral to a community mental health service in a town two hours away on April 11, 2014.

The referral included the troubling information that Circling Star, “feels someone else is controlling his mind, that his mind doesn’t seem to work quite right, he is bothered by headaches, has trouble sleeping, bothered by strange thoughts, thoughts are confused or go too fast.” Given Circling Star lived in a First Nations community, we were informed that the AFM referral was subsequently redirected by the provincially-funded community mental health service in the outside town, to the federally funded local health service provider. Although there is no policy or procedure directly governing the practice, provincial child and adolescent mental health service providers informed our office that they act to respect and promote utilization of Indigenous resources when possible (Interview, patient services representative, Health Authority, April 26, 2018).

Subsequently, the AFM counsellor informed Circling Star’s mother that she made the referral to the federally funded local health service provider and they opened a file on April 24, 2014 (Interview, local health service, December 7, 2017). The information Circling Star’s mother provided was that she was,

> “My life would be better if I was dead.”
> 
> AFM File
> April 24, 2014

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4 The Personal Experience Inventory tool is “a self-report inventory [that] documents the onset, nature, degree, and duration of chemical involvement in 12- to 18-year-olds and identifies personal risk factors that may precipitate or sustain substance abuse. In addition, six problem screens alert you to the possibility of family chemical dependency, sexual abuse, physical abuse, eating disorder, suicide potential, and need for psychiatric referral.” (National Institute on Alcohol Abuse and Alcoholism, 2003)
“concerned about son’s safety and anger issues” (Interview, local health service, June 14, 2018). None of the more detailed information on the seriousness of Circling Star’s mental health concerns were provided to the federally funded local health service. There is no documentation to indicate that Circling Star’s mother was given any information related to the concerns identified by the AFM counsellor. Circling Star’s mother expressed shock on learning the extent of what her son had shared with AFM. “I didn’t know it was that bad at the time,” she told our office (Interview, September 21, 2018).

According to community sources, members of the community are told they must utilize local band resources. Unfortunately, for quite a while, those resources were noted to have been unreliable. Although scheduled to be in the community every week, community members indicated incoming counsellors would often cancel travel plans to the community due to sickness, rescheduling, or travel conditions. At times, we were informed the community would go for several months without a counsellor working in the community, and often new counsellors would arrive, impacting continuity of treatment plans.

By May 2014, Circling Star was again required to do his schoolwork at home and asked not to return until the 2014 fall semester. He was placed on a home school program for his behaviour, including an aggressive attitude toward an unnamed teacher. Although this direction was recorded on a suspension report form, the principal did not consider this a regular suspension because the form indicated that Circling Star was welcome to receive continued support services in the school by appointment. There was no notice to his parents, nor a notification from the school division of a suspension greater than five days included on the school file, as required by policy. This was Circling Star’s sixth school-directed period of absence for 2013-2014, bringing the total of days he was out of school to 70 for this school year alone (See Appendix D: School Suspension History).

**Circling Star - Age 16**

**No Recognized Risk in Unstable or Volatile Living Arrangements**

On September 3, 2014, although Circling Star was no longer on probation, Circling Star’s grandfather notified the probation officer that he and Circling Star’s grandmother were caring for Circling Star, as he had been “kicked out” by his father. This information was not forwarded to CFS authorities. Circling Star’s school file included a document signed by his mother and witnessed by a Commissioner of Oaths that Circling Star’s mother had given legal guardianship to his grandparents, effective August 2014. Circling Star’s mother noted that this was for practical reasons, “So he could get his welfare and child tax [benefit]”, she said (Interview, Circling Star’s mother, September 21, 2018).

On September 23, 2014, Circling Star was involved in an incident with Teacher X. When Circling Star returned to class after lunch, he was reported to have exhibited threatening behaviour described as “gang signs and stare down” (Cumulative school file, September 27, 2016). For this, he was suspended for three days. As Circling Star was getting on the bus at the end of that day, he was quoted as telling the principal in response to his suspension, “I will give you a reason to expel me when I come back on Monday”
(Cumulative school file, October 22, 2016). Each of these incidents on September 23, 2014, resulted in separate threat assessments.\(^5\)

The following day, on September 24, 2014, a CFS agency of the Southern First Nations Network of Care received a report from Circling Star’s school that Circling Star had been out of school all week and that he had been kicked out of his grandparents’ home. He was described by the source of referral as very angry and aggressive, and his elderly grandparents were noted to be fearful for their safety. An intake file was opened by the CFS agency and a Family Enhancement/Prevention (FE) worker met with Circling Star’s grandparents the following day. The FE worker’s notes described Circling Star as a child who was “angry,” “aggressive,” “using drugs,” and “deliberately trying to get himself expelled.” The FE worker advised the grandparents to send Circling Star back to his parents. The grandparents reported they had not had contact with Circling Star’s mother for two months, that Circling Star had left their home “the other day”, and that his current whereabouts were not known. The FE worker then found Circling Star at the home of his girlfriend’s grandmother (“R family”). The grandmother’s partner agreed to look after Circling Star if he was able to obtain social assistance for Circling Star and if he could receive Circling Star’s Child Tax Benefit. The FE worker advised that he was able to do so. Circling Star agreed with this plan as a private arrangement. The FE worker concluded the intake and closed the CFS agency’s file.

Instead of intervening to address the apparent breakdown in Circling Star’s primary and extended family arrangements, the agency saw no role for itself. And despite the fact that Circling Star’s legal guardianship was still with his family, the CFS agency supported Circling Star’s (age 16) decision not to return to his home and not to live in the alternative family placement that his parents had arranged. Instead, the CFS agency facilitated Circling Star’s wish to live with his then 15-year-old girlfriend, and her family. The CFS agency did not have the legal authority to make a private arrangement since legal guardians must approve legal arrangements. Further, the CFS agency did not have the authority to indicate Circling Star’s child tax benefit could be redirected to his girlfriend’s family.

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5 As explained above, a threat assessment is an assessment procedure that can be triggered when staff are concerned about safety.
Comments in the CFS agency worker’s handwritten notes from a September 25, 2014, interview with Circling Star’s grandparents reflect the grandparents’ concern that Circling Star’s “[dad] was abusive” and that Circling Star was using drugs. In relation to the note regarding Circling Star’s dad being abusive, no further details were written and no context was explained. These concerns were not assessed by the CFS agency.

Further, the abuse allegation was not included in the Child and Family Service Applications (CFSA) electronic record and appear only in the CFS worker’s handwritten notes on the physical file. When asked about the allegation of abuse, the current CFS agency worker indicated no knowledge of such allegations (Interview, CFS agency staff, November 22, 2017). The Safety Assessment completed for the intake from this day includes no indication of the alleged safety concerns.

The intake was concluded/closed by the CFS agency on September 25, 2014. There was no recorded exploration of why Circling Star was not living at home, and no noted concern about the reported high risk behaviours. The failure to respond to a report about the safety of a child is of serious concern. Further, the complete transcription of handwritten notes into the electronic record is a necessary requirement for mandated CFS agencies in Manitoba. Instead of closing the file, the CFS agency should have investigated the abuse allegations, assessed both Circling Star and his family, and facilitated a collaborative meeting with stakeholders to discuss and resolve concerns. This pattern of Circling Star locating his own placements and the CFS agency following behind, endorsing his choices, was repeated throughout the CFS agency’s service provision, even when those placements were not safe.

Circling Star’s involvement in school continued to decline. On September 27, 2014, the school conducted a threat assessment of Circling Star’s noontime behaviour on September 23, 2014. The School Division’s Policy requires that perceived threats are assessed by a threat assessment team and outlines subsequent protocols for each level of assessed risk – low, medium, or high. The gang signs and “stare down” incident was assessed as “Worrisome Behaviours (LOW)” of minimal risk to students and staff.

On October 3, 2014, the Designated Intake Agency (DIA) for the region, received a call with a concern that Circling Star (age 16) had been asked to leave his grandparents’ home because he had been stealing from them. Circling Star had been suspended from school and the source of referral reported that he was possibly living with his girlfriend. The DIA notified the CFS agency that Circling Star’s caregivers were unable or unwilling to provide for him. The Safety Assessment portion of the intake completed by the DIA on
October 7, 2014, notes that “Caregiver(s) have not, will not, or are unable to meet the children’s immediate needs for food, clothing, shelter, and/or medical care.”

The CFS agency’s FE worker made several attempts to locate Circling Star and, after three days, on October 9, 2014, found him staying at the home of his biological father. His biological father was known to the CFS agency. He and his current partner had a history of significant child protection concerns and were prohibited from having children in their care. The FE worker spoke with Circling Star and he agreed to return to his grandparents. The FE worker and Circling Star then went to his grandparents’ home to discuss Circling Star’s possible return. Circling Star’s grandparents agreed to Circling Star’s return, and he was subsequently left in their home. This action was in keeping with the August 2014 private arrangement made by Circling Star’s mother. However, the file recording does not indicate what discussion, if any, took place related to the issues Circling Star and his grandparents were experiencing or the uncertain relationship with Circling Star’s mother. The Child and Family Services Applications (CFSA) record did not include details of a safety plan, an assessment, or supports provided. The CFS intake was concluded on October 10, 2014, with a supervisor note stating that the issues were addressed in the required time.

**Couch-Surfing, a Break-Up, and an Overnight Admission for Suicidal Thoughts**

Ten days later, on October 19, 2014, Circling Star (age 16), was admitted to an acute mental health facility. He had been found by a security guard at night on a local beach. Circling Star accepted the offer of help and was escorted by the RCMP to the mental health facility in a different community. As recorded in the acute mental health facility’s discharge summary on the AFM file, according to Circling Star, he and his girlfriend had just broken up. He explained that he had to leave his parents’ home because his mother did not approve of his girlfriend and, more recently, he had to leave his grandparents’ home for the same reason. He reported staying at his “girlfriend’s or spent nights on the street.” The discharge summary also stated:

[Circling Star] reported feeling that he had lost his whole family when choosing his girlfriend and now he felt he had no one. [Circling Star] reported feeling like he wanted to end his life. [Circling Star] reported that he had tried to hurt himself by throwing himself off his bike a few times and then went to the beach where he thought about trying to drown himself (p.1).

Circling Star’s mother recalled that night, when asked about it during the course of this investigation. She said Circling Star had been struggling. “He was trying to hang himself that night too,” she shared. She
described that during that time, Circling Star would often ask her for money, and while she knew he was not always using it for food, she would still give him what money she could. She described how hard it was to watch her son hurting. “Later, we made him care packages instead of giving him money,” she added (Interview, Circling Star’s mother, September 21, 2018).

Circling Star discharged himself from the acute mental health facility the next day, on October 20, 2014, and his grandfather picked him up. The brevity of his stay resulted in limited assessment. The discharge plan, which was dictated two months later, on December 17, and transcribed on December 19, 2014, recommended follow up with a counsellor or Elder in the community, follow up with the AFM counsellor, and utilization of the acute mental health facility’s Crisis Stabilization Unit for crisis support as needed. The summary was sent to the school counsellor and to the AFM counsellor for the area. The CFS agency had no open file or active intake at the time and, like Circling Star’s parents and grandparents, who were the legal guardians at this time, did not receive the discharge information.

While Circling Star’s stay at the acute mental health facility was brief, the discharge summary noted that he “did not have a permanent residence at the time of admission” and “[Circling Star] has a history of significant drug use (mostly marijuana) and has seen an Addictions Foundation of Manitoba (AFM) worker in the past regarding same. He is aware he needs to decrease his substance use.” Although page one of the discharge summary reports that, “Grandparents were refusing to have [Circling Star] return until he received treatment,” page two includes the statement: “It is assumed that [Circling Star] would return to live with grandparents.”

There is no indication that Circling Star was involved in his discharge plan or aware of the suggestions it offered for further support. On October 20, 2014, the acute mental health facility contacted Circling Star’s AFM counsellor indicating that Circling Star had given permission for them to share a copy of Circling Star’s discharge summary with AFM and his school and that “a package would be sent.” The acute mental health facility recommended that Circling Star set up an appointment with his AFM counsellor, and explained that information had been given to Circling Star’s grandfather to facilitate booking an appointment. The promised “package” appears to have been the discharge summary which was dictated on December 17, 2014; transcribed on December 19, 2014; and sent to the school and AFM two months after Circling Star’s discharge. This information, relevant in October of 2014, would have only been available to Circling Star’s supports in January of 2015 when school resumed after Christmas break.

Circling Star’s interaction with this acute mental health facility is another example of a missed opportunity. On October 20, 2014, Circling Star (age 16) was released from treatment having significant substance misuse issues, a recent suicidal episode, no stable placement (meaning he was homeless), and no safety net in place for him. Circling Star was picked up by his grandfather who wanted him to get treatment but was given a card to contact AFM instead. The discharge summary was not provided to Circling Star’s parent or guardian and no CFS referral was made, even though there was a legal duty to report to the CFS agency due to assessed or known safety concerns of a minor in accordance with the CFS Act s. 18(1) which provides clear provisions for reporting a child in need of protection.
Circling Star is Deemed a Threat by his School

A second threat assessment dated October 22, 2014, examined Circling Star’s September 23, 2014, threat that he would do something to get expelled. Circling Star was deemed to present a “medium” risk for violence. The determination of medium risk requires the development of an action plan. Examples of appropriate interventions according to the policy on threat assessments include:

- Suspend or delay re-entry pending further assessment and management plan,
- Disciplinary action,
- Counselling,
- Parent/guardian to assume supervision of student, and
- Charges laid (School Division, 2009, p. 7)

Circling Star had not attended school since the September 23, 2014 incidents. The school file contained no further information on the actions taken by the school, on Circling Star’s subsequent suspension, or on notification from the school division. There was no record of a re-entry plan, or of what information was shared with Circling Star’s parents. This incident was reported to the CFS agency worker during negotiations to get Circling Star back into school and recorded in the CFS file in February 2015.

As previously stated, the school had a responsibility to provide Circling Star with the opportunity to continue his educational program in an alternative way while suspended from school. The documentation related to a suspension is to include an outline of the steps to be taken to integrate the student back into school. In addition, given his previous suspensions, a Behaviour Intervention Plan was necessary. This plan would have to have included both proactive and reactive components to increase Circling Star’s opportunities for success. However, Circling Star did not receive the opportunities that the educational system was responsible to provide.

Beyond the October 22, 2014 threat assessment, the school file contains only one document – a summary of Circling Star’s marks in his Grade 10 Essential Mathematics course. He had an average mark of 77% in the course as of November 14, 2014. Of particular interest is the teacher’s comment: “Circling Star works hard when he is in class. He is respectful of staff in the classroom. He is pleasant to work with and polite.”

On October 28, 2014, the CFS agency became aware that Circling Star was again living with his biological father. Circling Star’s mother confirmed that she had made private arrangements for Circling Star to live with his grandparents. She said Circling Star was welcome to come home if he would agree to abide by family rules. Circling Star’s mother also told the CFS worker that Circling Star’s girlfriend “beats him.” There was no record of the CFS agency’s response to this report of violence in Circling Star’s intimate relationship.

At this point, the CFS agency’s FE worker concluded, “He needs help.” The FE worker made a referral to the CFS worker and together the workers agreed that a private alternate care arrangement was the best option to pursue. The CFS agency’s FE worker spoke with Circling Star’s mother and let her know that if they were
not able to find a private arrangement for Circling Star, they would take him into care. A family reconciliation option was not considered.

On November 5, 2014, the CFS agency’s FE worker met with Circling Star (age 16) to determine his living arrangements. It was rumoured that he had been sleeping in a vehicle and had made himself a bush camp. The FE worker suggested that Circling Star might need to come into care for his own safety and well-being. Circling Star indicated he was staying with his girlfriend at her grandmother’s home (R family). The FE worker approached the R family about letting Circling Star move in with them through a private arrangement. This was a repeat of the arrangement of September 25, 2014, with the same family. There is no documentation that the CFS agency involved Circling Star’s family in this decision. The decision was made with neither the legal necessity of the guardian’s permission, nor any canvass of the family’s support network. There was also no evidence of consideration given to the report the CFS agency had received that Circling Star’s girlfriend was alleged to be physically assaulting him. The R family agreed to allow Circling Star to live with them and the FE worker planned to get Circling Star back into school and into counselling.

Also on this date, Circling Star’s grandparents told the CFS agency’s FE worker about Circling Star’s thoughts of suicide, stating that Circling Star had a drug problem, and that his girlfriend had assaulted him. Although the information on suicidal thoughts was previously unknown to the CFS agency, there was no indication they acknowledged or responded to possible suicide risks or mental health concerns. The information that Circling Star’s girlfriend assaulted him had also been previously provided to the CFS worker by Circling Star’s mother; however, no follow up by the CFS agency was documented. As stated in the CFS agency’s opening summary document related to the October 28, 2014, referral:

Case plan is to monitor [Circling Star]’s living arrangement and ensure he has a safe and secure place to reside. Get [Circling Star] back into school as soon as possible. Have [Circling Star] continue seeing the AFM counsellor. Provide transportation monthly to these appointments (Circling Star’s mother’s file).

The CFS agency’s worker met with Circling Star and also completed a Safety Assessment on the same date – November 5, 2014, which noted that there were protection concerns:

1. Circling Star was a danger to himself or others,
2. Caregivers were not able to provide sufficient supervision to protect him from harm, and
3. Caregivers were not able to meet his immediate needs.

The safety assessment and safety plan that emerged initiated a private alternate care arrangement for Circling Star to live with the R family. According to a note which bore the date of November 6, 2014, the supervisory review indicated the safety concerns had been addressed. (This note was entered on the electronic record on June 24, 2016, the date of Circling Star’s death, more than two and a half years later.) On the contrary, by the CFS agency’s own assessment, Circling Star was a child in need of protection. He was “without adequate care, supervision or control” as provided in s.17(2)a of The Child and Family Services Act.

At this point, it was the CFS agency’s mandated responsibility to ensure the safety of a youth who was homeless, who was not attending school, misusing drugs and alcohol, and who had a known history of
suicidal thoughts, familial conflict, and unassessed intimate partner violence. The CFS agency’s assessment indicated Circling Star was in need of protection (see three concerns listed above), which was inconsistent with the supervisory review indicating safety concerns had been addressed.

The assessment conducted by the CFS agency of Circling Star did not indicate if the CFS worker assessed the R family’s ability to supervise Circling Star, if there was concern noted about his possible suicidal thoughts, or if there was an attempt to identify or mediate family of origin conflict. Additionally, there was no recorded discussion of how this private arrangement would be able to meet the needs that were identified in the Safety Assessment. However, a Voluntary Family Service file in the name of Circling Star’s mother was opened on November 5, 2014.

On December 16, 2014, the FE worker for the CFS agency received a message that the R family wanted Circling Star out of their home, citing damage to their property. In response, the FE worker left a message for Circling Star’s mother to pick him up from the R family. There is no further documentation until mid-January 2015 and the Advocate was unable to determine clearly where Circling Star had been living between December 16 and mid-February 2015. Although Circling Star indicated that he was living with a friend during this time, it appears that he was homeless.

Circling Star’s mother confirmed that because of a fracture in the relationship between Circling Star and his dad, Circling Star was unable to live at home and she knew he did not have a stable place to live. She spoke about how heart-breaking it had been for her to feel unable to repair the relationship between Circling Star and his dad. She noted that she helped Circling Star out during this time in the ways she was able, with food and money. The CFS agency did not intervene.

On January 13, 2015, the FE worker met with Circling Star’s mother who advised she was giving Circling Star money for food, but she did not know what else to do; he did not want to return home. When the option of Circling Star coming into care was presented by the CFS agency to his mother, she was in favour. On that same day, the FE worker met Circling Star by chance at the health centre and Circling Star said he was living with another friend. On January 15, 2015, the file was transferred within the CFS agency from the FE worker to the CFS worker. In the month that followed, the CFS agency’s FE worker continued to try to locate Circling Star. During this time, the CFS agency’s file recordings indicate one attempt to locate a suitable alternate placement for Circling Star with extended family.

It is deeply concerning that the safety and whereabouts of a youth involved with the CFS agency were unclear for a total of eight weeks, from December 10, 2014 to February 18, 2015, in the depths of winter.
On February 18, 2015, Circling Star (now 16 years old) was found staying with one of his friends: B, B’s partner, their young child, and B’s adult cousin. B was 18 years old, just two years older than Circling Star. They had been friends at school and, prior to B not returning to school, the principal described them as “cohorts in some behaviour” (Interview, school personnel, December 5, 2017). The CFS agency worker of the Southern First Nations Network of Care concluded that Circling Star’s safety was of paramount consideration, and, as such, apprehended Circling Star, placing him as a child in care with the B family. The CFS worker’s rationale was that he felt Circling Star would stay in this home, rather than be homeless in the community (Interview, the CFS agency’s staff, November 22, 2017).

The CFS agency began the required checks for approval of the home as a Place of Safety (POS). B’s criminal risk assessment came back as “high risk”. Because charges were not disclosed in the results of the assessment, the CFS worker was directed to follow-up so that the CFS agency could further evaluate the risks of this placement. There was no recorded indication of further inquiry or of the outcome of any further inquiry. Circling Star’s probation officer indicated that B was on probation at this time (Interview, community corrections staff, November 2, 2017). When our office enquired for further details of what information the CFS agency discovered at this time, the CFS worker could not provide any additional information other than it was thought to have something to do with firearms. The file information indicates that, as a result of his charges, B was given a 10 p.m. to 7 a.m. curfew, a non-contact order with three individuals, and a firearms prohibition.

“High Risk” is Not Understood as a Safety Concern

An apology letter written by Circling Star, date unclear. Source: School Division
Despite the “high risk” findings of the criminal risk assessment, the CFS agency continued the process for approving the B home as a Place of Safety for Circling Star. This included applications for a Child Abuse Registry check, a Criminal Risk Assessment and Prior Contact Checks by the CFS agency on adults living in the home. The CFS agency file reviewed for our investigation includes copies of those requested checks for only B and not the other two adults who were living in the home at the time. A Foster Home Checklist and Family Stability Assessment were completed for the couple in the home without reference to the third adult occupant. The Family Stability Assessment states in its entirety: “This is a young family. There have been no issues or concerns regarding relationship problem, health problem, alcohol or drug abuse, violence, etc.” This positive assessment was in direct contradiction with the criminal risk assessment that returned as high risk. The CFS agency’s file material reviewed during our investigation did not show evidence of further assessment of the B family home. Despite the high risk assessment and lack of other completed safety checks, Circling Star was allowed to remain in this home and the CFS agency began foster care payments to the couple. A Place of Safety designation was not pursued further and no foster home licence application was made. Circling Star remained in this home as a funded placement of the CFS agency from February 18, 2015, to May 7, 2015.

Section 19(l) of The Child and Family Services Authorities Act requires CFS authorities to “ensure the development of appropriate placement resources for children”. One of the difficulties for the CFS agency is the lack of licensed homes in Circling Star’s community. Provincial CFS minimum standards require that a child in care is to be placed in a home that is approved and licensed as either a Place of Safety or a foster home. Because the CFS agency was dealing with a home where risks were reported, an assessment and safety plan were required. If completed, these would outline the steps that the CFS agency would be required to follow to mitigate the risk and maximize the safety of the child in care under the circumstances. These steps might have included more frequent CFS agency contacts or extra in-home support, according to the identified needs. These steps could have mitigated the high risk nature of the placement that was identified by the CFS agency. During this placement from February 18, 2015 to May 7, 2015, the CFS worker had three recorded contacts with Circling Star:

- March 18, 2015, when the CFS agency worker drove Circling Star from school and explained the school plan;
- April 9, 2015, when Circling Star came to the CFS agency’s office with his grandmother for a purchase order to cover a family visit with his grandparents; and
- April 23, 2015, when the CFS worker visited the B family placement and spoke with Circling Star.

The CFS agency missed the opportunity to explore the concerns and decrease the risks associated with the placement. Further, the CFS agency did not assess for the safety of B’s own young child in the home when Circling Star was placed there.

On February 23, 2015, five days after initially locating Circling Star at the B family home and being placed there by the CFS agency, the CFS worker met with the school and began advocating for Circling Star’s return to his high school, as Circling Star had not attended school since September 2014. During the meeting, the principal expressed considerable concerns to the CFS worker about Circling Star’s placement with the B
family. He felt any effort that Circling Star put into his education would not be supported in this environment. Both the CFS agency file and the AFM file also describe the AFM counsellor’s strong advocacy against the placement with the B family. During the meeting with the school, the CFS agency worker was able to convince the school to allow Circling Star to attend one day per week for a program that would lead to adult education. The school informed the CFS agency that the CFS agency would be required to provide transportation to and from school, as well as supervision for Circling Star while he was in the school.

During the meeting with the school, the principal reported that, in the past, Circling Star had told him that he heard voices. He was unsure how genuine Circling Star’s report was, but felt it should be investigated. It was agreed that mental health follow-up would be part of the CFS agency’s care plan. At that time, Circling Star had seven Grade 9 credits with marks ranging from 50 – 56% (CFS file recording, February 23, 2015). Although the CFS files indicate there was some discussion of an Individual Education Plan (IEP) that recognized the need for a mental health follow up, there was no evidence of an IEP on the school file, CFS file, or with the Department of Education. The Advocate’s office consulted the Manitoba Department of Education, which confirmed IEPs are not centrally filed, and thus, they also had no IEP on file for Circling Star (Interview, Department of Education, September 25, 2018).

The school’s requirements that the CFS agency provide transportation for Circling Star were in direct conflict with the provisions of The Public Schools Act and its regulations. In-school supervision is the joint responsibility of the school and CFS, as transportation of students is the responsibility of the school.

43(2) Subject to subsection (1) and the regulations, each school board shall provide or make provision for the transportation of all resident pupils to and from school or may pay all or part of the living expense of such pupils in lieu of providing transportation.

By March 18, 2015, the plan was for Circling Star to attend school every Wednesday, work on modules as provided by the school, and meet with the AFM counsellor as part of his school day. Every Thursday, Circling Star was to meet with the counsellor from the federally funded local health service in his community. The CFS worker described the health counsellor as a mental health worker. The CFS agency’s file noted that while Circling Star remained with B, he was spending time with both his mother and his grandparents; his dad was not mentioned.

The federally-funded local health service provider informed our office during this investigation that it has no record of a 2015 referral from the school or CFS agency to their mental health counsellor. Their only referral was from Circling Star’s mother in April 2014.
On March 25, 2015, the AFM counsellor, who had been unable to reach the CFS worker, spoke with the CFS agency’s supervisor. The AFM counsellor expressed concern that Circling Star had lost weight and that she had observed him to be bruised. The AFM counsellor further informed the CFS agency that Circling Star was still using alcohol and drugs, and that his girlfriend was pregnant. An additional concern reported by the AFM counsellor to the CFS agency was that she believed Circling Star’s relationship with his girlfriend was at the point of breakup. The last time this happened, Circling Star had ended up at the acute mental health facility for thoughts of suicide. The supervisor’s notes, taken during this referral call, are on the file. However, there was no information on file from the CFS agency on the nature of direct follow-up to the information related to Circling Star’s physical condition. There was no recorded follow-up to the referral of a child who was possibly in need of protection. In this instance, the AFM counsellor shared information that was relevant to CFS and it was not acted upon.

A plan of care dated April 16, 2015, written by the CFS agency to meet court requirements, summarized the issues and outlined an intervention plan. The protection concerns identified were:

1. The relationship between adults in the home and the child,
2. Addictions with regard to the child,
3. Reluctance to attend school, and
4. Child’s behaviour increases risk to the child.

There is no mention of Circling Star’s mental health concerns, thoughts of suicide, Circling Star’s volatile and possibly violent intimate partner relationship, or his impending parenthood. The plan included reunification with family, but, prior to reunification, both Circling Star and his mother were required to participate “in extensive family counselling to resolve their differences.” Conflict with Circling Star’s father was not addressed. Contacts with Circling Star’s biological father’s family were to be set up if Circling Star or his biological father’s family requested them. Circling Star was to meet weekly with the AFM counsellor, and to participate in treatment counselling with the counsellor from the federally funded local health service provider. The CFS agency indicated that it would continue to provide a support worker to enable Circling Star’s return to school, and monitor and supervise his behaviour. The plan acknowledged Circling Star’s desire to work toward adult education and to resolve issues with his mom and dad. This plan was attached to the court report and did not include any other service providers in its development or implementation.

Expectations for others were also outlined in the CFS agency’s court-submitted plan. The CFS agency wrote that Circling Star’s parents were required to participate in extensive family counselling to address unresolved issues prior to reunification. There was also a plan for Circling Star’s biological father that included treatment intervention with AFM, parent education, anger management and family violence programming, and the acquisition of safe housing. Circling Star was to remain in his current placement with the B family until his parents engaged in counselling. The case plan focused only on Circling Star and did not include mention of his younger brother (age 12) who was living at home with their parents at this time or

“[Circling Star] says he wants to be a conservation officer, travel and experience different things.”

AFM file March 24, 2015
any assessment of family functioning. When our office described this plan to Circling Star’s mother, she was surprised by the content and informed our team that the CFS agency had never told her she was required to attend counselling. “I wish they would have actually told me and made that mandatory,” she told us. “That would have helped me get the boys and their dad to attend counselling and work things out,” she added (Interview, Circling Star’s mother, September 21, 2018).

On April 20, 2015, the CFS worker notified the CFS agency’s abuse unit that Circling Star had been the victim of a physical assault. Circling Star had not reported this assault to the CFS agency; however, the CFS worker had seen Circling Star at family court on that date and, upon seeing Circling Star’s injuries, immediately recognized the need for a child abuse investigation. There is no mention in file recordings whether the B family was informed by the CFS agency about their duty to report an assault on a child in care.

The abuse investigation conducted by the CFS agency determined that on April 16, 2015, Circling Star (age 16) had been in an altercation with his girlfriend’s uncle (age 34), at the home of the R family. Circling Star sustained injuries including a broken nose, black eye, and lump on his head. The CFS agency’s abuse unit, located in a nearby community, took the lead in managing the abuse investigation and the local CFS agency office ensured that Circling Star had the needed medical assessments and treatment, including a CT scan. Circling Star’s injuries healed without lasting effects. The abuse investigation concluded that child abuse was substantiated. The criminal assault case proceeded to trial. Then, on February 23, 2016, the uncle was convicted of assault and received a sentence of time served, 103 days, and a probation order to complete anger management sessions. He was placed on the provincial Child Abuse Registry for the standard ten years, from September 15, 2016 to September 15, 2026. The uncle subsequently left the community. There was no information on the CFS file recordings related to the assessed effects of this assault on Circling Star, his mental health, or his relationship with his girlfriend. Circling Star did not receive support through Victim Services (Written communication, Victim Services, June 22, 2018).

On April 23, 2015, the CFS worker made a home visit to Circling Star’s placement and B’s partner reported no concerns. She indicated that Circling Star did not want to continue seeing the AFM counsellor noting, “He does not drink at all anymore.”

Documentation suggests a crisis of some nature arose approximately two weeks later on May 7, 2015. On that date, the CFS worker needed to move Circling Star immediately to another placement; however, no details of the crisis were located on file. When interviewed on November 15, 2017, for this investigation, the CFS worker was unable to recall any specific detail associated with the emergency. However, the probation officer presented a version of events to our office, when interviewed for this investigation. The probation officer informed our office that when the school made the probation officer aware that Circling Star was placed with B, it was at a time that the probation officer was also supervising B’s probation. As such, the probation officer was aware of B’s use of narcotics and alcohol. The probation officer called the CFS agency and spoke with the CFS worker about the concerns. The probation officer indicated that they would take the matter further if Circling Star was not removed immediately from the B home. The probation officer’s statement to our office was, that as a result of this intervention, Circling Star was
immediately removed from the placement, which should never have been sanctioned by the CFS agency (Interview, probation officer, December 7, 2017).

**Instability Continues as Circling Star Becomes a Father**

On May 7, 2015, the CFS agency of the Southern First Nations Network of Care moved Circling Star 112 kilometres away from his home community to a foster home with other teens. This was Circling Star’s only placement outside of his home community. Following placement, the CFS worker set the next home visit for a month later, on June 3, 2015, noting the follow-up visit would be, “re transition to new community, school, home and other foster children.” Circling Star did not want to stay at the home and phoned the CFS worker the next day, on May 8, 2015, saying that he wanted to come home to his community and not stay in the foster placement; he was also upset that his cigarettes had been confiscated (AFM file). His CFS worker encouraged him to stay. Circling Star left the placement at about 5 p.m. that evening and walked the 112 kilometres home.

The foster parent waited 24 hours before calling the CFS agency’s after hours unit at 5 p.m. the following day to notify the CFS agency that Circling Star was missing from his placement. The RCMP were informed and Circling Star was located at his parents’ home at 2:40 a.m. on May 10, 2015. He remained in the family home for the next four months.

Circling Star’s mother was visibly upset in describing this event to our office. She recounted that they had visitors that night and were at their home when they got a call from Circling Star who had walked for a long time to a particular landmark before finding a phone from which he could call his parents. “Mom, I love you. I want to come home,” Circling Star had said. Circling Star’s dad had jumped up and immediately gone to pick up his son and bring him back home. Circling Star’s mom remembered that the walk had been hard on Circling Star: “He had a sore knee,” she told our office (Interview, Circling Star’s mother, September 21, 2018).

The delay by the foster parent in reporting Circling Star missing does not comply with provincial CFS Standard 1.4.7 *Absent and Missing Children* which directs a care provider to report a missing child to police and the supervising CFS agency as soon as there is a concern for the child’s whereabouts regardless of the time, day, or night. There is no need to wait 24 hours before reporting a missing child.

On May 10, 2018, a Structured Decision Making® (SDM®) Safety Assessment Plan was completed as a result of Circling Star leaving his placement. The safety decision identified was “conditionally safe/safe with a plan” as RCMP located Circling Star at his parent’s home. The protective abilities were described as, “parents able to provide support to Circling Star.”

On May 12, 2015, the CFS worker conducted a home visit with Circling Star at his parent’s home. The file states, “The [child in care] appears happy and healthy and the family home is neat and tidy.” Circling Star did not want to return to school and said he did not need to continue with the federally funded local health
service, adding that the counsellor often cancelled on him. The CFS worker encouraged Circling Star to return to school and indicated that the CFS agency would follow up with the counsellor.

By this time, Circling Star’s girlfriend had announced her pregnancy. The file includes no indication that the CFS worker engaged Circling Star in any assessment of his readiness or responsibilities related to his pending fatherhood. Circling Star’s mother proudly informed our office that Circling Star was the only expectant dad who attended pre-natal classes with his girlfriend. His mom, who knew many nurses through her own work, was told by a public health nurse that Circling Star did more than just attend to support his girlfriend, he was active and engaged and asked many questions during the classes (Interview, Circling Star’s mother, September 21, 2018).

Although Circling Star had returned to his parent’s home, the CFS agency was granted a Temporary Order of Guardianship on May 19, 2015, for a period of six months from May 19, 2015 until November 19, 2015. The CFS worker made a home visit the following day on May 20, 2015, to inform Circling Star’s parents and me with Circling Star and his dad. The CFS worker advised that, as per the case plan, the CFS agency was setting up family counselling with the federally funded local health service counsellor to begin as soon as possible. The notes state that both Circling Star and his dad agreed this would be a good idea. The CFS worker also indicated that child in care maintenance payments would be made by the CFS agency to Circling Star’s mother while Circling Star was in care and living at home.

The CFS worker made another home visit on June 8, 2015. Circling Star’s parents reported positive changes in Circling Star with regard to respect and managing his anger. Circling Star was able to walk away, calm down when angry, later return, and talk. Arranging counselling was still in process. Although the care plan included the involvement of the federally funded local health service counsellor, there is no record of a referral for that service in either the CFS or the health service files (Interview, local health service, June 7, 2018). The CFS worker committed to checking on the maintenance payments, which had not yet arrived.

The next scheduled home visit occurred on August 25, 2015. At that time, Circling Star’s father informed the CFS worker that Circling Star refused to see the federally funded local health service counsellor. Home visit attempts by the CFS agency in September 2015 were unsuccessful. During his home visit on August 25, 2015, Circling Star told the CFS worker that he “couldn’t wait for school to start.” However, he did not attend school, and there was no indication that the CFS agency followed up to support or encourage Circling Star to continue his school program, as previously planned.

On September 25, 2015, the CFS agency’s files indicates a placement change from family reunification to independent living effective this date. However, there were no file recordings located outlining an independent living plan.

In October 2015, Circling Star’s daughter was born. Circling Star stayed at the hospital with his girlfriend and daughter. The hospital viewed Circling Star’s 16-year-old girlfriend as capable and having adequate support to parent. The FE worker for the CFS agency conducted a home visit and met with both Circling Star and his girlfriend. She was still living with the R family. The pregnancy was managed as an intake only, no Expectant
Parent Services file was opened and no concerns were noted. There was also no indication that possible intimate partner violence occurred between the infant’s parents, nor was it considered in the assessment of the infant’s safety. The CFS agency’s FE worker, who had originally heard the allegation that Circling Star’s girlfriend assaulted him, was no longer with the CFS agency. The new CFS agency’s FE worker, who did the parental assessment, would not have found that information without a manual search of handwritten case notes. The October 28, 2014, allegation by Circling Star’s mother of intimate partner violence by Circling Star’s girlfriend against Circling Star was not included in the October 28, 2014 intake notes and neither was the November 5, 2014 allegation of the same made by Circling Star’s grandfather included in the November 5, 2014 intake notes.

On October 6, 2015, the CFS agency was notified by the School Division that Circling Star (age 17) had withdrawn from school. In three years of high school enrolment, Circling Star had achieved seven of the 30 credits required for graduation (School Division, Official Transcript). Although school is compulsory until age 18 and Circling Star was still a child in care, there was no recorded response by the CFS agency to this development. The Manitoba Education and Training (n.d.) policy related to school attendance is:

Children are required to attend school from the time they reach compulsory school age (7 years of age or will be reaching 7 years of age by December 31 in a given calendar year) until they attain the age of 18. Every parent or legal guardian of a child of compulsory school age is responsible for sending his/her child to school. Every student is responsible for attending school and classes regularly and on time, and completing assignments and other related work.

On October 22, 2015, Circling Star’s mother approached the CFS agency about Circling Star’s living arrangement. Circling Star was now living with a family friend. She expected that the arrangement would last until Circling Star got angry again and then he might return home. The CFS agency decided to make the family friend’s home Circling Star’s new placement. Payment to his mother was stopped retroactive to September 25, 2015, and a new caregiver, noted to be his uncle, was named so that the CFS agency could pay him as an extended family visit. The CFS file included no explanation or review of this new arrangement.

On October 27, 2015, the CFS worker reported alleged abuse to the CFS agency’s abuse unit. There was an allegation made involving Circling Star’s girlfriend and family members (the R family). Two days later, on October 29, 2015, the R family was ordered to be removed from the community by a Band Council Resolution (BCR). Circling Star’s girlfriend was included in the BCR and she left the community with Circling Star’s daughter. The physical violence allegedly committed by Circling Star’s girlfriend did not result in any response or investigation by the CFS agency. Our office was unable to locate information to indicate that the safety of Circling Star’s 26-day-old infant daughter was assessed as a result of the abuse allegations against Circling Star’s girlfriend.

**BAND COUNCIL RESOLUTION (BCR)**
Although not defined in a legal sense, BCRs can be seen as a record of a decision made by a majority of the council members of a First Nation. BCRs can be a way to provide instructions from a chief and council to community members, or to the federal government. (From: [https://www.tdslaw.com/publication/doing-business-with-first-nations/](https://www.tdslaw.com/publication/doing-business-with-first-nations/))
Circling Star was reported to have been active in his attempts to stay involved with his daughter (Interview, Circling Star’s parents, November 16, 2017). Although Circling Star’s girlfriend had moved to a community that was a two and a half hour drive away, Circling Star travelled there whenever possible.

The CFS worker wrote a closing summary on November 19, 2015, noting that, “the [child in care] and his family have resolved many of their outstanding issues, this child is no longer in need of protection and therefore this child file can now be closed.” Unfortunately, it is not known how the CFS worker came to this determination. The CFS worker did not outline what issues were resolved and there is no indication in the file of any resolution of family issues beyond the brief statement in June 2015, that Circling Star was managing his anger more effectively. Circling Star was not living with his parents at the time the file was closed and the degree of reconciliation that had occurred in the family over the course of the CFS agency’s involvement was not assessed.

In June 2016, two complaints were made to the RCMP related to Circling Star. He was suspected of damaging a vehicle and of another property damage occurrence. The first complaint was investigated and concluded due to lack of evidence. The second was concluded due to Circling Star’s death.

**Events Leading to the Death of Circling Star**

On June 23, 2016, Circling Star was five days away from his 18th birthday. In honour of the occasion, Circling Star’s father bought him an old SUV that they were fixing up. In the evening, Circling Star and two friends went to [name of community] in Circling Star’s SUV and had someone buy liquor for them. All of the boys were underage. It is not clear if they were drinking in a specific location or if they were drinking while driving around in Circling Star’s vehicle. As Circling Star was driving, his vehicle skidded sideways into the ditch, hit the side of the ditch, and became airborne. It finally came to rest on the driver’s side in the grass beyond the ditch. During the crash, Circling Star, who was not wearing a seatbelt, was ejected from the vehicle (Written communication, RCMP ‘D’ Division, December 13, 2017).

Circling Star’s parents received a phone call from a resident near the crash site telling them that Circling Star was in the ditch. Unaware of the seriousness of the accident, Circling Star’s father loaded up a spotlight and some chains to get the vehicle out of the ditch. When they arrived on the scene, Circling Star’s parents realized how serious the crash scene was, called an ambulance, and began CPR. Circling Star’s dad shared with our office that although he felt sure it was too late to help Circling Star, they continued resuscitation efforts for two hours. Emergency vehicles were dispatched, but the road conditions were bad and Circling Star’s parents reported that it took over two hours for the ambulance to arrive on the scene (Interview, Circling Star’s parents, November 16, 2017). Resuscitation attempts were unsuccessful. The other two boys in the accident were wearing seatbelts and sustained only minor injuries. Circling Star was pronounced deceased at the scene at 2:29 a.m. on June 24, 2016.

The manner of death was ruled “Accidental” by the Chief Medical Examiner and the cause of death was blunt force injuries as a result of a motor vehicle collision (driver; single vehicle rollover). A laceration in
Circling Star’s aorta meant that resuscitation had not been possible. The toxicology report showed that Circling Star had a blood alcohol level of 173 mg/dL, which was significantly beyond 80 mg/dL, the legal limit for driving for adults. The drug screen also detected cocaine and metabolites that are formed when alcohol and cocaine are ingested at the same time (Autopsy Report 2016-M0575).

**Events After the Death of Circling Star**

The CFS worker went to see the family on the day of Circling Star’s death; in keeping with their cultural practices, a sacred fire had been started at the family home. The CFS worker was able to speak with both parents. There was a wake on June 30, 2016, and a funeral followed the next day. The AFM counsellor was among those who attended the funeral.

The CFS worker made follow-up visits to the family two weeks later and again in August 2016. Both times counselling and CFS agency supports were offered but declined by the family. The family expressed gratitude for the support received by the CFS agency.

The CFS agency of the Southern First Nations Network of Care has indicated that there are no concerns for Circling Star’s younger brother. His parents report that Circling Star’s younger sibling is taking a different path from that of his older brother; after seeing the impact of alcohol and drugs, he has turned away from using them. The family continues to experience deep levels of grief. After Circling Star’s death, his parents observed one year of mourning as is their cultural practice. Now that they have erected a headstone, they are trying to move forward with their lives. However, Circling Star’s mother shared with our office that she is unable to provide the same kind of emergency medical support that she once did as part of the community’s emergency response team. She finds that providing CPR in other emergencies is too difficult for her. Circling Star’s dad has not worked since his son’s death and he shared with us that he is struggling to cope with the death of his son.

The Voluntary Family Service file remains open on CFSA, but there are no electronic entries regarding any further services having been provided to the family since August 9, 2016.
Findings, Analysis, and Recommendations

In the final five years of his life, Circling Star received services from education, mental health, addiction, youth justice, and CFS systems. However, instead of coordinating their interventions in the small region in which Circling Star lived and attended school, these public systems worked in isolation from each other and, as such, delivered disjointed services to Circling Star and his family. Services were ill-coordinated and sometimes even worked at cross purposes.

Even more concerning, as the section of this special report on Circling’s Star’s story establishes, these five systems passively interacted and some documented Circling Star’s deepening crisis but never intervened in any way that made a difference for him:

- Education had a lasting opportunity to provide some stability and a safe place to learn, especially because Circling Star continued to return to school, despite the distance and his challenges while there, but the school did not engage Circling Star effectively and suspended him repeatedly;
- Mental health services were involved at various points but referrals were dropped following significant concerns, and follow-up was demonstrated to be unreliable;
- Addiction services documented – starting from when Circling Star was 14 years old – serious safety concerns related to his ongoing and escalating use of substances and did not engage Circling Star’s parents in his course of treatment, nor did they provide any meaningful intervention services;
- Probation services ended with Circling Star never having completed his court-ordered conditions despite several services involved with him at the time being fully aware that he was not meeting the conditions of his probation; and
- CFS services did not respond appropriately to Circling Star’s needs or those of his family. Circling Star was placed in risky environments when he was a child in care.

Although there were good intentions, the services provided to Circling Star did not provide the meaningful interventions he needed. The purpose of this special report is to ensure that our systems improve their effectiveness and responsiveness as well as move from good intentions to meaningful interventions that prevent tragedies like this one from taking place in the future.

Supports were inadequate across service systems. Toward the end of his life, Circling Star was addicted to alcohol and other drugs, he was the victim of physical abuse, he spent more time suspended from school than in school, and he lacked supports and a stable environment in which he could live. It is hard not to wonder what the outcomes might have been for Circling Star if public systems had rallied to provide a course of short, intensive, and coordinated supports when he was 13 and when he first came to the realization he had a biological father he had never known.

Children and youth, like Circling Star, have fundamental rights that, as adults, we are responsible for ensuring and protecting. The United Nations Convention on the Rights of the Child (UNCRC) is an
international agreement between nearly all of the countries in the world, which describes more than 40 basic rights promised to the world’s children. The UNCRC includes specific protection rights, provision rights, and rights to participation. Our office views the UNCRC as a cornerstone to all of the work that we do alongside and on behalf of all young people for whom we have the privilege of serving. In addition to a child’s rights lens, for the last decade during which we have been completing investigations after the deaths of children, we have worked to write our reports through the eyes of the child. These perspectives help to anchor the child at the centre of each story to ensure that we are able to hear their voices, so those voices can guide our analysis of the services they may have received and so that all findings and recommendations reflect our commitment to child-centred practice.

As the Advocate for Children and Youth, I know that the vast majority of people who enter service fields as a profession do so out of a genuine desire to help people and build strong communities. And yet, when reviewing the evidence in this case, it is worrisome to see a pattern emerge of service providers interacting with a young man like Circling Star in the ways that many of them did. Our investigation revealed that service providers were unable to see past Circling Star’s behaviour to the underlying sadness and hopelessness growing inside of him. As he was increasingly acting out, services providers did not focus on the source of his pain through a trauma-informed lens, consider other approaches, or evaluate if what they were doing to intervene was working. It is concerning to realize that Circling Star was known to several public service systems as he was crying out for help, and yet this long list of professionals and organizations were unable to provide him with a chance to change the course of his life.

**Information Sharing**

**FINDING:** Public services involved with the same child, youth, or family continue to operate in silos. The lack of information sharing across systems continues to result in shortfalls with respect to communication and collaboration between services.

Throughout this special report, the disjointed nature of services and lack of information sharing which resulted in a lack of communication and collaboration between services was made clear. Our investigation into Circling Star’s story reiterated a common theme that has been pervasive in other child death investigations as well as within the cases open to our Advocacy Services program; public services in Manitoba operate in isolation from each other when involved with the same child or the same family. Due to apprehensiveness about sharing too much or the wrong information, public services tend to err on the side of not sharing information at all. The result, then, is that services are delivered in isolation, not coordinated, and can work at cross-purposes, contrary to the best interests of children, youth, young adults, and their families. Circling Star’s story is one where little effort was demonstrated by the service areas to work in concert; important information was not shared between service systems and this isolated approach weakened the overall effectiveness of all services attempting to provide supports.
**Sharing of Information between Collaterals/Interjurisdictional Issues** is an area of concern on which our office has gathered data and made recommendations over a number of years. Our direct advocacy and individual and systemic investigation work in this area is reflected in the 111 recommendations we have previously made where service coordination was a specific concern. Of those recommendations, 40 were contained within child death investigations and 20 were made in our previous special reports. The lack of coordination within and across systems is not new and has persisted. For example, in one child death investigation completed by our office in 2010, the Manitoba Advocate (then known as The Children’s Advocate) made the following recommendation:

...that the Addiction Foundation of Manitoba establish a policy that when servicing clients that have an open case with Child and Family Services that the Child and Family Services Case Manager be contacted even if they are not the source of referral. Further, that the policy describe the appropriate exchange of information between service providers. Duty to Report under the CFS Act should also be included in that policy.

This report was released under our previous legislated mandate which prevented the Advocate from publicly releasing the contents of child death investigations. In this matter, AFM did respond to the above recommendation in 2011, and identified they considered implementation to be complete.\(^6\) As described earlier, this specific issue was again a concern when Circling Star was involved with AFM between 2012 and 2015; however, this lack of service coordination is by no means only a concern inside the addiction services field – it permeates nearly all service delivery fields in Manitoba.

The Manitoba government has recognized the persistent inefficiency of systems operating within silos. An attempt to address this lack of service coordination came when the government introduced and passed *The Protecting Children (Information Sharing) Act*, which came into effect in September 2017. With stated advantages of, “improved services and outcomes for supported children,” leading to “timely sharing of information” and “informed decision making,”\(^7\) the intent of this legislation is good. The summary of this Act notes that the information-sharing law “…allows service providers in Manitoba to collect, use, and share personal information with other services providers about supported children and their parents and legal guardians.”\(^8\) Unfortunately, service providers remain largely uncertain about the parameters and guidelines of this legislation and thus, we frequently hear from service providers and families that services remain uncoordinated in their delivery. Information sharing is still not occurring in the manner in which it was intended to occur. Service providers we spoke with during this investigation and others are aware that *The Protecting Children (Information Sharing) Act* exists, but they do not know how to apply it. While many service providers express a desire to better coordinate, the knowledge gap seems to exist in the lack of education provided to systems about their options and obligations when this Act came into effect.

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\(^6\) Under our current legislation, *The Advocate for Children and Youth Act*, monitoring and reporting on compliance with recommendations is now the responsibility of the Manitoba Advocate. This new responsibility and The Manitoba Advocate’s plan for public education in this regard is discussed on page XX

\(^7\) See [https://www.gov.mb.ca/informationsharingact/about-the-legislation.html](https://www.gov.mb.ca/informationsharingact/about-the-legislation.html)

\(^8\) See [https://www.gov.mb.ca/informationsharingact/about-the-legislation.html](https://www.gov.mb.ca/informationsharingact/about-the-legislation.html)
RECOMMENDATION ONE: INFORMATION SHARING

The Manitoba Advocate for Children and Youth recommends that the Province of Manitoba respond to the persistent lack of coordination between services for children and youth by developing and implementing a provincial strategy to train service providers on the requirement to share information across systems and ensure children and youth are at the centre of all service provision. This is to be developed, delivered, and evaluated in consultation with Manitoba Education and Training, Manitoba Families, Manitoba Justice, and Manitoba Health, Healthy Living and Seniors.

DETAILS:
- In line with The Protecting Children (Information Sharing) Act, this training needs to be provided to all relevant service providers in Manitoba.
- As part of this strategy, an inter-ministerial working group at the director, manager, and staff levels is needed to identify and address barriers to collaborative sharing of information and ensure oversight of quality assurance protocols related to case management across service providers.

Education Services

FINDING: Circling Star’s High School and School Division did not use effective strategies to address the evident conflict between Circling Star and one particular teacher at his school.

A review of Circling Star’s suspension history at his high school reveals that almost all of the incidents for which he was disciplined or suspended involved him and one particular teacher (see Appendix D: School Suspension History). While the conflict with Teacher X became more pronounced, the school counsellor offered Circling Star a safe time-out space, encouragement, and behaviour strategies (Interview, Circling Star’s school counsellor, May 2018). Unfortunately, the only recorded behavioural interventions used by the school were suspensions that began in his first month at his new school. Circling Star was formally disciplined or suspended 19 times and 14 of the incidents that led to these suspensions involved Teacher X. What is repeated across the discipline referral forms are characterizations of ‘refusing to comply,’ ‘disruptive,’ ‘disrespectful,’ ‘violating the dress code,’ ‘late to class,’ and other similar infractions. During Circling Star’s second year at this high school, these incidents became more troubling and included ‘intimidation,’ ‘verbal abuse,’ ‘aggressive attitude,’ and ‘threats of violence.’ The school
administration had opportunities in the first few months to work with Circling Star and Teacher X to dig below the surface of these behavioural incidents, to ask questions about what was happening for each of them, and to work to address the relational problems that were present and growing. Instead, suspensions were handed out repeatedly, creating a picture of suspension as the ‘go-to’ strategy for dealing with this specific interpersonal conflict.

Further, the school’s approach to suspensions was to lay all of the blame at Circling Star’s feet, characterize him as not willing to follow the rules, and expect Circling Star to submit to the authority of the teacher-student dynamic. The behavior intervention plan was developed without the participation of either Teacher X or Circling Star and articulated the clear position of the school: Circling Star was to blame and must change his ways. Not surprisingly, the suspension approach was not effective in addressing the conflict, and the seriousness of the incidents increased over time.

In spite of School Division and Manitoba Public Schools policies to the contrary, multiple suspensions occurred without the development of a written behaviour plan. There were seven suspensions in the 2012-2013 school year for a total of 20 days out of school without a plan. However, after two suspensions early in the 2013-2014 year, a written behaviour plan was developed. As noted above, neither Circling Star nor the teacher were involved in creating the plan, which should have recognized or included specific strategies to assist in managing the conflictual relationship between Circling Star and this teacher. According to the school file, during Circling Star’s 2013-2014 year, he was suspended for at least 68 days.

Circling Star’s suspension in October 2014, related to his threat to do something to get himself expelled for good, was not recorded in his school file as a suspension. There are no copies of the required letters to his parents from the school or from the superintendent, nor is there an identified end date, or re-entry plan.

Although there is no record of it, school sources reported to the Advocate’s investigators that Circling Star’s parents were kept informed and were responsive to requests from the school (Interview, Circling Star’s principal, December 5, 2017; Circling Star’s school counsellor, May 22, 2018).
Outcomes of Out of School Suspensions

Understanding the individual effect of suspensions on the lives of children and youth is limited by the methodology of the current evidence base. Nevertheless, available analysis strongly suggests that out-of-school suspensions are risk factors for negative developmental outcomes including: poor academic achievement, school dropout, and criminal justice involvement.

Out of school suspensions have a detrimental effect on academic achievement and school outcomes (Noltemeyer, Ward, & Mcloughlin, 2015). Suspensions increase the risk that students will fail the curriculum (Hemphill, Toumbourou, Herrenkohl, McMorris, & Catalano, 2006) and double the risk that students will repeat a grade (Fabelo, Thompson, Plotkin, Carmicheal, Marchbanks, & Booth, 2011). There is evidence that a single suspension can decrease math and reading achievement for suspended students (Lacoe & Steinberg, 2018). More suspensions are associated with worse achievement; one study found that multiple suspensions are associated with lower math and language achievement, even after controlling for differences between students (Hwang, 2018).

Ultimately, suspensions are associated with an increased risk of dropping out (Noltemeyer, Ward, & Mcloughlin, 2015). Another study demonstrated that youth with a prior suspension were 68% more likely to drop out of school than students without suspensions (Suh, Suh, & Houston, 2007).

There is also growing evidence that suspensions independently predict involvement in the juvenile justice system. One review of existing studies found that exclusionary discipline is significantly associated with an increase in a youth’s odds of being arrested or having some contact with the juvenile justice system (Novak, 2018).

Researchers hypothesize that suspensions increase unsupervised time for students that are at high risk of further destructive behavior, while simultaneously reducing access to supportive services (Valdebenito, Eisner, Farrington, Ttofi, & Sutherland, 2015). There is some evidence to support this theory. For instance, one study of 1,354 delinquent adolescents in the United States found that being suspended from school increased the likelihood of arrest in the same month that the suspension took place.
place; this effect is stronger for youth without a history of delinquent behaviours (Monahan, VanDerhei, Bechtold, & Cauffman, 2014, *emphasis added*). The frequency of suspensions also increases the odds of juvenile justice system contact (Fabelo et al., 2011; Mowen & Brent, 2016). In Circling Star’s case, the fire he set occurred the evening of his first suspension, during his first three weeks of beginning at his new high school.

The effects of suspensions on the lives of children and youth may be long-lasting. Research reveals that being suspended increases the likelihood that the individual will experience criminal victimization, criminal involvement, and incarceration in adulthood (Wolf & Kupchik, 2016). “Suspension is often the first step in a chain of events leading to short- and long-term consequences, including academic disengagement, academic failure, dropout, and delinquency” (Skiba, Arredondo, & Rausch, 2014, p. 2).

**FINDING: There was little investment by Circling Star’s High School to encourage his academic success.**

Although the school had a responsibility to plan for Circling Star’s success on re-entry following suspension, attempts or interventions to improve his chances of success were lacking. Circling Star was assigned work to complete at home any time he was suspended for longer than one day. That was the plan for ten days of suspension in 2012-2013 and for possibly as many as 90 days in 2013-2014.⁹

In April 2013, Circling Star admitted to the AFM counsellor that he was not doing well at school but he was not sure he could do better because he did not understand the work. The next month, in May 2013, he told the counsellor he did not care about school anymore. Providing work to complete independently is an inadequate plan for a student who may already be experiencing academic challenges.

The High School’s *Educational Community Handbook* includes a Code of Conduct. The handbook includes a list of infractions that will result in staff intervention, although the handbook does not articulate how staff will intervene when infractions occur. The infractions include:

- Smoking on school property
- Off-task behaviour
- Inappropriate language
- Disrespectful to staff and students
- Defiant or uncooperative
- Head or neck gear inside the school
- Inappropriate clothing: exposed midriff, inappropriate messages, gang related, etc.
- Skipping or late for classes/school
- Leaving school property without permission
- Photography, video, or audio recording without an individual’s consent

⁹ Note: The length of time Circling Star was suspended between December 13, 2013, when the documented suspension ended, and February 3, 2014, when Circling Star had a re-entry meeting, is unclear.
- Inappropriate use of electronic devices: iPod, smart phone, mp3, laptop, gaming station, etc.
- Public display of affection; only holding hands is permitted
- Not following school bus ridership and transportation policies
- Not adhering to [Name of School]’s Community’s Handbook
- Not adhering to the School Division’s Use of Internet and Communication Technology (p. 4)

The handbook notes that suspensions are at the discretion of the principal. The School Division Policy (2009) on Student Suspension states:

The Board of Trustees believes there are a range of behaviours that must be addressed through alternatives to suspensions. Each school is required to develop a planned approach to alternatives to suspensions and to include this plan in the school’s Code of Conduct (p. 1).

The school’s Code of Conduct (n.d.) lists a dozen examples of “strategies that will be utilized to assist students, when inappropriate behaviour is exhibited, make better choices in the future” (p. 2). In addition to suspensions, Circling Star’s school file indicates Circling Star was referred to the Addictions Foundation of Manitoba’s (AFM) counsellor in the school and the guidance counsellor in his first year in high school.

It is important for schools to employ alternatives to school suspensions whenever possible since, as stated above, excluding youth from school can increase their risk of experiencing negative outcomes. Alternative approaches to exclusionary discipline can be employed at different intervention levels, including targeted approaches to children and youth, and district level programs and policies (Steinberg & Lacoe, 2017).

Despite policies which restrict suspensions to a measure of last resort, reserved for serious offences, research suggests that suspensions continue to be used for minor offences such as missing school, tardiness, and minor disruptions (Munn, Cullen, Johnstone, & Lloyd, 2001; Skiba, 2014; Fenning & Rose, 2012; Liu 2013). Skiba & Sprage (2008) speculate that school administrators may use exclusionary disciplinary measures because they do not know of alternatives to these approaches. In Circling Star’s case, this appeared to be true; he was suspended multiple times for seemingly minor infractions such as missing class and “disrespect.” Suspending students for incidents of intoxication or when addiction issues are a factor is not supported by the evidence, unless threats to others are a factor. The evidence suggests suspensions in these incidents can place youth at greater risk.

Targeted interventions focus on changing the behavior of children and youth. One example of the many alternative approaches that might have been implemented is restorative justice. A restorative justice approach aims to institutionalize peaceful and non-punitive methods to address harm and facilitate problem solving (Fronius, Persson, Guckenburg, Hurley, & Petrosino, 2016). School-based interventions may be universal in the form of training on restorative justice principles for staff, or can be used as an approach to respond to specific incidents.
There is some indication that restorative justice approaches may be a viable alternative to exclusionary practices including suspensions (Agard, 2018). For instance, a Texas school reported an 84% drop in out of school suspensions among sixth graders during the first year a restorative justice model was implemented (Armour, 2013). Further, case studies report positive impacts on attendance, absenteeism, and academic outcomes (Fronius et al., 2016).

Work can also be done at the broader, division level to ensure policies and procedures reflect best practices within education. Certainly, a division-led examination of behaviour-change interventions can proceed with the greater human and funding resources available at the district level versus the individual school level. Districts have more human and financial resources available than schools; thus, district-led changes to exclusionary discipline can have broad impact. Two specific areas of interventions which can be led at the district level include reviewing disciplinary policies and ensuring robust teacher training.

Manitoba Education and Training has recognized the limitations of exclusionary discipline. A quote on their website states: “Extensive research shows that excluding children from school for disciplinary problems is often ineffective, even counterproductive” (Dufresne, Hillman, Carson & Kramer, 2010 in Manitoba Education and Training). They further state that, “Negative consequences may be necessary when other approaches to problem behaviour are unsuccessful; however, they are not effective when overused.” (Manitoba Education and Training, n.d.)

In Manitoba, the following are some promising initiatives developed to address exclusionary practices:

- Manitoba Education and Training issued an overview and planning document to assist school districts, boards, and school administrators to cultivate healthy school cultures, guided by Safe and Inclusive Schools legislation. The planning document, A Whole School Approach to Planning for Safety and Belonging (2017) outlines this approach;
- Manitoba Education and Training issued its ministerial directive to the provincial education system in its Safe and Caring Schools: Provincial Code of Conduct – Appropriate Interventions and Disciplinary Consequences (2014, Revised September 2017); and
- The board of the Winnipeg School Division (WSD) reported in 2016 to CBC News that the WSD suspensions dropped by 40% due to restorative justice approaches (CBC News, March 31, 2016).

While Manitoba Education and Advanced Learning has begun to acknowledge the negative impact of out-of-school suspensions, there is no province-wide strategy, central direction, or monitoring to guide evidence informed decisions related to suspensions. At present, (1) there is no articulated commitment to reducing exclusionary discipline, (2) no quality assurance and evaluation mechanisms related to suspensions are in place, and (3) there is little public accountability for the programs and initiatives that are being developed.

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10 To view the planning document, see: [https://www.edu.gov.mb.ca/k12/docs/support/whole_school/document.pdf](https://www.edu.gov.mb.ca/k12/docs/support/whole_school/document.pdf)

11 To view the directive, see: [https://www.edu.gov.mb.ca/k12/safe_schools/pdf/code_conduct.pdf](https://www.edu.gov.mb.ca/k12/safe_schools/pdf/code_conduct.pdf)
The recommendation below takes into account the evidence on the harmful effects of suspensions and school exclusion practices to the lives of children and youth, the correlations between school suspensions and criminal justice system involvement, standards that contradict the use of out-of-school suspensions for minor infractions, and research on the protective effects of school involvement.

**RECOMMENDATION TWO: EDUCATION**

The Manitoba Advocate for Children and Youth recommends that the Department of Education and Training through Healthy Child Manitoba, and with participation from all school divisions, conduct an urgent review of the current use of out-of-school suspensions and expulsions, and develop a province-wide strategy to limit, reduce, and phase-out exclusionary practices, except in situations of imminent safety risk to students and staff. This review and strategy should provide evidence-informed disciplinary alternatives that are in line with the best interests of the child and respect the right of children and youth to education.

**DETAILS:**

- The Department of Education and Training will develop quality assurance and information management processes to: (1) define “imminent safety risk to students and staff”, (2) assess the prevalence, duration, and nature of school suspensions and expulsions in Manitoba, (3) analyse and ensure compliance with standards and best practices, (4) provide school boards with the necessary information to develop strategies to reduce and end school suspensions and exclusionary practices, and evaluate initiatives. Changes should be data informed and made considering the unique dynamics in Manitoba.
- The Department of Education and Training will implement province-wide and evidence-informed suspension and exclusion prevention policies and procedures for Manitoba schools. This is to then, in turn, inform training for:
  - School division training for teachers, principals, and superintendents;
  - Mentorship programs; and,
  - Alternative approaches to suspension.

**FINDING:** Circling Star was not offered appropriate clinical mental health services matched to his level of need.
The need for mental health assessments was noted several times over the course of Circling Star’s involvement with services. The school, the AFM worker, and the CFS worker all expressed concern about Circling Star’s mental health and, consistently, they each indicated Circling Star’s need for a formal mental health assessment. In response, Circling Star’s mother gave permission to the AFM worker to make a mental health referral for Circling Star in April 2014. A plan for mental health intervention services was written into the CFS agency’s plan in March 2015. The AFM worker made a referral to the provincial child and youth mental health service and, subsequently, that referral was re-directed to the federally-funded local health service in Circling Star’s community. Unfortunately, that referral was not acted upon. Further, Circling Star’s mother’s attempts to secure her son mental health services were hindered by AFM’s privacy rules: her referral to the federally-funded local health service provider did not include the details of Circling Star’s mental health needs. The CFS agency considered the federally-funded local health service an appropriate resource for Circling Star’s mental health therapy. However, this federally-funded local health service provider indicated to the Advocate’s investigators that their services do not conduct mental health assessments or deliver clinical mental health therapy (Interview, health counsellor, December 7, 2017). Further, records show that the service provider of the federally-funded local health service saw Circling Star only four times in a period of 19 months (from April 2014 to November 2015). This dose of intervention does not match the documented concerns regarding Circling Star’s mental health needs. According to the records of this service provider, Circling Star, at age 15, demonstrated significant mental health concerns, as follows:

- he felt someone was controlling his mind;
- he felt his mind wasn’t “working quite right”;
- he had headaches;
- he had disturbed sleep patterns;
- he felt his thoughts were confusing and too rapid;
- he had at least one known previous suicide attempt;
- he had addiction issues; and
- he expressed difficulties in coping with the discovery of information related to his parentage

Related to the discovery of his parentage, records show that supports were not offered to Circling Star to help him cope with this significant life event.

**FINDING:** The acute treatment mental health facility did not comply with its legal duty to report the known safety concerns of a child in need of protection to the CFS agency.

The discharge summary record of the mental health facility was not provided to Circling Star’s parent or guardian; further, a CFS agency referral was not made, despite the mental health facility’s legal duty to report. Circling Star presented with significant mental health concerns and was admitted to an acute mental...
health facility on October 19, 2014, though he discharged himself the next day. Circling Star’s brief interaction with this mental health facility is another example of a missed opportunity: When he was released from this facility, following a one-day stay, Circling Star (at age 16) was exhibiting significant substance misuse issues and expressing suicidal thoughts. Additionally, he had no stable placement to go home to; nor did he have a safety plan in place despite his reported thoughts of suicide. When Circling Star’s grandfather picked him up from discharge, his grandparents were noted on the discharge summary form to have told the facility that they were not willing to have Circling Star return home with them until he had received treatment; instead, the facility wrote that they “assumed” Circling Star would return to live with his grandparents, and his grandfather was given a referral card for AFM. The discharge summary record of the mental health facility was not provided to Circling Star’s parent or guardian; further, a CFS agency referral was not made, despite the mental health facility’s legal duty to report.

**FINDING: Manitoba’s mental health and addictions service system does not apply a children’s rights impact assessment lens to its policy-making process.**

Released this year, the Government of Manitoba’s commissioned-report, Improving Access and Coordination of Mental Health and Addiction Services: A Provincial Strategy for all Manitobans (2018), (“Virgo report”), cites many recommendations related to improving the province’s provision and delivery of youth mental health and addictions supports, including the need to: enhance capability and capacity; improve transitions across sectors and the lifespan; improve access and flow; and advance system-level integration (p. 235). A mixed methods research design, reflecting quantitative and qualitative data collection and analysis, was used to assess the strengths and challenges of Manitoba’s mental health and addictions systems. Further, a variety of data sources were gathered and reviewed, including: community consultations, service user and service provider consultations; on-line surveys for service providers and the general public; and administrative program data (e.g., occupancy rates, wait times), as provided by service providers (e.g., health authorities, community-based clinics and service organizations). Missing from its analysis, unfortunately, are the voices of children and youth, including Indigenous children and youth, who have been impacted by mental illness, including addictions.

MACY’s work is informed by the calls of action of The Truth and Reconciliation Commission of Canada. Our work is also guided by our commitment to uphold the rights of all children and Indigenous peoples as per The United Nations Declaration on the Rights of Indigenous Peoples and The United Nations Convention on the Rights of the Child (UNCRC). The guiding principle of the UNCRC is that children have a right to the conditions and supports they need for healthy development; conditions and supports that are not provided out of pity, sympathy, benevolence, or paternalism, but because children are entitled to them as natural rights holders (Howe, 2007). The UNCRC defines children’s rights as rights of provision, rights of protection, and rights of participation. The right of participation ensures children have a voice in all of the decisions that affect them, based on their evolving capacity. It is our conclusion that the right of participation for children and youth was limited in the Virgo report and that process did
not prioritize the voices of youth who are vulnerable and who struggle to access mental health services in Manitoba.

While certainly no substitute for the lived experience narratives of children and youth, the following section provides statistical information on the prevalence and breadth of mental health and addictions issues that impact children and youth:

- Many children and youth, especially those exposed to significant risk factors (e.g., complex trauma, involvement with the child welfare system), experience a mental health problem or addiction issue. In Canada, 15 to 24 year-olds are more likely to experience mental illness and/or substance use disorders than any other age group, and 17% of Canadians aged 15 years or older identify as having a mental health concern or addiction issue within the past year (Data source: Centre for Addiction and Mental Health).
- Manitoba-level data on youth mental health is equally compelling: 10.8% of children aged 6-12 years have experienced a significant mental health concern; for youth aged 13-19 years this prevalence rate increases to 17% (Data source: Manitoba Centre for Health Policy).
- In Manitoba, many children and youth are lost to suicide each year. Indeed, since 2009, 143 children and youth have died by suicide. Most recently, this past August, alone, 8 youth died by suicide (Data source: MACY). Table 2 illustrates the suicide rates for youth in Manitoba over this 10 year period.

Table 2 – Children and Youth Lost to Suicide in Manitoba (2009-2018) by Fiscal Year

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-2010</td>
<td>15</td>
<td>15</td>
<td>12</td>
<td>18</td>
<td>11</td>
<td>6</td>
<td>22</td>
<td>9</td>
<td>22</td>
<td>7**</td>
<td>143</td>
</tr>
</tbody>
</table>
| *Until August 29, 2018
| **Under 18 years of age
| ***Between 18 and 21 years of age

NOTE: With the proclamation of the ACY Act, MACY now reports on suicide up to age 21 years

**FINDING:** Manitoba’s mental health and addictions service system does not apply a harm reduction lens to its policy-making process.

In total, the Virgo report puts forward 125 recommendations to the Manitoba government for its review and decision-making. These recommendations are organized by the following six priority areas:
1) Population health-based planning, disparity reduction and diversity response: Recommendations within this priority area recognize the importance of a “whole of government” and “whole of society” approach to enhance the health and mental health of all population groups in Manitoba. Importantly, recommendations within this priority area identify opportunities for mental illness and addictions prevention and mental health promotion.

2) Comprehensive continuum of evidence-informed services and supports: Recommendations within this priority area recognize the need to consider variations in regional and population needs in the development of a staged approach to the development of a treatment and recovery system.

3) Seamless delivery of integrated services across sectors, systems and the life span: Recommendations within this priority area identify the need for improved connectivity and coordination between the two currently-divided systems of mental health and addictions.

4) Mental wellness of children and youth: Central to MACY’s review, the children and youth-centred recommendations within this priority area relate to improving the province’s mental health and addictions system in order to redress the limitations of Manitoba’s current system of supports for children and youth. Importantly, the review noted significant limitations, including: inadequate funding for services; insufficient early intervention services; and the need for universal prevention resources and supports for all children and youth.

5) Mental wellness of Indigenous Peoples: Recommendations within this priority area focus on the systemic issues of inequity for the province’s Indigenous Peoples in Manitoba, including concerted and sustained efforts to redress these inequities; the need for more culturally-informed services (e.g., land-based programs, language supports); and the call to resolve jurisdictional challenges related to mental health and addictions systems.

6) Healthy and competent mental health and substance use workforce: Recommendations within this priority area relate to the capacity development of and the resource allocation to the workforce that underpins the province’s mental health and addictions systems, including focused enhancements (e.g., funding, data collection and reporting, engagement, and change management) to facilitate the implementation of the Virgo report recommendations.

After a thorough review, MACY finds that the Virgo report provides a detailed assessment of the gaps and limitations with the province’s current mental health and addictions systems, including those that relate to children and youth. Indeed, the review corroborates much of MACY’s existing research and advocacy work in the area of mental health and addictions. Moreover, the Virgo report recommendations echo many of MACY’s existing recommendations, including the need to:

- address federal/provincial jurisdictional barriers to services for First Nations children and youth;
- improve communication and collaboration among service providers;
- increase access to services in Northern and geographically-isolated communities;
- advance research and knowledge, including Indigenous ways of knowing, of mental health and addictions issues affecting children and youth;
- develop trauma-informed approaches to mental health and recognize the impacts of inter-generational trauma;
• increase funding allocation for children and youth mental health and addictions services;
• enhance access to mental health and addictions treatment and culturally-safe mental health and addictions treatment models for children and youth;
• ensure suicide prevention education, training, and resources are available to all children and youth-serving organizations;
• improve access to culturally-safe resources, supports and training, especially for Indigenous children, youth, families, and communities.

Importantly, one recommendation that the Virgo report does not address relates to supervised consumption sites, and MACY believes this is an oversight. Harm reduction approaches, including supervised consumption sites, are considered best practice by international mental health experts (Rhodes, Kimber, Small, Fitzgerald, Kerr, Hickman, Holloway, 2006; Toumbourous, Stockwell, Neighbors, Marlatt, Sturge, Rehm, 2007).

FINDING: Access to appropriate mental health services in rural and geographically remote communities is a long standing issue of inequity. As a First Nations youth, Circling Star was not offered equitable access to mental health services in his home community.

The CFS agency made the assumption that the services provided by the federally-funded local health service would address mental health concerns and did not seek clarification or confirmation that appropriate treatment or intervention was actually occurring. Even if counselling had been offered regularly, a comprehensive mental health assessment was required. The CFS agency indicated that a referral to an acute mental health facility was the only resource available to them. However, the CFS agency did not pursue mental health interventions for Circling Star beyond making a passive referral to a federally-funded local health service.

The lack of service equity for families living on First Nations communities is a long-standing issue. Children who reside in First Nations communities, where the federal government has funding responsibility, continue to bear the weight of that ongoing and persistent discrimination. Community advocates and activists have repeatedly called for equality in services for children living on First Nations communities. The need for mental health services is an area that has been well-established, particularly for families who receive services from CFS agencies.

Recent research published by the Manitoba Centre for Health Policy reports that, “Children with diagnosed mental and developmental disorders and suicidal behaviours are more likely to have been taken into the care of Child and Family Services....” (Chartier, Brownell, MacWilliam, Valdivia, Yao, et al., 2016, p. xxiv). The

12 For the full decision from the Canadian Human Rights Tribunal, see: [https://fncaringsociety.com/sites/default/files/2016%20CHRT%20Ruling%20on%20FN%20child%20welfare%20case.pdf](https://fncaringsociety.com/sites/default/files/2016%20CHRT%20Ruling%20on%20FN%20child%20welfare%20case.pdf)
need for CFS agencies to have access to reliable mental health resources is critical to effective service provision. The Indigenous perspectives outlined in a Healthy Child Committee of Cabinet (2016) report include jurisdictional issues and community inequities as barriers to clinical mental health services. In the case of Circling Star, both of these barriers limited his much-needed access to clinical mental health services.

For too long the CFS system has been expected to manage the complex care needs of families beyond the scope and capacity of the CFS system. This is ineffective and unsustainable. Too often, CFS workers – most of whom have training limited to child protection – are expected to manage the complex and multi-faceted needs of children in care and their families. MACY has long witnessed the efforts of overwhelmed CFS workers attempting to mitigate the significant gaps of our mental health and addiction systems for those on their sizable caseloads. It is little wonder that this places unsustainable strain on all involved including, children, families, caregivers, social workers, and allied support workers.

The issue of how mental health services are funded and delivered on First Nations communities has been examined by the courts in numerous inquest reports (e.g., Nadine Beaulieu, 2004; Susan Capella Redhead, 2004; Tracia Owens, 2008; Jaylene Redhead, 2014).

These inquests have called for several important recommendations, including:

- Improve and stabilize long-term, viable funding for mental health services on reserve;
- Improve coordination between the provincial and federal governments in the delivery of mental health services;
- set aside differences in jurisdictional disputes;
- streamline organizational structures in the delivery of mental health services on-reserve; and
- Prioritize mental health resource development for all levels of government.
Additionally, MACY has issued repeated calls for action on numerous recommendations related to Jordan’s Principle.\textsuperscript{13} Jordan’s Principle is a “child first” legal principle that ensures First Nations children expedient access to any public service when they are required. As such, payment and jurisdictional disputes must not delay health care access, including mental healthcare, by First Nations children and youth.

For the most part, these recommendations by the Advocate and from past inquests by the courts pertaining to mental health have not been implemented in a meaningful way. At present time, some progress in the allocation of resources and funding has been seen. Compliance with the Orders from the Canadian Human Rights Tribunal (2017) will be monitored to ensure Jordan’s Principle is upheld in good faith.

The findings above and the lack of equitable access to mental health services for Circling Star in his home community can be addressed by the Virgo report’s recommendation 5.4: \textit{the need to address access issues related to clinical mental health services for children and youth in rural and remote communities; and the need to address the inequity of services for Indigenous children and youth who live in First Nations communities.}

Services that support the mental health of Indigenous children and youth, including those who live in geographically remote communities, require significant enhancement and investment. Central to ensuring fair and equitable access to services, mental health service providers must establish and implement information-sharing protocols in order to make and respond to referrals among community-based service providers. Further, when youth discharge themselves from healthcare or mental healthcare facilities, service providers must abide by their legal duty to report safety concerns to CFS. Moreover, policy decision-making related to services for children and youth must adopt a children’s rights impact assessment lens and a harm reduction lens.

\textsuperscript{13}Jordan’s Principle is named for Jordan River Anderson, who died in the hospital at the age of five, never having spent a day in his family home due to jurisdictional disputes over his healthcare.
RECOMMENDATION THREE: MENTAL HEALTH

The Manitoba Advocate for Children and Youth recommends the Department of Health, Seniors and Active Living implement, in full, recommendation 5.4, per the Virgo report, as follows:

*Establish a concerted cross-sectoral process to reduce perceived and real jurisdictional boundaries that challenge access to, and coordination of, services. The process of developing this [Manitoba’s Mental Health and Addictions] Strategy, as well as any new opportunities and resources for working together (e.g., through Jordan’s Principle), should be viewed as an accelerator of a new period of trust and collaboration based on shared beliefs and strengths among all partners, and should include an interest in wellness, hope and family/community health.*

DETAILS:

- Specifically, provisions in the following areas are needed within Manitoba’s Mental Health and Addictions Strategy:
  - Post-discharge supports for children and youth who have experienced mental health concerns, including addictions issues;
  - A continuum of services, reflective of culturally-safe and trauma-informed approaches, for all of Manitoba’s children and youth, including Indigenous children and youth, and those who live in First Nations communities; and
  - A continuity of care model that ensures equitable standards of service when First Nations children and youth return to their home communities.

Addiction Services

**FINDING:** The Addictions Foundation of Manitoba (AFM) did not recognize that Circling Star’s ongoing and escalating addiction constituted a threat to his safety and resulted in AFM having a duty to report their concerns to Circling Star’s parents or to the child and family services agency as required under *The Child and Family Services Act.*
Of all the service providers who supported and worked with Circling Star, the school-based AFM counsellor had the longest and most consistent relationship with him. The information found in the AFM file record provides a detailed look at Circling Star’s perspectives on specific areas of his life. The AFM counsellor made a referral for mental health services in April 2014, as well as referrals to CFS in September 2014 and March 2015, when AFM felt that Circling Star’s living situation was unsafe. The AFM worker advocated strongly for a suitable foster placement for Circling Star once he was in care in 2015.

Circling Star’s history was one of escalating involvement with alcohol and drugs. At age 14, when he began meeting with AFM (October 2012), Circling Star estimated he was spending $180.00 a month on drugs and alcohol; was using a half gram of cannabis daily, with more on the weekends; was drinking 26 ounces of alcohol at a time; and using cocaine and prescription drugs irregularly. Two months later, in December 2012, Circling Star reported using 2 grams of cannabis daily. When he met with AFM in February 2013, he reported his substance use included alcohol several times a week, T3s, and clonazepam. In October 2013, one year after beginning his AFM sessions, Circling Star indicated that he had not planned to drink on a particular day but could not resist. He added that he had not used cocaine for about a month. By June 2015, he told his AFM counsellor that he was using 6-8 grams of cannabis each weekday and that he was drinking “lots.”

In March 2014, in an assessment tool used by AFM, Circling Star strongly agreed with the statement: *It would be better if I was dead.* In April 2014, with parental permission, the AFM counsellor made a mental health referral. In a May 2014 Youth Counsellor Directed Assessment, the AFM counsellor wrote that two years ago, Circling Star had tied a belt around his neck but was too scared to follow through on harming himself. On October 3, 2014, the AFM counsellor heard from school staff that Circling Star had been asked to leave his grandparents’ home, where he was residing, and may not have had a place to stay. The AFM counsellor called CFS and spoke to the supervisor. In October 2014, Circling Star was transported to the acute mental health facility with suicidal thoughts. The AFM worker approached CFS on March 9, 2015, with concerns about Circling Star’s placement. She expressed further concerns to CFS on March 25, 2015, when she described Circling Star as bruised and thin looking, with a history of suicidal thoughts.
When concerns related to Circling Star’s mental health or living situation arose, the AFM counsellor did not hesitate to access additional services. However, Circling Star’s escalating alcohol and drug use was not seen as meeting a threshold that would suggest a need for information sharing. However, the disclosures that Circling Star was making to the AFM counsellor did, indeed, constitute a duty to report to Circling Star’s parents or to CFS, as required under s.17 of The Child and Family Services Act, as follows:

Child in need of protection

17(1) For purposes of this Act, a child is in need of protection where the life, health or emotional well-being of the child is endangered by the act or omission of a person.

Illustrations of child in need

17(2) Without restricting the generality of subsection (1), a child is in need of protection where the child

(a) is without adequate care, supervision or control;

(b) is in the care, custody, control or charge of a person
   (i) who is unable or unwilling to provide adequate care, supervision or control of the child, or
   (ii) whose conduct endangers or might endanger the life, health or emotional well-being of the child, or
   (iii) who neglects or refuses to provide or obtain proper medical or other remedial care or treatment necessary for the health or well-being of the child or who refuses to permit such care or treatment to be provided to the child when the care or treatment is recommended by a duly qualified medical practitioner;

(c) is abused or is in danger of being abused, including where the child is likely to suffer harm or injury due to child pornography;

(d) is beyond the control of a person who has the care, custody, control or charge of the child;

(e) is likely to suffer harm or injury due to the behaviour, condition, domestic environment or associations of the child or of a person having care, custody, control or charge of the child;

From a 2012 UNCRC poster campaign by our office and some of our inter-provincial partners
(f) is subjected to aggression or sexual harassment that endangers the life, health or emotional well-being of the child;

(g) being under the age of 12 years, is left unattended and without reasonable provision being made for the supervision and safety of the child; or

(h) is the subject, or is about to become the subject, of an unlawful adoption under The Adoption Act or of a sale under section 84.

**Reporting a child in need of protection**

18(1) Subject to subsection (1.1), where a person has information that leads the person reasonably to believe that a child is or might be in need of protection as provided in section 17, the person shall forthwith report the information to an agency or to a parent or guardian of the child.

In discussion with AFM staff, there do not appear to be guidelines, policy, or procedures for AFM youth counsellors that would suggest a need to share information with parents or guardians. However, contrary to their indication, a policy regarding information sharing was subsequently made available to MACY. As such, there appears to be a lack of staff awareness regarding the existence of a policy, and a lack of training concerning its implementation.

There is a significant difference between substance use treatment and addictions service available in Winnipeg and services in rural areas, and the ability to include families in treatment plans. Records indicate that counsellors in Winnipeg try to engage with parents and prefer to have youth consent to regular AFM contact with parents (Interview, AFM staff, May 10, 2018). Family therapy, parent intervention and support are available in Winnipeg. In contrast, Circling Star’s AFM counsellor indicated that AFM usually expects the parent to reach out to the CFS agency. However, it is unreasonable to expect parents and guardians to know when and how to reach out if they are kept in the dark about the disclosures their child may be making during AFM sessions. According to AFM, in rural areas, there are no additional support options available.

AFM uses a biopsychosocial model of addiction and a client-centred approach in the provision of services. The model recognizes “that complex interactions between various biological, psychological and social factors appear to contribute to the development of addiction problems” (Addictions Foundation of Manitoba, 2000, p. 2).

AFM’s client-centred approach is defined as:

- Philosophically and practically prioritizing clients within the work; recognizing that all other work is done in support of the main priority

- A way of working based on client-centred principles (value and dignity, engagement and access, collaboration which values autonomy, effectiveness, staff are integral); puts the needs and strengths of the clients at the heart of service development and delivery (Addictions Foundation of Manitoba, 2013, p.3)
Within this framework, Motivational Interviewing (MI) was the only technique used with Circling Star. “MI seeks to enhance clients’ motivation towards change through empathic, non-authoritarian and non-coercive methods” (Addictions Foundation of Manitoba, 2012, p.14). This method prohibits direct persuasion, aggression, or argumentation. The AFM counsellor strives to be an appreciative ally focussing on engagement, motivation, and sharing professional knowledge. Treatment goals are choices made together based on circumstances, experiences, needs, strengths, wishes of the client, and available resources (Addictions Foundation of Manitoba, 2013). Staff “are encouraged to use Motivational Interviewing and Brief Intervention techniques to assist the clients in making the best decision regarding their treatment and the goals they set for themselves” (Addictions Foundation of Manitoba, 2012, p. 20).

MI was the only consistent intervention that Circling Star received through AFM, yet at the time there was little evidence that this approach was effective to address the treatment needs of children and youth. In 2014, a quantitative review of randomized trials measuring the effectiveness of MI on adolescents found the effect of MI to be too small for practice relevance, concluding that there are no substantive benefits for the prevention of alcohol use of MI (Foxcroft, Coombes, Wood, Allen, & Almeida, 2014). A more recent review and meta-analysis of ten randomized controlled trials of MI with a sample size of 1,466 participants found that motivational interviewing had no statistically significant effect on the drug use behaviours of adolescents (Li, Zhu, Tse, Tse, & Wong, 2016). AFM indiscriminately applied an intervention used for adults to children, notwithstanding the lack of support for this practice. As a result, Circling Star was deprived of his right to access the highest standard of healthcare as detailed by Article 24 of the United Nations Convention on the Rights of the Child. As part of MACY’s analysis for this special report, the Advocate met with a leadership representative of AFM who concurred with our assessment that the MI-focused approach taken with Circling Star was limited.

Despite increasing evidence suggesting that Circling Star’s substance misuse and mental health were deteriorating, no alternative approaches, treatments, or interventions were explored. From age 14 to age 17, when he was attending counselling sessions with AFM, Circling Star’s drug and alcohol use escalated and created significant levels of risk in his life. And, still, AFM continued to rely on MI, listening and recording disclosures of risks he was experiencing in his life related to his addictions, without offering treatment or other interventions to prevent harm. In viewing Circling Star’s life, it is clear that the motivational interviewing approach was neither a brief intervention as is intended, nor was it effective in assisting Circling Star to become motivated toward change or increased safety.

It is unacceptable that Circling Star’s parents were never afforded any meaningful opportunities to be brought into the treatment plan that was being used with their son. Meaningful involvement of a child’s family is considered best practice and leads to better outcomes for children and youth. Family-based interventions conceptualize youth addictions as a multidimensional problem and simultaneously address the individual, family, and environmental factors that are associated with the adolescent substance misuse. These interventions have been rigorously evaluated and have demonstrated clinically significant changes (Austin, Macgowan, & Wagner, 2005; Das, Salam, Arshad, Finkelstein, & Bhutta, 2016). There is some indication these interventions are not only superior to no treatment, but may be
more effective than other treatments at addressing adolescent substance misuse (Hartnett, Carr, Hamilton, & O’Reilly, 2017).

While AFM’s intentions were good, service providers who held a responsibility of care witnessed and documented Circling Star’s dangerous decline instead of implementing meaningful interventions. Beginning at age 14, Circling Star’s addiction issues impacted nearly all of the areas of his life and his drug and alcohol use were significant contributing factors to his death.

On September 21, 2018, the Manitoba Advocate released her Statement of Concern with Manitoba’s mental health and addictions strategy and the lack of action regarding the Virgo report recommendations. Importantly, the Advocate calls for a continuum of youth mental health and addiction services and supports that are evidence-based, culturally-safe, trauma-informed, and accessible when they are needed. These services and supports must reach out and work with children and youth where they are at. What Manitobans may not know is that too many services funded by the public have restrictive admissions criteria that prevent our youth from getting the treatment and support they need. When youth are struggling with mental illness and addiction issues, we often only have a small window of time to make a difference in a young person’s life. Barriers to treatment must be knocked down, including long wait lists for scarce programming. The full statement of concern can be found at the following link: http://manitobaadvocate.ca/wp-content/uploads/Advocates-Statement-of-Concern-MH-Addictions.pdf

The Addiction Foundation of Manitoba’s (AFM) worker developed an enduring relationship with the youth and conducted a thorough documentation of the case. However, while the AFM worker had good intentions, the youth did not receive an effective treatment for his addiction issues because: 1) effective treatment was not available in rural areas; 2) treatment did not include family and environmental factors; and 3) treatment was not evidence-informed. Further, AFM policies and procedures do not clearly recognize escalating drug use as a child protection concern. As a result, the child was denied the right to protection from harm and the right to access the highest standard of healthcare (UNCRC, Article 24, Article 33).
RECOMMENDATION FOUR: ADDICTION

The Manitoba Advocate for Children and Youth recommends that the Department of Health, Seniors and Active Living, together with front-line addiction service providers in Manitoba, Healthy Child Manitoba, Indigenous communities, and subject matter experts on addictions, immediately respond to the lack of effective substance use treatment services for youth by prioritizing the development and implementation of a youth addiction action strategy. This strategy should be based on best practice evidence with the objective of ensuring that children and youth across Manitoba can exercise their right to the highest attainable standard of health.

DETAILS:

- That the Department of Health, Seniors and Active Living, go beyond the VIRGO analysis and conduct a service inventory of all child and youth addiction services in Manitoba, their locations, target populations, philosophies, eligibility criteria, utilization rates, and occupancy rates.
- That the Department of Health, Seniors and Active Living expand upon the VIRGO analysis to evaluate existing gaps in substance use treatment and addiction services available to children and youth, including recommendations as to how existing services could be repurposed.
- That the Manitoba’s Mental Health and Addictions Strategy developed by the Department of Health, Seniors and Active Living include a plan that ensures implementation of evidence-informed family-centred substance use and addiction programs.
- That the Department of Health, Seniors and Active Living oversee regular performance monitoring and program evaluations to ensure that all publicly-funded and provincially-mandated agencies are accountable to provide evidence-informed addiction services and programs for children and youth.
- That all provincially-funded addiction service providers working with children and youth implement policies and procedures for ongoing training on the identification and reporting of cases where a child is in need of protection as outlined in The Child and Family Services Act.
### Table 3 – Judicial Pre-Sentence Report and Probation Order Process

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Youth is found guilty or pleads guilty. A Pre-Sentence Report (PSR) may be requested by the Crown and/or Defense. In the case of a youth, the judge, may at his own discretion, request a PSR.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2</td>
<td>Judge orders a PSR, which may include reference to Gladue considerations if the person is of Indigenous descent.</td>
</tr>
<tr>
<td>Step 3</td>
<td>Probation Officer (PO) is assigned to write the PSR. The PO is provided by the Crown with the arrest report, the criminal record, and any other documents agreed to between Counsel.</td>
</tr>
<tr>
<td>Step 4</td>
<td>PSR is prepared by a PO, which includes recommendations with respect to Community Dispositions (e.g. the Probation Order).</td>
</tr>
<tr>
<td>Step 5</td>
<td>PSR is provided by the PO to the Court, the Crown, and Defense.</td>
</tr>
<tr>
<td>Step 6</td>
<td>PSR is dealt with at the sentencing hearing along with submissions by the Crown and Defense concerning the Disposition.</td>
</tr>
<tr>
<td>Step 7</td>
<td>Court orders Disposition, including Probation Conditions, if warranted.</td>
</tr>
<tr>
<td>Step 8</td>
<td>A supervising PO is assigned. Generally this is the same PO that originally prepared the PSR.</td>
</tr>
<tr>
<td>Step 9</td>
<td>The PO monitors the Probation Order conditions and oversees that the conditions are complied with, failing which there is the option of breaching the youth or to apply for a variance to add/delete/change the conditions.</td>
</tr>
<tr>
<td>Step 10</td>
<td>If the individual fails to comply, the Probation Officer will make a referral back to the Crown Attorney to determine how to proceed with the court-ordered violation.</td>
</tr>
</tbody>
</table>

As explained in the section of this special report on Circling Star’s story, following the arson for which he was convicted, Circling Star was sentenced to one year of probation with conditions to:

- keep the peace;
- report to the probation officer as required;
- attend school and follow rules;
- attend and participate in addictions assessment and counselling and any or all other counselling;
- have no contact with two named youth;
- observe a curfew from 10:00 p.m. to 6:00 a.m., unless he was with his parents;
• abstain from alcohol and drugs; and
• complete 120 hours of community service.

Problematically, he was not equipped, adequately supported, or in a position to meet many of these conditions. Consider a few examples that highlight that meeting these conditions was arguably unachievable.

Firstly, as noted above, in his Gladue pre-sentence report, Circling Star was described as believing “he has problems with drugs and alcohol” (p. 8). Circling Star explained that, “the amount of alcohol, drugs and pills being used in [my home community] does have a negative impact on me.” He also said, “seeing it all around me, all the empty baggies and beer cans, it’s hard to deal with, but I’m trying my hardest to avoid it”(p. 8). His mother further explained that he was around quite a bit of drinking and occasional drug use. In spite of this youth’s own words and actions that, in hindsight, clearly demonstrate he was struggling with an addiction to alcohol and drugs, he was ordered to completely “abstain from alcohol and drugs”. This is not an achievable intervention for a youth struggling with an addiction. Further, Circling Star was to participate in addictions counselling, but the counselling he was ordered to attend was with a school-based AFM counsellor. The Advocate wonders how he was expected to meet with this counsellor when he was suspended on numerous occasions, including long stretches of time.

Thirdly, Circling Star’s probation conditions included attending school, which again, was not possible when he was suspended from school.

In light of this, it is little wonder that Circling Star made only short-term and modest attempts to meet his conditions. There is no evidence that he formed a meaningful relationship with the probation officer or the ISSP worker with whom he had inconsistent contact. He did not take advantage of his school suspensions to complete his community service hours. His use of alcohol and drugs increased significantly despite one of his conditions being abstaining from substance use. His school attendance was marked with a number of suspensions and disciplinary referrals. He was breached once for lack of compliance and this, too, did not have the effect of helping Circling Star change any of his behaviours.

These outcomes do not align with the principles of The Youth Criminal Justice Act, under which, as per s. 3(1)the criminal justice system is intended to promote the rehabilitation of young persons who have committed offenses, emphasize “fair and proportionate accountability”, “timely intervention”, and “be meaningful for the individual young person given his or her needs and level of development and, where appropriate, involve the parents, the extended family, the community and social or other agencies in the young person’s rehabilitation and reintegration” (YCJA, S.C 2002, c.1(3)).

Furthermore, the lack of meaningful probation conditions for Circling Star points to a disconnect between the Community Safety Division’s core values and what is transpiring in reality for children and youth in Manitoba.
According to the Community Safety Division’s website, it “manage[s] offenders with appropriate control, supervision and support” and “provide[s] programs and services that help offenders learn to become productive members of society.” (Manitoba Justice, n.d.) However, as seen above, appropriate supervision, support, programming, and services were not provided to Circling Star.

The Community Safety Division further explains that its core values are:

- **Respect** – we accept diversity and the unconditional worth and rights of all people.
- **Accountability** – we openly communicate and manage our services, evaluate ourselves and take responsibility for the results.
- **Growth and development** – we believe every person has potential and we provide opportunities and support for change.
- **Recognition** – we believe our strength and most important resource is our staff and that they are most effective in a safe, challenging and rewarding work environment.
- **Working together** – we work with individuals, communities and organizations to create a safe, crime-free society. (Manitoba Justice, n.d.)

Based on Circling Star’s experience, the Advocate would like to draw attention to how the principles of accountability and working together could have been better implemented. With respect to accountability for results, Circling Star’s probation orders were too general and not child specific. With respect to working together, the evidence reviewed by the Advocate reveals inconsistent contact with his probation officer and Intensive Support and Supervision Program (ISSP) worker, challenges and missed opportunities to work together with his community and family to ensure he was adequately supported. For instance, Circling Star could have benefitted from community service under the supervision of a local Elder. Such an intervention could have better helped restore the community’s trust and repair Circling Star’s reputation in his community. As a result of the lack of accountability and working together, Circling Star did not meaningfully benefit from his probation conditions.
In rural Manitoba, there are additional challenges to delivery of a relevant probation service. At the time of Circling Star’s supervision, his probation officer had a blended caseload of 50-60 youth and adults across a wide geographical area. There was limited opportunity to establish and maintain a relationship with Circling Star and his family. The increased monitoring offered by the additional ISSP worker was also made less effective by distance. In-person contact was reduced to once every two weeks instead of weekly, as a result of distance. In the view of Circling Star’s probation officer, a partnership with the parents or guardians of a youth on probation is the key to compliance and progress (Interview, Circling Star’s probation officer, November 2, 2017). Unfortunately, as reported to our office during this investigation, in Circling Star’s case, the relationship between his family and the probation officer did not develop in a positive way and there does not appear to have been intervention to resolve this.

**FINDING:** The entire community may have benefitted from and been able to heal through a facilitated process of restorative justice, which was not made available to them.

Perhaps of greater long term impact on Circling Star was the community’s response to the consequences dealt out by the court. Circling Star’s charge, conviction, and conditions did not allay the community’s need to see him take responsibility for the crime committed. As his parents and the AFM counsellor noted, Circling Star became a target in the community. The anger in the community was not lessened by the court process and Circling Star continued to suffer from that anger long after his probation was ended. Circling Star was called a “terrorist,” by some community members; he was the first one blamed for things that occurred in the community. He also had to avoid traffic if he was walking on the roadside, as he had been threatened by people swerving at him in the past. Circling Star’s father stated that he bought Circling Star the SUV, the vehicle in which Circling Star died, so that he would not be vulnerable as he walked around the community (Interview, Circling Star’s parents, November 23, 2017; Circling Star’s AFM worker December 5, 2017).

A meaningful, community-focused conflict resolution process, either instead of or in addition to his court conditions, could have been useful. Circles (healing circles or sentencing circles) provide a space for an encounter between the victim and the offender and move beyond that to involve the community in the decision making process. In Circling Star’s case, the victim of the arson for which he was charged was the community. The circle process is value driven, based on respect, honesty, listening, truth, and sharing. The purpose is primarily to bring healing and understanding to the victim and the offender (Parker, 2001, para.3). Reinforcing this goal of healing empowers the community to be involved in deciding what is to be done in the particular case and to address underlying problems that may have led to the offense (Parker, 2001, para.5).

Although few rigorous studies have been done on the effectiveness of sentencing circles, those that have examined the process have reported positive results overall. In a Minnesota study:

(... respondents noted the stronger connectedness of people in the community as an important feature (...) For the most part, the process is seen as fair in that it allows each person to have a voice
and to work together in finding a solution (...) In general, the process has been viewed as a good way of building relationships and strengthening the community. (Parker, 2001, para. 11)

**JUSTICE CIRCLES**

Circles are found in Indigenous cultures, and are used for many purposes. Their adaptation to the criminal justice system developed in the 1980s as First Nations peoples of the Yukon and local justice officials attempted to build closer ties between the community and the formal justice system. In 1991, Judge Barry Stuart of the Yukon Territorial Court introduced the sentencing circle as a means of sharing the justice process with the community.

Circles have been developed most extensively in the Yukon, Saskatchewan, and Manitoba. The process is now used throughout North America and in other parts of the world for both juvenile and adult offenders in a wide variety of offences and settings.

(Centre for Justice and Reconciliation, n.d.)

The Advocate recognizes that circles are not always possible, but stresses the need to explore this alternative approach and others so that youth like Circling Star benefit from effective rehabilitation and reintegration.

The need to implement alternative measures, including restorative justice, has long been acknowledged and recommended. This dates back, for instance, to *The Aboriginal Justice Inquiry* (1991) and *The Aboriginal Justice Implementation Commission’s Final Report* (2001) which recommended that “Manitoba’s alternative measures guidelines be amended to allow any young offender to be referred to an alternative measures program. The police, lawyers, Crown attorneys and judges should consider such measures in *every case*” (Ch.15, emphasis added).

In 2018, the Government of Manitoba released its *Criminal Justice System Modernization Strategy*, in which a key objective was to “more effectively use restorative justice options to improve public safety, reduce delay in the court system, and ultimately reduce reliance on incarceration, especially in the case of Indigenous offenders” (2018, p. 2). At this time, it is unclear how restorative justice programs and commitments, including the *Restorative Justice Act*, are being implemented and what their effects are on youth and their communities.

The Advocate has also made at least five justice related recommendations based on findings in our investigations and systemic reports.

In spite of the repeated findings and commitments made by numerous stakeholders to create systemic change to the justice system, Circling Star (aged 14 years old) was charged and given probation with no consideration to alternative measures such as restorative justice approaches. During his time on probation, Circling Star was threatened by community members who were upset with his behaviour and remained isolated from potential sources of support in his community. Probation services did not contribute to the resolution of the underlying causes of Circling Star’s behaviour and did little to support his reconciliation and reintegration with his community.
RECOMMENDATION FIVE:
JUSTICE

The Manitoba Advocate for Children and Youth recommends that the Department of Justice improve communication across the divisions within its department, including probation services, victim services, and prosecution services, as well as with the legal community (e.g. legal aid), and the courts to ensure that probation orders are relevant, effective, child-centred, realistic (given limitations in remote and rural communities), and achievable. The Advocate further recommends that the Department of Justice evaluate their capacity to provide the programming for youth to meet their probation conditions and determine whether or not existing programs and services are sufficient and accessible to youth living in rural and remote locations. When gaps are identified, strategies for culturally appropriate alternatives and program delivery need to be developed.

DETAILS:

- The Advocate recognizes that it does not have jurisdiction over the courts. Following this report, we recommend that the Department of Justice initiate a process of improved communication and dialogue within its department, with the courts, and other key stakeholders to ensure that probation orders are relevant, effective, child-centred, realistic, and achievable.
- The Department of Justice’s evaluation of existing capacity to provide programming for youth to meet their probation conditions should contain an overview of existing accountability data and analysis of the effectiveness and accessibility of current services and programming delivered to youth in Manitoba.
- A plan is needed for situations when probation services do not have the capacity to provide ongoing supervision, monitoring, or formal programming such that collaboration and partnership with local communities occurs to devise a strategy to deliver these services.
As noted previously, The Child and Family Services Act (CFSA) provides illustrations of a child in need of protection, including a child who is without adequate care, supervision, and control. Throughout his involvement with the CFS agency, Circling Star was without adequate care, supervision, and control, and was therefore a child in need of protection. The CFS agency’s primary responsibility was to ensure his safety and security; however, this was limited by the CFS agency’s lack of intervention and further complicated by Circling Star’s resistance to any sustained intervention. As a strategy, the CFS agency supported Circling Star in whatever residential option he chose. Consequently, Circling Star chose options that allowed him to avoid supervision and control. His placement choices sat in contrast to his need for safety and security and the CFS agency’s obligation to ensure his safety. The CFS agency had a responsibility to make Circling Star’s safety, security, and best interests their paramount consideration, both in the times he was a child in care as well as when his guardianship rested with others. However, instead of thoughtful planning based on assessments and collaboration with his family and the many service providers involved in Circling Star’s life, the CFS agency did not provide meaningful interventions to protect Circling Star as his risk continued to increase.

The ways in which CFS services are to be delivered in Manitoba are set out in the Child and Family Services Standards Manual, which describes the minimum service standards that must be met by all workers in each agency delegated by the Minister of Families (through the relevant CFS Authority) to deliver CFS services in the province. Volume 1 Agency Standards of the manual is organized into eight chapters:

1. Case Management,
2. Services To Families,
3. Child Protection,
4. Children In Care,
5. Foster Care,
6. Adoption Services,
7. Service Administration, and
8. Agency Operations.14

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14 The minimum CFS services standards manual is online and can be accessed at this link: https://gov.mb.ca/fs/cfsmanual/index.html
The minimum provincial CFS standards are meant to establish the baseline of CFS work in the province. However, the ability of the system to consistently meet these minimum standards has long been viewed as an unachieved goal not only by The Advocate, but by many others, including the Department of Families itself. Workers not meeting minimum standards and confusion regarding standards are concerns that have been previously examined in Manitoba by Commissioner Ted Hughes during the Phoenix Sinclair Inquiry.

The introduction to the online standards manual notes that it is the responsibility of the Department of Family Services (now the Department of Families) to set minimum standards. The manual further acknowledges that standards are in various stages of completeness and are located in various locations that workers may access:

- The Department of Family Services has a statutory obligation to establish standards for the delivery and administration of child and family services and adoption services in Manitoba.
- With proclamation of The Child and Family Services Authorities Act, responsibility for the development of standards is now shared with child and family services authorities. The province retains responsibility for the establishment of provincial standards.

Existing provincial standards are currently in various manuals. The format and content of these manuals vary. Also, the manuals have not been consistently updated and distributed.

The Director of Child and Family Services (Child Protection Branch) and child and family services authorities have jointly identified the need for an on-line manual that is readily available and revisable.15

An element of the challenge regarding establishing standards and then ensuring all CFS work meets these standards at a minimum, lies not only in that the CFS manual is lengthy and onerous, but that when CFS workers begin working with families without having been trained in these minimum standards, it is unrealistic to expect that they will deliver services to families that meet these standards. The Manitoba CFS system has been partly devolved from a centrally-controlled system (as seen in most other provinces whereby a government department is wholly responsible for delivering provincial child and family services), to a system unique to Manitoba where four culturally-based CFS authorities receive their mandates from the provincial government to oversee their own agencies and service delivery that is intended to be more responsive to community and cultural needs. Devolution of the CFS system in this province began with the proclamation in 2003 of The Child and Family Services Authorities Act. Since that time, families receiving CFS services in Manitoba have been able to receive those services from the authority that aligns with their cultural preference.

An additional challenge observed by our office is that service can be inconsistently delivered to families, depending on a number of factors. The minimum provincial service standards are intended to ensure that regardless of where a family is located in the province or which agency or authority they are in

15 See https://gov.mb.ca/fs/cfsmanual/0.0.0.html
contact with, that service standards are similar, while also reflecting local context. When families are not receiving services that meet minimum standards of practice, *The Child and Family Services Act* and *The Child and Families Authorities Act* describe the lines of accountability and which entity is responsible for what element of service delivery.

**Table 4 – Brief Summary of Duties by Area of CFS System Structure**

<table>
<thead>
<tr>
<th>Role</th>
<th>Duties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minister of Families</strong></td>
<td>• Duties including: administration of <em>The Child and Family Services Act</em> (CFSA), administrative oversight of the Director of Child Protection; delegating through regulations powers and duties from the Director to the Authorities; in consultation with the Authorities, passing regulations respecting any other matter the minister considers necessary or advisable for ensuring the appropriate delivery of CFS services.</td>
</tr>
<tr>
<td><strong>Director of Child Protection (Child and Family Services Division)</strong></td>
<td>• Duties including: administering and enforcing the CFSA (with the Authorities); ensuring the development and establishment of standards of practice for service delivery; carrying out investigations and making enquiries into the welfare of any child; performing any such duties as may be prescribed by the CFSA or as may be required by the minister</td>
</tr>
<tr>
<td><strong>The 4 CFS Authorities (Northern First Nations, Southern First Nations, Metis, General)</strong></td>
<td>• Duties partly include: administering and enforcing the CFSA (with the Director of Child Protection); administering and providing for the delivery of child and family services through its agencies; promoting safety and protecting children; advising the minister about child and family services matters; developing culturally appropriate standards; ensuring standards are consistent with provincial minimum standards; ensuring agencies deliver services that meet minimum standards and ensure safety of children; allocating funding among agencies; ensuring development of appropriate placement resources for children, etc.</td>
</tr>
<tr>
<td><strong>CFS Agencies in Manitoba</strong></td>
<td>• Duties including: protecting children, delivering services that meet minimum provincial standards; working with other systems to resolve issues likely to place children at risk; investigating allegations a child may be in need of protection; providing family guidance and counselling; providing services to families that will help them care for their own children, providing care for children in care; providing other services and performing other duties under the CFSA or The Adoption Act; and conforming to direction given by the Authorities</td>
</tr>
</tbody>
</table>

Minimum provincial standards are not optional. They are required to be met so that families can be assured a minimum standard of care. As noted in the Phoenix Sinclair Inquiry (2014), “The Department [known now as The Child and Family Services Division] has the responsibility to develop foundational standards to ensure a level of consistency of practice across the province” (Volume 2, p. 373). And further, the final report of the inquiry noted, “A set of provincial foundational standards had been
released to all agencies and the Authorities in January 2005. Their development is ongoing and the current standards are posted online...These standards apply across the system, both on and off reserve” (Volume 2, p. 374).

CFS workers have an obligation to deliver services that meet standards, supervisors have the responsibility to ensure their workers are meeting those expectations, and so the chain of accountability connects, from agency, to authority, to CFS Division, and, ultimately, to the Minister of Families.

**FINDING:** The services provided by the Child and Family Services (CFS) agency under the responsibility of the Southern First Nations Network of Care suggest a need for improved training for CFS workers and supervisors to ensure they consistently follow legislation and meet minimum provincial standards, particularly in the areas of assessment, planning, service provision, and evaluation.

Case management in CFS service delivery has four basic components: assessment, planning, service provision, and evaluation. These components are described in the *Child and Family Services Standards Manual*.16

**Assessment**
The power of an assessment does not lie in the documents that it might produce but in the process of developing a joint understanding between a child, their family, and a CFS agency about what is needed and how those needs might be met. Thorough assessments provide a necessary and robust basis for meaningful intervention. The CFS agency’s files reviewed by the Advocate’s office for this investigation included some case summaries, but the required assessments were not evident. The CFS Standards Manual describes assessment as the ongoing process of gathering and analysing information on the strengths, needs, and resources of a person or family. Assessments must be updated as circumstances change or new information becomes available. Assessments include a determination of the level of risk to the child and the child’s ongoing safety. Minimum provincial standards require agencies to complete both family and child assessments. The family assessment should determine the family’s ability to care for its children and the level of service required. Where possible, it should include all members of the household. The child assessment should determine the child’s individual needs separate from the family (Child and Family Services Standards Manual 1.1.2).

Assessments are required to be completed and documented. However, they were absent from the file material. An early assessment of a youth who was refusing to live at home would have necessarily involved developing at least a rudimentary understanding of the family dynamic that was unfolding prior to Circling Star’s mother initially calling the CFS agency for assistance. Reviewing the initial intake in 2011 would have alerted the CFS agency to the emotional crisis that lay at the foundation of at least

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16The minimum required service standards can be found here at the Child and Family Services Standards Manual: [http://www.gov.mb.ca/fs/cfsmanual/index.html](http://www.gov.mb.ca/fs/cfsmanual/index.html)
some of the family difficulties. Meeting with both parents and the youth separately and together is required in order to fully understand strengths and challenges. A meaningful assessment process could have been the beginning of increased communication and understanding between Circling Star and his parents.

Throughout their involvement with Circling Star, the CFS agency’s primary assessment was that Circling Star needed a safe place to stay. Secondary to that was his need to attend school. While this was accurate on both counts, it was far from a complete view and the CFS agency’s assessment did not go beyond identifying these basic needs. Once the CFS agency felt that Circling Star’s immediate safety had been addressed, they were not successful in moving forward to address the issues that caused the safety concerns. No comprehensive assessment of Circling Star, of the growing family conflict, or of intrafamilial issues was undertaken. In fact, many of the red flags that appeared were ignored, for example, concerns of physical conflict between Circling Star and his dad, excessive drinking and drug use, and physical assaults on Circling Star by his girlfriend. When interviewed for this investigation, the CFS agency’s staff acknowledged a level of discomfort with their ability to complete assessments and recognized that some additional training would be helpful. (Interview, the CFS agency’s staff, November 15, 2017).

The lack of thorough assessments completed by Manitoba CFS agencies that are working with families is not a new issue. Indeed, it has been, and continues to be, an area of ongoing concern and one on which the Advocate’s office has made repeated recommendations (See Table 5, page 88). It is unreasonable to expect that CFS workers will be able to understand the needs of a family if proper assessments have not been completed, and this case is just one example of many. Accurate assessments are the core foundation of all interventions that follow, and so, a lack of assessments will nearly always mean that a CFS agency is operating from a deficit of knowledge about a family. As such, the offered interventions fall short or completely do not meet the family’s needs.

**Planning**

Planning is a basic building block of good casework. A good plan can lay out the needs of the family and identify which supports and services will be mobilized to support the family. The absence of a plan means that a CFS agency is left to react in the moment to emerging events and crises. According to
minimum provincial Case Management Standards, a case plan is required on every open family file and every child in care file. The case manager:

...invites, and when possible, involves all individuals in the family assessment relevant to the development of a written plan for the family regardless of a child’s status in care.... A written copy of the Ongoing Family Plan must be given to the family (Child and Family Services Standards Manual 1.1.3).

Case plans related to the 2014 intakes in September, October, and November were minimal. The CFS agency attempted to identify a safe residence for Circling Star without acknowledging, intervening, or mitigating any of the issues that led to him not living with his parents. As his needs were not outlined in an assessment, the only support need recognized was that of a place for him to stay. His parents were willing to house him, but put limits on his behaviour. From the time that he left home, there was no evidence that he was ever in a situation where he was in receipt of “adequate care, supervision or control” [Child and Family Services Act, Part III, s.17 (1)]. The family of Circling Star’s girlfriend did not follow through with the initial arrangement made in September 2014. Without any recorded exploration of why this plan did not work the first time, the plan was repeated in November 2014. The November 13, 2014, case plan was to “monitor Circling Star’s living situation and ensure he has a safe and secure place to reside.” What stands out for the Advocate is that at this point, the CFS agency was aware that Circling Star was experiencing homelessness and sleeping either in a car or in a bush camp of his own making. Additionally concerning was that the CFS agency had received reports that Circling Star’s girlfriend was physically abusive towards him, and, yet, with no investigation into these reports, the CFS agency moved forward with a plan for Circling Star to begin living in the same home as his girlfriend.

The Structured Decision Making® (SDM) minimum service levels and contact guidelines for the “moderate” Probability of Future Harm identified in the November 13, 2014 assessment tool are: a face-to-face contact between Circling Star and the case
manager every two weeks and one of every two of these contacts to occur in the family home.¹⁷ The CFS agency’s family enhancement (FE) worker had one face-to-face meeting with Circling Star in December 2014, to transport him to his AFM counsellor at school. There was no evident concern expressed by the CFS agency that Circling Star was not regularly attending school. By December 16, 2014, the family of Circling Star’s girlfriend was asking for Circling Star’s removal. At this point, the CFS agency simply left a phone message for Circling Star’s mother asking that she pick up Circling Star from the placement that had broken down.

In February 2015, the CFS agency took Circling Star into care to ensure that he had a safe place to stay because they had become aware, once again, that Circling Star was experiencing homelessness. In what appears to be a contradiction to their plan, the CFS agency then placed Circling Star in a home that the CFS agency assessed as high-risk.

During March 2015, Circling Star’s AFM worker unsuccessfully tried to speak with the CFS agency’s worker, and ultimately spoke with the CFS supervisor to relay her concerns. AFM reported to CFS that Circling Star lost weight, was bruised, and was still using alcohol and other drugs. In addition, AFM reported to CFS that Circling Star’s girlfriend was pregnant and that the relationship appeared to be near break-up. The AFM worker expressed concern for his safety, because after the last break-up Circling Star had a period of suicidal thoughts. The Advocate was unable to locate any information to suggest these significant concerns for the safety of Circling Star were acted upon by CFS.

There was no plan developed to address the growing crises in Circling Star’s life. A month later, in April 2015, the CFS agency developed a more detailed case plan to be presented to court in support of their application for Temporary Guardianship of Circling Star. At that time, the plan noted that Circling Star was to remain living with the B family, deemed high-risk, until his parents attended counselling. A number of other elements were included such as CFS agency transportation support so Circling Star could attend school, a mental health intervention that was part of the school plan, continued appointments with AFM, and counselling for Circling Star and his parents.

As cited above, Standard 1.1.3 requires family involvement in the development of the case plan.

However, this plan appears to have been made without the involvement or even knowledge of Circling Star or his parents. The CFS agency missed the opportunity that is afforded by meeting with the family to identify and acknowledge their concerns in the assessment phase of case management. This disadvantage was further compounded by excluding the input of the family in the development of the case plan. Circling Star’s parents informed our office that they were unaware of the CFS agency’s plan (Interview, Circling Star’s parents, November 16, 2017). The file documentation does not indicate that Circling Star or his parents had any knowledge, involvement, or commitment to the plan. The plan that was developed in April appeared to change in May and further attempts to engage the family in planning did not occur. Throughout this process, the CFS agency’s service was not consistent with standards or best practice.

When interviewed a second time for this investigation, Circling Star’s mother again confirmed that the CFS agency never communicated the details of the case plan presented in court to the family. She told our office that she had not known, at any time, that the CFS agency listed family counselling as an element of the intervention plan (Interview, Circling Star’s mother, September 21, 2018). Circling Star’s mother further noted that if the CFS agency had required the family to attend counselling, that this imposed condition might have made it more likely that the fractures in the relationship between Circling Star and his mom and dad might have been addressed in a meaningful way. Instead, it appears that the case plan articulated for the court process was completed solely to satisfy the court and not done to support the needs of the family.

Given that Circling Star’s mother agreed with the CFS agency’s intention to bring Circling Star into care as of January 13, 2015, a Voluntary Placement Agreement could have been used. This would have had the advantage of further involving Circling Star’s parents in discussion and decision-making.

**Service Provision**

The next step in case management, the service provision phase, is meant to implement the mapped out plan. To meet their intent of ensuring Circling Star was living in a safe place, the CFS agency twice advocated for him to live with his girlfriend, informed his biological father that he could not provide a residence for Circling Star, eventually took Circling Star into care, placed him in a home that did not meet the requirements as Place of Safety or a foster home, placed him for one day in a licenced foster home, and finally returned him to his parents.

On November 13, 2014, the CFS worker recorded that the plan was to “get Circling Star back to school as soon as possible.” On March 11, 2015, the CFS worker met with the school to make a plan for Circling Star’s return. The CFS agency made a great effort to overcome the barriers the school put in place to address the school’s fears about managing Circling Star’s behaviour. From the school and the CFS agency’s records, it was unclear what Circling Star’s attendance was in the three and a half months left of the 2014-2015 term. However, the AFM worker documented his attendance on seven of nine Wednesdays between March 18, 2015 and June 10, 2015.
The plan to involve Circling Star and his mother in counselling was implemented as far as referrals were made to the federally funded local health service. However, the CFS agency did not establish any feedback mechanism that would have indicated whether this intervention was actually occurring or being effective. When the CFS worker was told these appointments were not happening, the CFS worker indicated there would be follow-up. The file does not describe any follow-up or the results of any follow-up.

During the course of our investigation, the CFS agency staff indicated to our office that they had formerly received much stronger support in regard to counselling through a program by the CFS agency that sent a CFS agency’s employed counsellor to their community. This program was terminated due to lack of funds. It had the advantage of providing a more experienced counsellor who did not have close, personal connections with the community. The work of the CFS agency is made more complicated by concerns of confidentiality. Community residents are reluctant to disclose personal information to other members of the small community. CFS staff have kin relationships with many in the community that further complicate service provision. Additionally, CFS agency’s staff reported their desire for greater support from the political leaders in their community. They named other communities where the CFS agency receives recognition and appreciation for their role in serving the community (interview, CFS agency’s staff, November 15, 2017).

**Evaluation**

The final step in case management is to consider how successful the plan and service provision were in meeting the needs outlined in the assessment. The CFS agency made no formal evaluation of the service Circling Star received. However, in looking back on the service they provided, the CFS agency’s workers said they “strongly believe we did our best.” They believed that Circling Star was no longer actively involved with alcohol and drugs and his relationship with his family was improving (Interview, CFS agency’s staff, November 15, 2017). A review of the case management that Circling Star received offers additional insights.

Flaws in the CFS agency’s safety plans were highlighted when Circling Star was assaulted while residing with the R family and again, when the B family was assessed as high-risk. B’s use of drugs and his criminal record made him an unsafe choice as a guardian for a youth struggling with a number of issues of his own, including his own addiction issues.

CFS did not evaluate the success of the school plan and there was no indication that Circling Star’s attendance or his progress were analysed in a meaningful way. Circling Star abandoned school all together in the fall of 2016.

Counselling was a significant priority in plans for Circling Star as a child in care. Counselling was to occur with the AFM worker and the federally funded local health service counsellor. There was also intent to include Circling Star in counselling related to his relationship with his parents. Circling Star was resistant to continuing counselling with the AFM worker and with the federally funded local health service counsellor. In both instances, his reluctance was neither explored nor challenged. It is clear that the
statement about Circling Star from the B family caregiver that he “doesn’t drink anymore” was untrue and required further evaluation by the CFS agency. This was another missed opportunity to evaluate the plan and its implementation. Because the CFS agency had no information on the nature of the counselling Circling Star was receiving from either mental health or addiction service providers, the CFS agency was not in a position to realistically evaluate the effectiveness of this part of the plan.

The majority of the CFS agency’s interventions validated, supported, and funded the choices Circling Star was making. Whether he was choosing to live with his girlfriend or with a friend, the CFS agency supported his choice and either helped to arrange or directly provided financial support. The CFS agency did not question his drinking or drug use, did not offer any relationship counselling related to his parents or his girlfriend, and did not challenge any of his thinking or decisions, nor did they work to prepare Circling Star for fatherhood.

This led to a number of difficult situations. The CFS agency was put in the position of funding a placement that would not qualify for Place of Safety designation because of being deemed as criminal - high risk. If an investigation of the home had proceeded, other disqualifying factors known to the probation officer would likely have been identified. The CFS agency supported Circling Star in living with his girlfriend possibly without an awareness that this relationship was one of the reasons for his not living at home. In this instance, the CFS agency contributed to the continued disruption in the family. Accepting without question statements attributed to Circling Star (for example, that he was not drinking anymore; that he did not need to see a counsellor), may have led to negating a case plan for positive improvement. The CFS agency was also compromised when Circling Star returned home and the CFS agency was put in the unusual circumstance of providing financial support to the parents of a child who had just been made a temporary ward. When the CFS agency developed a comprehensive case plan dated April 16, 2015, it was abandoned by May 10, 2015, when Circling Star went home rather than staying in his foster placement.

Without adequate assessment, planning, service delivery, and evaluation, a CFS intervention can be ineffective at improving outcomes for a family, particularly if the CFS agency is unaware of many of the dynamics or issues, and is therefore unable to represent the youth and family’s voices.

In this case, the case work delivered by the CFS agency consistently fell short of minimum provincial standards. Many opportunities were missed to engage Circling Star and his family and to collaborate with other service providers active with the family. The Advocate can acknowledge that service delivery in rural areas can be more complicated due to fewer available services and that working in a small community can include certain challenges because of existing interpersonal relationships. However, neither of these issues provide sufficient justification for service delivery decisions that leave children in unsafe situations, or placed in unsafe environments. Child safety is non-negotiable and all measures must be taken to ensure safety is the priority concern for all service provided by a CFS agency.

The issues described here are not unique to Circling Star’s story; the Advocate’s office sees similar circumstances far too often in our province. (See Tables 5 and 6, pages 88 and 89)
CFS legislation and minimum provincial service standards are essential tools to protect the safety and wellbeing of children. Agencies must ensure their CFS workers and supervisors are properly trained and have a full understanding of the mandate of child protection. Minimum provincial service standard 1.8.1 *Workforce Qualifications* dictates the minimum requirements for education and training for all frontline, supervisory, and managerial staff within agencies.\(^{18}\) These standards outline what steps agencies must take if they hire staff who do not hold a social work degree, steps which include a written learning plan, additional training, increased supervision, and assigned mentors. Yet, in Manitoba, due in part to the lack of coverage capacity while staff attend training, ongoing workload pressures, lack of access to basic training, and how most training has been centrally delivered, some CFS agencies find themselves in a situation where they have to send new workers into the field with little training and without clarity on the minimum standards of service.\(^{19}\)

Given that the delivery of child protection services is complex and challenging, the standard in Manitoba is that frontline workers “…receive specialized training in family-centred child protection services within 12 months from the date they are hired.”\(^{20}\) This requirement may be met through the province’s series of trainings known as Core Competency or an equivalent course recognized by the Director of CFS in consultation with the agency’s mandated authority. The provincial standards manual further notes that “it is strongly recommended new staff receive this training within six months from the date they are hired.”\(^{21}\) However, most workers must travel to receive in-service training, the various modules are required to be taken in a particular order, workers must not miss any class time in order to achieve a certificate of completion, waitlists for Core Competency have historically been long, and, at times, CFS workers may have already been in the field for a year or longer before they attend training on the minimum standards of child protection work. Our office met with representatives from the agency, the Southern First Nations Network of Care, the CFS Division, and the Deputy Minister of Families to review the relevant sections of this special report. At this time, the Director of CFS advised that Core Competency training is not mandatory and that waitlists no longer exist (Administrative fairness meeting, CFS service domain, October 9, 2018). Notwithstanding this information, our office continues to hear from agencies that their staff members wait long periods of time to access Core Competency.

In the CFS system, robust and detailed training is fundamental and should be seen as non-negotiable. The Advocate believes that there would be a reasonable and wide scale public outcry if paramedics, police, and other first responders were active on duty prior to receiving basic training. Although CFS workers are not considered first responders in the traditional sense, they are often responding to emergent crises in unsafe conditions. Workers in the CFS system have a critical need to receive early, comprehensive training that ensures they understand the essential components of good case work: assessment, planning, service delivery, and evaluation. Training requirements on minimum standards

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\(^{18}\) See [http://gov.mb.ca/fs/cfsmanual/1.8.1.html](http://gov.mb.ca/fs/cfsmanual/1.8.1.html)

\(^{19}\) For more information on standards related to field staff, supervisors, and managers, see: [https://gov.mb.ca/fs/cfsmanual/1.8.0.html](https://gov.mb.ca/fs/cfsmanual/1.8.0.html)

\(^{20}\) See *In-Service Training for Child Protection Work* [https://www.gov.mb.ca/fs/cfsmanual/1.3.1.html](https://www.gov.mb.ca/fs/cfsmanual/1.3.1.html)

\(^{21}\) See [http://www.gov.mb.ca/fs/cfsmanual/print,1.3.1.html](http://www.gov.mb.ca/fs/cfsmanual/print,1.3.1.html)
must be clarified and prioritized by the province and continue to be augmented by the authorities via culturally appropriate standards and services models. In addition, training needs to be funded appropriately at the CFS Division and authority levels, delivered via modernized methods (e.g. webinars, online modules, or DVDs) and made available to all CFS workers and supervisors in a timely way so they can meet minimum standards and the cultural needs of the many diverse communities throughout Manitoba.

While some authorities have established robust training units that deliver diverse training to their agency workers, supervisors, and support staff, a gap remains in consistent, accessible, timely, province-wide training for all workers on the minimum provincial service standards, and how that training on standards is then translated to improved services to families through supervision. Further, the critical role played by supervisors to mentor and monitor the ongoing implementation of training cannot be underemphasized.

As part of this investigation, The Advocate analysed 569 recommendations that have been made in previous child death investigations by our office since February 2009, when The Manitoba Advocate for Children and Youth (MACY) office was known as The Office of the Children’s Advocate. As noted in Table 5 below, our office has made many recommendations related to concerns in the areas of: assessments (risk/family/child), planning, service delivery, service coordination, training, documentation, abuse investigations, and more. These are all areas covered by Core Competency basic training and described in minimum provincial service standards. In the previous nine years, the CFS system has reported that 462 (81%) of the 569 recommendations the Advocate has made are “complete,” and yet many of the same issues persist throughout the province and within the same agencies and CFS authorities.

Table 5 – CFS Recommendations by MACY (2009-2018)

<table>
<thead>
<tr>
<th>Theme Area</th>
<th>Mentions in Recommendations</th>
<th>Sub-Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>173</td>
<td>Assessment, Service Delivery, Case Planning, Evaluation</td>
</tr>
<tr>
<td>Service Coordination</td>
<td>111</td>
<td>Sharing of information between collaterals</td>
</tr>
<tr>
<td>Training for CFS Workers</td>
<td>108</td>
<td>Enhanced Training for Frontline Staff, Minimum Service Standard Training for Agency Staff, Suicide Awareness Training</td>
</tr>
<tr>
<td>Accountability</td>
<td>82</td>
<td>Proper File Recording, Proper Supervision</td>
</tr>
<tr>
<td>Safety/Risks to Child</td>
<td>61</td>
<td>Suicidality</td>
</tr>
<tr>
<td>Placement Issues</td>
<td>39</td>
<td>Licensing</td>
</tr>
<tr>
<td>Abuse Investigations</td>
<td>34</td>
<td>Proper Response to Reports of Abuse</td>
</tr>
</tbody>
</table>

22 The training unit of the Southern First Nations Network of Care provides a wide variety of training in the areas of caseworker requirements, supervisory skills, FASD awareness, trauma care, and computer skills. For more information, see https://www.southernnetwork.org/site/education
Recommendations in the area of Case Management in the table above have been made to each of the four CFS Authorities in Manitoba. This includes specific recommendations in regards to implementing training related to case management.

The Advocate continues to see gaps in minimum service delivery. These concerns are flagged not only by the Advocate’s investigators conducting child death reviews, but also extend to the Advocate’s advocacy services staff who work with children, youth, and young adults currently receiving services from the CFS system in Manitoba. Approximately 40% of cases open to our advocacy services program this year were related to concerns in the areas of assessment, planning, service delivery, and evaluation. The following table breaks down recent advocacy cases where at least one or more of the above areas of concern related to case management were reported to our Advocacy Services Program.

<table>
<thead>
<tr>
<th>OCA/MACY Advocacy Services Program cases with case management as an issue of concern</th>
<th>2016-2017</th>
<th>2015-2016</th>
<th>2014-2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>37%</td>
<td>39%</td>
<td>41%</td>
</tr>
</tbody>
</table>

This demonstrates that since Circling Star’s death there continues to be concerns with respect to the minimum standards of service being provided. It illustrates the continued need for training specific to minimum standards and, more importantly, the critical role supervisors have to mentor and monitor the ongoing implementation of minimum standards.

**RECOMMENDATION SIX: CHILD AND FAMILY SERVICES**

The Manitoba Advocate for Children and Youth recommends that the Department of Families in partnership with the Child and Family Services (CFS) Authorities: (1) clarify training content and expectations of workers and supervisors with respect to CFS minimum provincial standards, and (2) prioritize the development of high quality, culturally appropriate, modernized, and accessible training on the minimum provincial service standards within two years. The Advocate further recommends that all existing workers who have not received training on minimum standards and all new CFS workers be required to complete this training within three to six months.

**DETAILS:**
- That the Department of Families work with the four CFS authorities to clearly define training content, timelines, and requirement for CFS workers and supervisors per s.1.3.1 of the minimum standards manual.
- That the CFS authorities ensure that their CFS agencies adhere to standard 1.8.1 *Workforce Qualifications* and that clear education and training plans are developed and monitored for staff who do not meet this standard.
A Note About Recommendations:

With the proclamation of the Advocate’s new mandate provided by the *The Advocate for Children and Youth Act (ACYA)*, the Manitoba Advocate is empowered to monitor and report publicly on the level of *compliance* with recommendations made by the Advocate. Our new mandate includes child welfare, adoption, disabilities, education, mental health, addiction, victim, and youth justice services.

Our office is also committed to improving public awareness and opportunities for public education. To that end, the Advocate has initiated processes whereby systems, which receive recommendations for change, will be required to report their progress to the Advocate every six months. Those updates will be analysed by our office and this analysis will be shared publicly so that Manitobans can further monitor improvements in publicly funded, child-serving systems.
A Final Thought from the Manitoba Advocate

Circling Star became briefly known to the local CFS agency when he ran away from home in 2011, after learning the identity of his biological father. While the immediate issue subsided and he returned home, his family shared with us that the shocking impact of this revelation in his life was the starting point for all of the challenges that arose for Circling Star during the five years before his death. Circling Star entered high school in 2012 and struggled in that new environment. He was suspended from school many times for behaviour incidents, which appeared to reflect an ongoing conflict with one specific teacher that was never effectively addressed by the school or the division. He was referred to addictions counselling for his early and ongoing misuse of alcohol and drugs, and Circling Star met with his addictions counsellor consistently between 2012 and 2015, while his substance use escalated to dangerous levels. He was found guilty of arson and sentenced to one year of probation in 2013. Probation services monitored Circling Star’s compliance with his conditions from 2013 -2014, but Circling Star did not modify his behaviour enough to meet any of the imposed conditions before the end of his probation order. He sporadically attended school and he continued to regularly use drugs and alcohol. In 2014, family conflict became so escalated that he was no longer living with his parents or his grandparents. For his own safety, he was made a temporary ward of the CFS agency of the Southern First Nations Network of Care for six months in 2015. Throughout his involvement with the CFS agency, he did not settle into any of the placement options open to him. His tumultuous relationship with a girl a year his junior was reported to have been marked by violence. The couple became parents when their daughter was born in 2015. Shortly thereafter, Circling Star died as the intoxicated driver in a single motor vehicle accident when he was seventeen years old.

The story I have shared with you today is larger than what my team could describe on these pages because Circling Star was a child within a family and he was deeply loved not only by his parents and his siblings, but by many members of a wider community who suffered a deep loss when he died. The love that a family has for one of their own is difficult to capture in special reports such as this. We feel honoured that our work allows us to try.

During one of the visits my team and I had with Circling Star’s parents, they shared a story with us: A friend in the community who lived near the site of the crash was sitting on his porch the morning before the accident. Across the road, where the road bent and where, hours later, Circling Star’s accident would happen, the family friend saw a large bear standing at that spot. The bear stood up on its hind legs and looked around for a time before dropping down on all fours and walking back into the bush. Circling Star’s parents shared with us that they have felt their son’s presence with them during the time since he died and that they believe his spirit has stayed close to them as they grieved for him. They told us that they are hopeful lessons will be learned and systems can be improved in ways that might help other children and youth. After reading this special report with us, Circling Star’s mother told us that she feels she can let him go and that her son would be proud of the story we have tried to tell here.

I wish we could tell the story of every child that we meet through our advocacy services program and each child we learn about when we review public services after their death. Our office is not often called or
alerted when systems are working well; our role is to advocate for the voices and rights of children and youth when systems are breaking down or falling short of where they should be. My role, as the Manitoba Advocate for all children, youth, and young adults is to listen to the voices and experiences of young people and to raise issues of concern. Through my legislation, *The Advocate for Children and Youth Act*, I collect and analyse data on public systems and how they deliver services, I seek out best practices and what is working well. Armed with that knowledge, my role as an independent officer is to educate the public, advise the government of the concerns I am seeing, and to make formal recommendations for where changes are needed. All of this work begins with the stories of children and youth.

This is the first of many special reports I intend to release to the public. I hold my duty of public education with reverence and I will always aim to be transparent and accountable – to the children, youth, young adults, and their families; to the public; and to the people who stand up every day to deliver and administer public services in our province. In the coming weeks and months it is my intention to release additional reports, including further special reports of child death investigations currently underway at my office. None of these are easy stories to tell, but each one of them carries with it important lessons we must all learn so we can work together to build a safe and healthy society that hears, includes, values, and protects all children, youth, and young adults.

Respectfully submitted,

Daphne Penrose, MSW, RSW
Manitoba Advocate for Children and Youth
APPENDICES

Appendix A: List of Findings and Recommendations

Information Sharing

Finding 1: Public services involved with the same child, youth, or family continue to operate in silos. The lack of information sharing across systems continues to result in shortfalls with respect to communication and collaboration between services.

RECOMMENDATION: The Manitoba Advocate for Children and Youth recommends that the Province of Manitoba respond to the persistent lack of coordination between services for children and youth by developing and implementing a provincial strategy to train service providers on the requirement to share information across systems and ensure children and youth are at the centre of all service provision. This is to be developed, delivered, and evaluated in consultation with Manitoba Education and Training, Manitoba Families, Manitoba Justice, and Manitoba Health, Healthy Living and Seniors.

Details:
- In line with The Protecting Children (Information Sharing) Act, this training needs to be provided to all relevant service providers in Manitoba.
- As part of this strategy, an inter-ministerial working group at the director, manager, and staff levels is needed to identify and address barriers to collaborative sharing of information and ensure oversight of quality assurance protocols related to case management across service providers.

Education Services

Finding 1: Circling Star’s High School and School Division did not use effective strategies to address the evident conflict between Circling Star and one particular teacher at his school.

Finding 2: There was little investment by Circling Star’s High School to encourage his academic success.

RECOMMENDATION: The Manitoba Advocate for Children and Youth recommends that the Department of Education and Training through Healthy Child Manitoba, and with participation from all school divisions, conduct an urgent review of the current use of out-of-school suspensions and expulsions, and develop a province-wide strategy to limit, reduce, and phase-out exclusionary practices, except in situations of imminent safety risk to students and staff. This review and strategy should provide evidence-informed disciplinary alternatives that are in line with the best interests of the child and respect the right of children and youth to education.

Details:
- The Department of Education and Training will develop quality assurance and information management processes to: (1) define “imminent safety risk to students and staff”, (2) assess the prevalence, duration, and nature of school suspensions and expulsions in Manitoba, (3) analyse and ensure compliance with standards and best practices, (4) provide school boards with the necessary information to develop strategies to reduce and end school suspensions and exclusionary practices,
and evaluate initiatives. Changes should be data informed and made considering the unique dynamics in Manitoba.

- The Department of Education and Training will implement province-wide and evidence-informed suspension and exclusion prevention policies and procedures for Manitoba schools. This is to then, in turn, inform training for:
  - School division training for teachers, principals, and superintendents;
  - Mentorship programs; and,
  - Alternative approaches to suspension.

Mental Health Services

Finding 1: Circling Star was not offered appropriate clinical mental health services matched to his level of need.

Finding 2: The acute treatment mental health facility did not comply with its legal duty to report the known safety concerns of a child in need of protection to the CFS agency.

Finding 3: Manitoba’s mental health and addictions service system does not apply a children’s rights impact assessment lens to its policy-making process.

Finding 4: Manitoba’s mental health and addictions service system does not apply a harm reduction lens to its policy-making process.

Finding 5: Access to appropriate mental health services in rural and geographically remote communities is a long standing issue of inequity. As a First Nations youth, Circling Star was not offered equitable access to mental health services in his home community.

RECOMMENDATION: The Manitoba Advocate for Children and Youth recommends the Department of Health, Seniors and Active Living implement, in full, recommendation 5.4, per the Virgo report, as follows: Establish a concerted cross-sectoral process to reduce perceived and real jurisdictional boundaries that challenge access to, and coordination of, services. The process of developing this [Manitoba’s Mental Health and Addictions] Strategy, as well as any new opportunities and resources for working together (e.g., through Jordan’s Principle), should be viewed as an accelerator of a new period of trust and collaboration based on shared beliefs and strengths among all partners, and should include an interest in wellness, hope and family/community health.

Details:

- Specifically, provisions in the following areas are needed within Manitoba’s Mental Health and Addictions Strategy:
  - Post-discharge supports for children and youth who have experienced mental health concerns, including addictions issues;
  - A continuum of services, reflective of culturally-safe and trauma-informed approaches, for all of Manitoba’s children and youth, including Indigenous children and youth, and those who live in First Nations communities; and
  - A continuity of care model that ensures equitable standards of service when First Nations children and youth return to their home communities.
**Addiction Services**

**Finding 1:** The Addictions Foundation of Manitoba (AFM) did not recognize that Circling Star’s ongoing and escalating addiction constituted a threat to his safety and resulted in AFM having a duty to report their concerns to Circling Star’s parents or to the child and family services agency as required under The Child and Family Services Act.

**RECOMMENDATION:** The Manitoba Advocate for Children and Youth recommends that the Department of Health, Seniors and Active Living, together with front-line addiction service providers in Manitoba, Healthy Child Manitoba, Indigenous communities, and subject matter experts on addictions, immediately respond to the lack of effective substance use treatment services for youth by prioritizing the development and implementation of a youth addiction action strategy. This strategy should be based on best practice evidence with the objective of ensuring that children and youth across Manitoba can exercise their right to the highest attainable standard of health.

**Details:**
- That the Department of Health, Seniors and Active Living, go beyond the VIRGO analysis and conduct a service inventory of all child and youth addiction services in Manitoba, their locations, target populations, philosophies, eligibility criteria, utilization rates, and occupancy rates.
- That the Department of Health, Seniors and Active Living expand upon the VIRGO analysis to evaluate existing gaps in substance use treatment and addiction services available to children and youth, including recommendations as to how existing services could be repurposed.
- That the Manitoba’s Mental Health and Addictions Strategy developed by the Department of Health, Seniors and Active Living include a plan that ensures implementation of evidence-informed family-centred substance use and addiction programs.
- That the Department of Health, Seniors and Active Living oversee regular performance monitoring and program evaluations to ensure that all publicly-funded and provincially-mandated agencies are accountable to provide evidence-informed addiction services and programs for children and youth.
- That all provincially-funded addiction service providers working with children and youth implement policies and procedures for ongoing training on the identification and reporting of cases where a child is in need of protection as outlined in The Child and Family Services Act.

**Youth Justice Services**

**Finding 1:** Circling Star’s probation conditions were not realistic or child-centered, and he had inconsistent contact with his probation officer and Intensive Support and Supervision Program (ISSP) worker. As a result, his imposed probation conditions were not meaningful or beneficial in relation to his needs.

**Finding 2:** The entire community may have benefitted from and been able to heal through a facilitated process of restorative justice, which was not made available to them.

**RECOMMENDATION:** The Manitoba Advocate for Children and Youth recommends that the Department of Justice improve communication across the divisions within its department, including probation services, victim services, and prosecution services, as well as with the legal community (e.g. legal aid), and the courts to ensure that probation orders are relevant, effective, child-centred, realistic (given
limitations in remote and rural communities), and achievable. The Advocate further recommends that the Department of Justice evaluate their capacity to provide the programming for youth to meet their probation conditions and determine whether or not existing programs and services are sufficient and accessible to youth living in rural and remote locations. When gaps are identified, strategies for culturally appropriate alternatives and program delivery need to be developed.

Details:

- The Advocate recognizes that it does not have jurisdiction over the courts. Following this report, we recommend that the Department of Justice initiate a process of improved communication and dialogue within its department, with the courts, and other key stakeholders to ensure that probation orders are relevant, effective, child-centred, realistic, and achievable.
- The Department of Justice’s evaluation of existing capacity to provide programming for youth to meet their probation conditions should contain an overview of existing accountability data and analysis of the effectiveness and accessibility of current services and programming delivered to youth in Manitoba.
- A plan is needed for situations when probation services do not have the capacity to provide ongoing supervision, monitoring, or formal programming such that collaboration and partnership with local communities occurs to devise a strategy to deliver these services.

**Child and Family Services**

**Finding 1:** The interventions provided by the Child and Family Services (CFS) agency of the Southern First Nations Network of Care did not meet CFS minimum provincial standards to ensure Circling Star was safe, nor did the CFS agency put into practice alternative ways to work with Circling Star and his parents that would ensure a youth-centered and safe plan.

**Finding 2:** The services provided by the Child and Family Services (CFS) agency under the responsibility of the Southern First Nations Network of Care suggest a need for improved training for CFS workers and supervisors to ensure they consistently follow legislation and meet minimum provincial standards, particularly in the areas of assessment, planning, service provision, and evaluation.

**RECOMMENDATION:** The Manitoba Advocate for Children and Youth recommends that the Department of Families in partnership with the Child and Family Services (CFS) Authorities: (1) clarify training content and expectations of workers and supervisors with respect to CFS minimum provincial standards, and (2) prioritize the development of high quality, culturally appropriate, modernized, and accessible training on the minimum provincial service standards within two years. The Advocate further recommends that all existing workers who have not received training on minimum standards and all new CFS workers be required to complete this training within three to six months.

Details:

- That the Department of Families work with the four CFS authorities to clearly define training content, timelines, and requirement for CFS workers and supervisors per s.1.3.1 of the minimum standards manual.
- That the CFS authorities ensure that their CFS agencies adhere to standard 1.8.1 *Workforce Qualifications* and that clear education and training plans are developed and monitored for staff who do not meet this standard.
Appendix B: Acronyms

AFM – Addictions Foundation of Manitoba  
BCR – Band Council Resolution  
CFS worker – Child and Family Services worker  
PO – Probation Officer  
CFSA – Child and Family Services Applications  
DIA – Designated Intake Agency  
FE – Family Enhancement  
ISSP – Intensive Supervision and Support Program  
PSR – Pre-Sentence Report  
RCMP – Royal Canadian Mounted Police  
SFNNC – Southern First Nations Network of Care defined as a CFS Authority under The CFS Authorities Act  
SDM® – Structured Decision Making®  
THC – Tetrahydrocannabinol or cannabis
Appendix C: Terms of Reference

The Manitoba Advocate for Children and Youth is notified of all deaths of children, youth, and young adults up to age 21, holds the legal responsibility to assess each death, and the discretion to further review or investigate the public services that were or which should have been providing support to the young person or to their family.

Section 20 of The Advocate for Children and Youth Act (ACYA) describes the Advocate’s jurisdiction and purpose for conducting a review:

Jurisdiction to review — death of child or young adult
20(3) After receiving notice of the death of a child or young adult from the chief medical examiner under The Fatality Inquiries Act, the Advocate may review
(a) a child’s death, if the child or his or her family was receiving a reviewable service at the time of the death or in the year before the death; and
(b) a young adult’s death, if the young adult was receiving services under subsection 50(2) of The Child and Family Services Act at the time of the death or in the year before the death.

Purpose of review
20(4) A review under this section may be conducted for the following purposes:
(a) to determine whether to investigate the serious injury or death under section 23;
(b) to identify and analyse recurring circumstances or trends
   (i) to improve the effectiveness and responsiveness of reviewable services, or
   (ii) to inform improvements to public policies relating to designated services.

Following the review of a death, the Manitoba Advocate has the discretion to initiate a comprehensive investigation of public services. Section 23 of the ACYA outlines the conditions for an investigation:

Investigations of serious injuries and deaths
23(1) The Advocate may investigate a serious injury or death of a child or young adult if, after completing a review under section 20, the Advocate determines that
(a) a reviewable service, or related policies or practices, might have contributed to the serious injury or death; and
(b) the serious injury or death,
   (i) in the case of a child, was or may have been due to one or more of the circumstances set out in section 17 of The Child and Family Services Act (child in need of protection),
   (ii) occurred in unusual or suspicious circumstances, or
   (iii) was, or may have been, self-inflicted or inflicted by another person.

The ACYA provides broad powers to access electronic or paper documents and other file recordings, as well as to compel, via an order to comply, any person to appear before the Advocate to answer questions the Advocate deems necessary to complete the investigation. Section 25 of the ACYA describes these powers:

Right to enter and inspect
25 For the purpose of an investigation under this Part, the Advocate may at any reasonable time enter and inspect any place where a reviewable service being investigated is or was provided.

Power to compel persons to answer questions and order disclosure
26(1) For the purpose of an investigation under this Part and subject to subsection 17(3) (privileged information), the Advocate may make one or both of the following orders:
(a) an order requiring a person to attend, personally or by electronic means, before the Advocate to answer questions on oath or affirmation, or in any other manner;
(b) an order requiring a public body or other person to produce for the Advocate a record or other thing in the person’s custody or under his or her control.

Order to comply
26(2) The Advocate may apply to the Court of Queen’s Bench for an order directing a public body or person to comply with an order made under subsection (1).

As of March 15, 2018, the Manitoba Advocate may make special reports public about any matter dealt with under the ACYA. Section 31 of the ACYA describes this responsibility and its limits:

Special reports
31(1) In order to improve the effectiveness and responsiveness of designated services, the Advocate may publish special reports.

31(2) Subject to section 32 (limits on disclosure of personal information), a special report may
(a) Include recommendations for
   (i) A minister responsible for the provision of a designated service, and
   (ii) Any public body or other person providing a designated service that the Advocate considers appropriate;
(b) Refer to and comment on any matter the Advocate has reviewed or investigated under Part 4; and
(c) Include information the Advocate considers necessary about any matter for which the Advocate has responsibility under this Act.

The purpose of special reports is to examine the services provided to the child and his/her family to identify ways in which those services may be improved to enhance the safety and well-being of children. Special reports are intended to give voice to the experience of the child or young adult who has died. As such, they are conducted “through the eyes of the child,” that is, with a primary focus on the needs of the child, youth, or young adult.

In carrying out the investigations that inform special reports, Investigators are authorized to examine records and to make necessary confidential copies as required; to interview staff, service recipients, and other service providers; and to exercise any other investigative powers under the ACYA. As such, special reports will include factual information relevant to the events preceding the death of the child, youth, or young adult, may include analysis of those events, and may make formal recommendations to a reviewable body or any other public body or person that the Manitoba Advocate considers appropriate.
## Appendix D: School Suspension History

The following table depicts Circling Star’s school suspension history as written in his school file.

<table>
<thead>
<tr>
<th>Age</th>
<th>School year</th>
<th>Date</th>
<th>Disciplinary Referral</th>
<th>Suspension</th>
<th>Reason</th>
<th>Initiated by</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>2012 - 13</td>
<td>Sep 20</td>
<td>X</td>
<td>Disruptive, refusal to comply</td>
<td>Disruptive, refusal to comply with teacher</td>
<td>Teacher X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sep 24</td>
<td>X</td>
<td>Disrespect, refusal to comply</td>
<td>Disrespect, refusal to comply with Teacher</td>
<td>Teacher X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sep 25</td>
<td>1 day</td>
<td></td>
<td>Re above</td>
<td>Teacher X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sep 26</td>
<td>X</td>
<td>Intimidation/bullying</td>
<td>Teacher X</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sep 26</td>
<td>X</td>
<td>With other boys intimidation</td>
<td>Teacher X</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oct 10</td>
<td>X</td>
<td>Skipping</td>
<td>Teacher X</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oct 25</td>
<td>1 day</td>
<td>Disrespect, disrupting class,</td>
<td>Disrespect, disrupting class, refusal to</td>
<td>Teacher X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nov 15</td>
<td>X</td>
<td>Late, disruptive, disrespect,</td>
<td>Late, disruptive, disrespect, refusal to</td>
<td>Teacher X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nov 20</td>
<td>X</td>
<td>Alcohol</td>
<td>Alcohol</td>
<td>Principal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nov 20</td>
<td>5 days</td>
<td>Alcohol</td>
<td></td>
<td>Principal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nov 21</td>
<td>5 days</td>
<td>Alcohol</td>
<td></td>
<td>Superintendent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dec 10</td>
<td>x</td>
<td>Disruptive, refusal to work,</td>
<td>Disruptive, refusal to work, disrespect,</td>
<td>Teacher X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dec 17</td>
<td>1 day</td>
<td>Disrespect</td>
<td>Disrespect</td>
<td>Teacher X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dec 18</td>
<td>x</td>
<td>As above</td>
<td>As above</td>
<td>Principal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Jan 7</td>
<td>x</td>
<td>skipping</td>
<td>skipping</td>
<td>Teacher X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Jan 9</td>
<td>1 day</td>
<td>Disrespect, refusal to comply</td>
<td>Disrespect, refusal to comply</td>
<td>Teacher X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mar 4</td>
<td>x</td>
<td>Late, refusal to work, refusal</td>
<td>Late, refusal to work, refusal to comply</td>
<td>Teacher X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Apr 9</td>
<td>4 days</td>
<td>Skipping, refusal to comply</td>
<td>Skipping, refusal to comply</td>
<td>Teacher X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May 23</td>
<td>2 days</td>
<td>skipping</td>
<td>skipping</td>
<td>Teacher B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May 29</td>
<td>X</td>
<td>Skipping, intimidation</td>
<td>Skipping, intimidation</td>
<td>Teacher X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>11</td>
<td>7 for 20 days</td>
<td>14 Teacher X</td>
</tr>
</tbody>
</table>

| 15  | 2013 - 14   | Sep 16    | 1 day                 | Behaviour, verbal abuse         | Behaviour, verbal abuse                    | Principal    |
|     |             | Sep 18    | X                     | Disruptive, intimidation        | Disruptive, intimidation                   | Teacher X    |
|     |             | Sep 18    | 2 days                | Brass knuckles threats of       | Brass knuckles threats of violence         | Principal    |
|     |             | Oct 18    | 5 days                | Alcohol                         | Alcohol                                     | Principal    |
|     |             | Oct 21    | 6 weeks               | Alcohol                         |                                             | Superintendent|
|     |             | Feb 3     | x                     | Re-entry contract               |                                             |              |
|     |             | Feb 26    | X                     | Disruptive behaviour,           | Disruptive behaviour, disrespect, language | Teacher X    |
|     |             | Apr 22    | X                     | Refusal to comply               | Refusal to comply                           | Teacher X    |
|     |             | Apr 22    | 1 day                 | Skipping, refusal to comply     | Skipping, refusal to comply                | Teacher X    |
|     |             | May 15    | To end of term        | Behaviour, aggressive attitude   | Behaviour, aggressive attitude to teacher  | Principal    |
|     |             |           | Total                 | 3                               | 68+ days                                    |              |

| 16  | 2014-15     | Sept 23   | 3 days                | Behaviour, verbal abuse         | Behaviour, verbal abuse                    | Principal    |
|     |             | Sep 23    | Until further notice  | Threat ‘I will you a reason to   | Threat ‘I will you a reason to expel me     | Principal    |

No further info on school file.
Appendix E: References


National Institute of Health website


