



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

TINA MICHELLE FONTAINE

1999-2014



Table of Contents

Acknowledgements	5
Executive Summary	6
Methodology	12
Tina's Story	15
Understanding a Story by How it Began	15
Tina's Parents	15
Tina's Birth and Early Years	18
A Stabilizing Force: Tina Moves in with her Grandma	21
The Death of Tina's Father	23
Absenteeism is an Important Indicator of Risk	25
Missing Persons Reports: Another Significant Indicator of Risk	28
As Risk Increases, the Family Asks for Help	31
What is needed? A place"where she feels like its home."	36
August 8, 2014: The Last Day Tina is Seen by Service Providers	45
Events Prior to the Death of Tina Fontaine	47
Events After the Death of Tina Fontaine	50
Findings, Analysis, and Recommendations	55
A Call to Action for Early Intervention and Prevention	55
Education	58
Mental Health	64
Victim Services	71
Child and Family Services	76
Sexual Exploitation	90
A Note about Recommendations	107
APPENDIX A – FINDINGS AND RECOMMENDATIONS SUMMARY	108
APPENDIX B – TERMS OF REFERENCE	109
APPENDIX C - REFERENCES	111



Photo supplied by family

Acknowledgements

The mandate of our office extends throughout the province of Manitoba and we therefore travel and work on a number of treaty areas. Our offices in Southern Manitoba are on Treaty 1 land, which is the traditional territory of Anishnaabeg, Cree, Oji-Cree, Dakota, Ojibwe and Dene peoples, and the homeland of the Metis nation. Our new Northern office is on Treaty 5 land, and the services we provide to children, youth, young adults, and their families extend throughout the province and throughout Treaty areas 1, 2, 3, 4, 5, 6, and 10. As an organization, we are committed to walking in Reconciliation and strive to demonstrate this in the ways we work: in our practice and organizational priorities, and in our adherence to principles of inclusivity, social justice, and promotion of the beautiful diversity that surrounds and represents us.

A thank you to the family

Our entire team extends its gratitude to members of Tina's family – the people who best knew her and loved her deeply – for their bravery and valuable participation in this special report. The information and insights they shared with our office, particularly Tina's grandma, Tina's cousins, and other extended family and friends, are reflected throughout. As a result, this special report is much richer and more complete. We offer our deepest thanks and we hope you feel we have honoured Tina's memory in telling her story.

Executive Summary



Tina Fontaine might always be known for the tragic way in which she died, but it is her life that is an important story worth knowing. It was on August 17, 2014, when most people would learn her name, but Tina's story began long before that day. It began even before Tina was born on New Year's Day in 1999. To know Tina's story, to really understand how she came to symbolize a churning anger of a nation enraged, each of us can look as far back as the arrival of European settlers, and as close to home as the depth of our own involvement or indifference in the lives and experiences of Indigenous youth.

It is a certain challenge to conduct a child death investigation. To gather files and evidence, to sort through boxes of information, to speak with an ever-growing list of people who knew the child, and then to create an accurate and thoughtful story about the life of that child. This is a process of honouring legacy and uncovering truths. To understand the complexities of any child and to truly understand their life within the broader context of a family, a surrounding community, and then to set out to carefully analyse all information through the lenses of: best practice, best interests, and the rights of children, can be a path filled with challenges.

As the Manitoba Advocate for Children and Youth, these activities are part of my sworn promise to all citizens in our province. Most especially, I make a promise to all children, youth, and young adults that I will approach this work ready to listen carefully to their voices, and to use my knowledge and experience to do my best to improve our province for the sake of the many young people who require or rely on public services each day. My job is made infinitely more achievable when I am able to speak directly with young people through our outreach and advocacy services, and in the cases of child death investigation, when families and friends who have lost a young person agree to participate in the process of an investigation.

My team and I would not have been able to write the report I am releasing today without the participation of some of Tina's family and friends. We also follow a practice of, whenever possible, travelling to and spending time in the home community of the child where we can come to a better understanding of their life and the people who surrounded them. While family participation is not required, it is the practice of my office to invite family to speak with us about their memories of the child and their perspectives on the public services that were active in their life and which are part of my legislated scope of review.

Tina was a deeply loved member of a large family and while not all people we reached out to were able to meet with us, we give thanks to all of Tina's family and friends who sat with us, and we acknowledge those who were unable to do so. Whether you met with us or chose not to, we hope you see that we have tried to honour Tina and her legacy by the way we have written this report. Ultimately, we hope our communities and this province are inspired to take up the challenge of building legacies of good from the sadness born of tragedy.

This report is structured in two main parts. The first large part is the chronology of Tina's life, which includes the time before she was born to the time after she died. This section, which is standard in all of our child death investigations, is an accurate and chronological summary that reflects countless sources of information. The chronology focuses on which public services were active during Tina's life and we seek to identify where gaps in services existed or where there were opportunities for better interventions and supports.

The chronology is an overarching account of all of the historical file information, case information, assessment reports, and numerous interviews from the public systems that are in scope for review by my office. While not all systems within my scope were relevant to Tina's story, the services my team and I are empowered to formally review include: child and family services, adoption, disabilities, education, youth justice, mental health, addictions, and victim supports.

The second large section of this report is focused on our analysis. In addition to the requirements laid out in my legislation, and based on the detailed and accurate chronology of events, we analyse the information and interactions to look for information such as:

- What were Tina's needs and those of her family?
- What interventions and supports were offered and when?
- What is the family perspective on the services they received?
- What needs to be improved?
- What do the experts say needs to happen?
- What do the Elders say we need to remember?
- What do youth say they need to feel supported? And,
- How can tragedies like Tina's death be prevented in the future?

When we have the answers we need to these questions, my team and I carefully consider what could have made a difference for someone like Tina and what needs to be changed. By law, I am empowered to make formal recommendations to the government, government systems, and other public bodies. I am further empowered to track and monitor the *compliance* with the recommendations I make, and with the introduction of *The Advocate for Children and Youth Act* last year, I have decided that I will be tracking government compliance publicly.

There are limits to what these investigations can achieve. My role is not to blame anyone individually for why Tina died. I acknowledge that there is a significant and high-profile history and criminal developments that people speak of when they speak of Tina, but finding fault for how and why Tina died is not what I am empowered to do. In our province, that responsibility falls to law enforcement, to the justice department, and to the courts. My role is to formally review child-serving systems and to hold them accountable for the ways in which families receive public services in Manitoba.

My role encompasses a responsibility to speak the child's truth and to describe the gaps that exist in the infrastructure of our public systems. One thing we know to be true, and which you will read about in Tina's story is that she carried a burden that was not her own.

In order to understand the story of Tina's life and death it is important to first recognize the history of colonization. This includes the residential school system and the Sixties Scoop, and their lasting impacts on the social, psychological, spiritual, and economic health of Indigenous peoples and Indigenous communities. Like so many, Tina's parents were significantly impacted by historical traumas; their struggles with housing, intimate partner violence, addictions, and mental illness can be directly tied to Canada's history of colonial practices and the implications of this history that continue to exist today for so many Indigenous families.

I have included some information in this report that is not Tina's. For example, I have included summarized information about Tina's parents, her great-aunt (whom Tina called "grandma"), and a few details of Tina's siblings. This decision was made carefully and with much consideration and discussion because I know by including pieces of the stories of other people I expose them to the possibility of undeserved or ignorant criticism for the casual reader who is intent on casting blame.

However, I know that to tell Tina's story in a vacuum and without mention of those who loved her and surrounded her is to fail in my duty to tell the truth of Tina's story. Tina was influenced by many people and she had two moms who loved her. Tina's first mom loved her and tried to manage her growing family, but was unable in the long-term to provide the care Tina needed in her life. Tina's second mom, the great-aunt she called "grandma" ensured Tina had the experiences of family connections and a stable home for many years of her life, in a traditional customary care arrangement.

Tina's story was her own, and yet, it mirrors the stories of many others. The losses she experienced, the fracturing of her family, the inability to access necessary support, the promises of services that were never delivered, these are the echoes of so many other children and their families. These barriers that are experienced much more often and pervasively by Indigenous families is the story of Tina and the one we have the opportunity to change.

While I know that the child and family services (CFS) system has long been blamed for Tina's death, this is short-sighted and serves only to reinforce the existing structures and beliefs. In fact, Tina did not spend much time inside the CFS system before she died. While she was in care a for a few short periods when she was very young, what Tina had a family who were a significant protective force— especially her grandma and grandpa— who loved her and raised her from the time she was five years old, and until a month before she died. In their home, Tina found the stability and nurturing that all children need to feel like they matter and that they belong.

The event that changed Tina's life was the violent and sudden death of her father. This was the experience that many people who knew Tina look to when they think back to when things started to change for her. Tina was 12 years old when he died, which is a critical time of discovery and development for all children and the impact of his death was profound. Despite all the other details of his history, Tina loved her dad, as any child would. What followed was significant sadness that grew and expanded until it began to manifest in difficulty at school, experimentation with drugs and alcohol, running away, increasing violence, and being sexually exploited by adult men who preyed on her.

Throughout her life, Tina needed an array of services from child and family, education, victim support, law enforcement, health, and mental health systems. At times, particularly in the final months of her life, some of these services were unavailable, not easily accessible, or ill-coordinated, which did not provide the supports and interventions she desperately needed. The education system was active in her life and through which Tina met some dedicated educators, but attendance was an issue and there was little effort demonstrated to re-engage her through her sadness.

Tina had acute mental health needs following her father's death but she was never provided with a single counselling session or other cultural healing, despite ongoing assessments and recommendations that this was a critical need in her life. Further, Tina developed acute addictions in her final months of life and used many different drugs and alcohol but was unable to find the help she needed that would support her to address her underlying pain.

Victim services also played a role after the death of her father, but that system also never met directly with Tina to ask her what she needed, nor did they follow through with providing counselling sessions to Tina, despite her right to this services and the obligation of victim services to provide it during the two and half years in which they were involved with Tina's family.

Child and family services were involved historically with Tina's parents and with Tina when she was young, and then again in the months before her death. Our concerns with CFS following our investigation include the ways in which the family unit was allowed to fracture and split, the need for public systems to recognize Indigenous customary care arrangements, the barriers that are built when multiple service providers argue

over jurisdiction, and the desperate need that exists in Manitoba for safe and secure placement resources when youth are at imminent risk of harm and death.

This report also looks closely at the issue of the sexual exploitation of youth. It is a difficult fact that Tina was exploited by adults and that Manitoba has a shameful reputation for the numbers of children and youth who are preyed upon every year in our province.

I make five formal recommendations in Tina's name and in this report. My first recommendation is to Manitoba Education and Training and builds on the report I released in October 2018, about Circling Star. In that story, and in Tina's, my team found compelling reasons and growing research on the impacts of absenteeism that calls into question the practice of expulsions and suspensions in public schools. My recommendation is that the recently formed *Commission on Kindergarten to Grade 12 Education* carefully examines the uses of these measures so they can be limited, reduced, and phased out.

My second formal recommendation is to Manitoba Health, Seniors, and Active Living. It has been ten months since the province released their mental health and addiction strategy, and while announcements and investments have been made by the government regarding Manitoba adults, children and youth — which the government identified as a population in desperate need — remain waiting to hear the implementation plans for the changes that are coming. If early intervention and upstream investments are more than mere buzzwords, then, as my recommendation lays out, the government will expedite the public release of a clear implementation plan to address the child and youth-specific recommendations contained in their Virgo report.

I make a recommendation also to Manitoba Justice - Victim Services to address the quality control measures that were lacking in their interactions with Tina and her family. While this system was involved for a number of years, barriers to access the service were plenty and overall, the service was not delivered to Tina in child-centred ways.

My recommendation to child and family services is focused on their responsibilities for child safety and in responding when children are in need of protection. What Tina might have benefitted from was access to the full continuum of services for children at imminent danger, and this continuum includes safe and secure treatment facilities that are therapeutic, culturally-informed, and effective – or, as Tina described to her CFS agency, a place where it feels like home.

Finally, in recognition that access to time-sensitive safety and care information about children who are missing might mean the difference between life and death for some youth, I make a recommendation to Manitoba Families to create a new protocol to ensure that tailored and individual response plans are

created for each child and youth who goes missing, given the strong correlation between missing persons, sexual exploitation, and other harms that can place young people at immediate risk of injury and death.

Some of these recommendations are large and will take some time to work through, and some can be more quickly implemented. However, what I hope the public hears from me today, through this report, and as we carry on in Tina's memory, these changes cannot wait. What has been a persistent message to my team and me as we moved through this investigation and the writing of this special report is that not enough has changed since Tina died in 2014. In fact, what we know to be true from the youth we are working with in our advocacy program and who are still alive today, and which has been confirmed by public systems throughout this process, is that children and youth who present with the same issues today may find themselves getting the same responses and experiencing the same barriers to service that Tina did.

With some of those youth, we have seen them struggle with structural barriers for many months and years and they continue to try to access support and try to get help for themselves. For other youth, such as Tina, the downward spiral gathers speed rapidly and crisis response measures – where most of our public dollars continue to be invested – are only triggered into action when certain thresholds are met. For Tina, those interventions came too late to save her.

Our track record in Manitoba is not good. We are home to the highest numbers of children in care, highest numbers of youth in custody, and highest numbers of missing children. These are the outcomes when services and investments are not intensively targeted on the early years and on the prevention of crisis.

The solutions lie upstream. If the focus of our resources and interventions keep our eyes locked on the *results* of trauma, then we will ignore the reasons that cause the trauma and our province will continue to see ballooning numbers of youth involved in child and family services, youth justice, and youth who are in need of emergency detox and treatment. We can do better. We must improve the ways we see our systems and ensure that they are built and deliver services that prioritize the needs not of service providers, but of the people who rely on those services. Those of us who are engaged, empowered, and switched on need to ensure we are standing up and getting involved so that all Manitobans can grow up supported. If we take up these calls to action to speak up and move forward in a spirit of equity, justice, and Reconciliation, we can work to honour the name of Tina Fontaine and do right by the lessons and legacy she leaves behind so that she can truly be allowed to rest.

Daphne Penrose, MSW, RSW

Manitoba Advocate for Children and Youth

Methodology

The Manitoba Advocate for Children and Youth (the Manitoba Advocate) is notified by the Chief Medical Examiner of all deaths of children, youth, and young adults up to age 21 in Manitoba. The Manitoba 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 by the Office of the Chief Medical Examiner of Tina's death on August 19, 2014. Following receipt of the official notification, it was determined that Tina's death was in scope for review as Tina was a child in care at the time of her death. As such, formal notification of the Manitoba Advocate's intent to conduct an investigation of services was sent to Agency #2and the Southern First Nations Network of Care Child and Family Services Authority. The investigation was assigned internally to an Investigator, and a review was initiated under this office's former legislated mandate.

As Tina's death was considered suspicious and a criminal investigation was initiated immediately upon the recovery of her body, the investigation required by our office under provincial legislation was necessarily constrained in its scope from August 2014, to the conclusion of the appeal window following the criminal trial regarding Tina's death, which came to an end in March 2018. While the criminal processes were underway, our investigation was limited to reviewing file materials; we did not conduct interviews, gather information in communities, or hold meetings with service providers or government officials during that time. Upon conclusion of all criminal processes in March 2018, our investigation widened and we were able to undertake those activities we had previously limited in order to conclude our investigation and analyse our findings.

On March 15, 2018, *The Advocate for Children and Youth Act* (ACYA) was proclaimed and the scope of the investigation was broadened under the Manitoba Advocate's new mandate. Additional notifications were sent about the ongoing investigation and the Manitoba Advocate's intention to make this special report public.

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

¹See 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).

- A CFS agency named as "Agency 1" in this report, which is the historical CFS agency of record, and which existed prior to the coming-into-force of *The Child and Family Services Authorities Act* in 2002;
- A CFS agency named as "Agency 2" in this report, which is an agency of the Southern First
 Nations Network of Care Child and Family Services Authority ("Southern Authority"), and which
 receives its mandate from the Manitoba Department of Families;
- A CFS agency named as "Agency 3" in this report, which is an agency of the Southern First
 Nations Network of Care Child and Family Services Authority ("Southern Authority"), and which
 receives its mandate from the Manitoba Department of Families;
- A CFS agency named as "Agency 4" in this report, which is an agency of the Southern First
 Nations Network of Care Child and Family Services Authority ("Southern Authority"), and which
 receives its mandate from the Manitoba Department of Families;
- A CFS agency named as "Agency 5" in this report, which is an agency of the General Child and Family Services Authority, and which receives its mandate from the Manitoba Department of Families; and
- Tina's school, a school under the authority of a provincial school division, which receives its mandate from the Manitoba Department of Education and Training;
- Victim Services, a division under the responsibility of Manitoba Justice.

Additionally, files reviewed included the report of the medical examiner and autopsy, as well as records under the authorities of: the Royal Canadian Mounted Police (RCMP); Winnipeg Police Services; Pine Falls Health Complex; Health Sciences Centre; two youth shelters; a short-term addictions detox resource; StreetReach program at the Child and Family Services Division. Originals or copies of written records were reviewed by the Investigator either at the organization in question's office or at the Manitoba Advocate's office.

In addition to file reviews, one or more interviews were conducted with: Tina's grandma and grandpa,² Sagkeeng First Nation Chief and Council, Tina's principal, and the school social worker. Our office also met with several staff, former staff, and supervisors of Agency 3, the CFS agency that held legal guardianship of Tina at the time of her death. We were unable to interview Tina's assigned Agency 5 worker as they are no longer with the agency, although our office did interview the supervisor for Agency 5. In addition, in order to complete this investigation, we interviewed the executive director of one of the youth shelters where Tina accessed placement supports.

²While they are actually Tina's great-aunt and great-uncle, Tina called them "grandma" and "grandpa" and in respect of their special relationship, this is how we have chosen to name them in this report.

Over the past year, the Manitoba Advocate and staff have been in regular contact with Tina's grandma, reaching out to offer support, travelling to her home to spend time with her, and spending time in community in order to gain an understanding of Tina, her community, and the events of her life. In addition to reaching out to Tina's grandma and grandpa, our team also contacted Tina's mother to invite her participation in this review and a sibling of Tina's to extend a the same invitation to participation. Each declined initial and subsequent invitations to participate and to provide our office with their perspectives on the services their family received and their memories of Tina. In the month before the public release of this report, we also met with additional friends, cousins, and extended family members who knew Tina and shared their memories with us.

In late February 2019, in the interest of report accuracy and administrative fairness, agencies and departments that provided file material and other information for this investigation were given an opportunity to meet with the Manitoba 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. The Indigenous Knowledge Keeper for our office 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 invitations to the Chief of Tina's home community of Sagkeeng, the Grand Chiefs of the Southern Chiefs Organization, the Assembly of Manitoba Chiefs, and Manitoba Keewatinowi Okimakanak, plus the Regional Chief of the Assembly of First Nations. Meetings were held with these leaders and members of their offices to discuss the Manitoba Advocate's findings, the pending recommendations being made, and to discuss the release of the report to ensure our office was approaching our responsibility in a good and respectful way.

The Manitoba Advocate acknowledges that 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 of service providers or those who have received services. Further, in some cases there was a lack of documentation all together. While, in many cases, data was verified and cross-checked with multiple sources, this was not always possible.

Tina's Story

Understanding a Story by How it Began

In order to understand the story of Tina's life and death it is important to first recognize the history of colonization, including the residential school system and the Sixties Scoop, and their lasting impacts on the social, psychological, and economic health of Indigenous peoples and Indigenous communities. Like so many, Tina's parents were significantly impacted by historical traumas; their struggles with housing, intimate partner violence, addictions, and mental illness can be directly tied to Canada's history of colonial practices and the implications of this history that continue to exist today for so many Indigenous families.

Tina's family has experienced involvement by various public systems for several years and over many generations. While we reviewed and considered a large volume of historical family information, we have given considerable and careful thought to which information is ultimately being included in this report. Tina's experiences during her life are important to be seen within a broader family and social context if our systems and our province are ever truly to be reconciled for the benefit of all families. Tina's experiences of family fracturing, domestic violence, exploitation, addiction, loss, grief, resilience, determination, hope, and searching for belonging, must not be viewed in a vacuum. Tina's life, in many ways, echoed experiences lived by others, including her parents and the many members of her extended family, some whom she knew, others whom she did not. This context is important because only when we come to a universal acceptance and understanding of the realities of historical and current discrimination, injustices, systemic racism, and that not all people are allowed access to opportunities on equal measure, will we ever have a hope to correct historical, long-standing, and ongoing injustice.

Tina's Parents

Tina's father was a member of Sagkeeng First Nation. Tina's paternal grandfather was a survivor of residential schools and his experiences as a child led to years of severe alcoholism and violence. At the age of twelve, Tina's father left Sagkeeng to move to Winnipeg where he would often fend for himself on the streets. While in Winnipeg, Tina's father began to struggle with alcohol addiction (Transfer summary, November 30, 1999, Child in care file, Agency 1).³

Tina's mother was raised in her home community of Bloodvein First Nation until she was approximately six years old. At the age of six, concerns with what was happening in the home brought the family to the attention of child and family services (CFS). Tina's maternal grandmother's relationships were marked by violence and addiction, which at times, left Tina's mother without adequate care and protection. Tina's

³"Agency 1" is the historical CFS agency of record, which provided services prior to the coming into force of *The Child and Family Services Authorities Act*.

mother was apprehended by CFS and then returned home to her mother several times. As one assessment would later state, Tina's mother experienced a number of significant traumas as a young child, details which we are not including in this report. These experiences were not appropriately addressed by the systems which were involved in the family's life and were viewed by service providers as key contributing factors to the challenges that would emerge in Tina's mother's life (Clinical assessment report, May 29, 1994, Child in care file, Agency 1).

In 1992, at the age of 10, Tina's mother became a permanent ward of CFS Agency 1. Documentation reviewed for this investigation detailed the difficult circumstances that Tina's mother faced while she was in care, including being moved repeatedly by CFS, that she began to use alcohol and drugs, and that CFS workers knew her to be sexually exploited by adults starting from a young age, and did little to intervene and protect her from harm.

In 1994, Tina's mother met the man who would eventually be the father to Tina and two of her seven siblings. When Tina's father met Tina's mother, she was a 12 year old child in care, and he was a 23 year old adult. CFS documentation indicates the CFS agency knew the relationship to be sexual and knew that Tina's father had a past that involved violence and severe addictions. Files noted that Tina's mother would frequently run from her foster placements to stay with Tina's father, who would willingly harbour her.

During this time, the CFS agency documented many indicators of sexual exploitation and also that they did not approve of the relationship. However, there was little evidence discovered in our investigation that the CFS agency worked to intervene to protect Tina's mother, despite their role as her legal guardian, the known exploitation that was occurring, and with an understanding that at age 12, Tina's mother was unable to legally consent to any sexual relationship and was a child in need of protection. Shortly after meeting Tina's father, CFS files documented that Tina's mother moved in with him. Agency 3, which would later be responsible for case management with Tina's mother, noted in a later summary that despite their often violent relationship, Tina's mother described Tina's father as, "someone who would take care of her as she had no one in her life to play this role" (Closing summary, September 18, 2015, Protection file, Agency 3).

In 1994, Tina's mother confirmed to her guardian CFS agency that at her then-age of 12, she was being sexually exploited by adults in the community and was using the money to buy alcohol. Tina's mother described to her worker feeling "depressed," "suicidal," "isolated, alone, and unloved." Tina's mother continued to be in a relationship with Tina's father, and told her CFS worker that the "streets are her only friend" (Case note, March 29, 1994, Child in care file, Agency 1).

In 1995, at the age of 14, Tina's mother became pregnant with her first child. A birth alert was issued for safety and protection reasons, including her frequent running away, ongoing drug use, lack of adequate

prenatal care, and the risks associated with being exploited by adults in the community (Hospital Alert for High Risk Families, October 27, 1995, Child in care file, Agency 1). Tina's father (age 25), was identified on record as the father of the child. Again, there was little evidence that the CFS agency actively tried to intervene to protect Tina's mother and provide the support and nurturing she needed; however, the agency documented in their files their ongoing concerns about the relationship. CFS case notes further indicate that Tina's paternal grandmother, who was interviewed at the time of the pregnancy, confirmed to the CFS agency that Tina's father was profiting financially from sexual exploitation (Case note, March 18, 1996, Child in care file, Agency 1).

Tina's mother gave birth to her first baby in the spring of 1996. The infant was apprehended by CFS at birth for safety and protection reasons, remained in care, and was made a permanent ward of Agency 3 at the age of seven months. Tina's older sibling was placed in a foster home in Winnipeg. CFS agency records indicate that in the summer of 1996, Tina's mother continued to run away from her placement and continued to be sexually exploited by adults in the community. She was known to be using drugs and alcohol, and according to CFS files, the violence between Tina's father and her escalated to a major incident (Case note, August 19, 1996, Child in care file, Agency 1). File documentation noted that Tina's

What Is "AGE OF CONSENT"?

Some children and youth are at risk of, or are currently being sexually exploited by adults in our communities. Prior to 2008, it was illegal for any child or youth under the age of 14 to consent to any sexual activity. However, exploitive sexual activity, including commercial sexual exploitation ("prostitution," "pornography," and "trafficking") remained illegal for anyone under the age of 18 years old.

In 2008, the federal government of Canada made changes to the criminal code, which raised the age of consent to 16. Exploitive sexual activity remains illegal.

"The spirit of the new legislation is not to regulate consensual teenage sexual activity. To this effect, there are a few notable exceptions to the law:

- 1. Youth 12 or 13 years of age can consent to non-exploitative sexual activity with peers when the age difference is no more than two years. For example, a 12-year-old child is deemed capable of consenting to sexual activity with a 14-year-old, but not a 15-year-old.
- 2. Youth 14 or 15 years of age can consent to non-exploitative sexual activity when the age difference is no more than five years. For example, a 15-year-old can consent to having sexual intercourse with a 20-year-old, but not with a 21-year-old" (Bellemare, 2008).

father had not completed substance use treatment and continued to struggle with addiction. The agency documented in their files their ongoing concerns about Tina's father (age 25) "harbouring" Tina's mother (age 14). There was no evidence the agency took any further steps to intervene to protect Tina's mother, or to provide her with the care and support she needed to work toward safe reunification with her young baby.

⁴CFS was aware that Tina's father was engaged sexually with Tina's mother who was a child in care and was also dependent upon him.

Tina's Birth and Early Years

Tina was the second child born to her parents. Tina's mother was 17 years old and was still a child in care of CFS when Tina was born on January 1, 1999; Tina's father was 28 years old. Prior to Tina's birth, her parents worked towards making positive changes in their lives and were attending parenting and prenatal classes as well as programs through the Addictions Foundation of Manitoba. In addition, Tina's mother was attending supportive programming through other community-based organizations. Following Tina's birth, the hospital noted no concerns and given the progress the couple had made, Tina was discharged home to her parents' care. A protection file with Agency 1 was opened under Tina's mother's name on January 7, 1999. Six months later, in June 1999, Tina's mother aged out of CFS care by turning 18, and her child in care file was closed; the protection file with Agency 1 remained open.

During the summer of 1999, Tina's father continued to struggle with his addiction; Tina's mother would often leave the home if Tina's father was using substances. Their relationship continued to be marked by violence—often while one or both were under the influence of substances. The CFS agency continued to note their concerns with Tina's parents' abilities to parent Tina safely, given the ongoing intimate partner violence and substance misuse. Although Tina's mother was working to improve her family situation, she continued to struggle to complete the programming she attended.

Shortly after Tina's birth, Tina's mother had expressed to her CFS agency a desire to rescind the permanent order on Tina's older sibling so that her firstborn child could be reunited with the family. Records show that Agency 1 tried to connect with the assigned worker from Agency 3 to further discuss Tina's mother's desire to parent her oldest child. Our investigation found that Agency 1 documented that they were not supportive of the idea the parents take on any parental role with their oldest child at that time, although Agency 1 was supportive of visits being scheduled as a starting plan, depending on how well the parents were functioning. However, CFS documents reflect that Agency 1 was unable to connect with Agency 3 to discuss the options, and there is no evidence that the agencies worked together to support any form of connection between the firstborn child and Tina's parents.

Tina's mother gave birth to her third child in June 2000. Tina's parents indicated they planned to parent Tina and her younger sibling and had been receiving support services through the CFS agency. Tina's older sibling continued to reside in Winnipeg in a foster home under a permanent order of guardianship.

In October 2000, Tina (age 1) and her younger sibling (age 4 months) were apprehended by CFS as their parents had left the children with their maternal grandmother for an extended period of time and their grandmother was unable to continue to provide care for them. Tina and her sibling were placed in a hotel. The CFS agency worker spoke with Tina's mother who indicated she had left her children with her mother

before and committed to finding suitable child care in the future. Tina and her sibling were returned to their mother four days later. No CFS assessments for safety purposes, family dynamics, or parenting capacity were completed prior to returning Tina and her sibling to their parents.

In the beginning of 2001, Tina's mother and father, and the children began to live with Tina's paternal grandmother in Winnipeg. Tina's mother and father briefly separated as Tina's mother was noted to be feeling overwhelmed and stressed with managing her responsibilities as a parent and as a partner. While separated, Tina and her sibling continued to live with Tina's father in their paternal grandmother's home.

In March 2001, Tina's parents resumed their relationship and Tina's mother's protection file with CFS was closed as the agency indicated there were no further protection concerns. No safety assessments or parental capacity assessments were completed prior to the return of the children.

Three months later, on June 20, 2001, Agency 1 received a call from an individual who reported that there was a large party occurring next door, that two intoxicated individuals were seen leaving the home with two young children, and that the intoxicated adults then brought one of the children back into the home. Shortly after receiving this information, Winnipeg Police Services (WPS) brought Tina (age 2) to the CFS after-hours office, as police had removed Tina from her parents' care due to safety issues. Police informed the CFS after-hours workers that a citizen had caught their attention and reported that he observed two adults "weaving down the street" with a young child in tow. The police officers were able to locate the parents and confirmed they were intoxicated and unable to safely care for Tina. Tina's father was described in documentation to be severely intoxicated and nearly incoherent. Tina's mother was also described as being severely intoxicated and uncooperative with police.

While at the CFS agency office, police received a further call requesting that they needed to come back as Tina's mother was on Main Street causing a disturbance. The CFS after-hours worker requested WPS also return to the address provided by the earlier source of referral to see if any other children were in the home. WPS went to the address and then called back to Agency 1 to report that Tina's younger sibling (age 1) was in the home and that there appeared to have been a drinking party earlier that evening. The police advised that Tina's paternal aunt presented as "reasonably sober" and that there were a number of other intoxicated adults in the home. The CFS after-hours worker requested police remove the intoxicated individuals from the home, as well as a specifically identified adult due to recent domestic violence concerns. After-hours workers attended the home to further assess the situation for child safety and protection reasons. Tina's sibling was deemed unsafe to remain in the home and was apprehended. Tina and her sibling were placed in a hotel for nine days and then placed in a foster home in Winnipeg on June 29, 2001. The intake report for Agency 1 was transferred internally for ongoing services and a protection file under Tina's mother's name was re-opened.

On July 4, 2001, a three-month temporary order of guardianship was granted to CFS for Tina and her sibling, however, the agency's expectations of the parents were unclear. Agency documentation did not list the expectations for Tina's parents, and the required copy of the legal guardianship order was not on the CFS file. A further three-month temporary order of guardianship was subsequently granted on October 17, 2001, "as all of the expectations were not completed during the first Order." Agency documentation again did not indicate what the agency's expectations were, which would have made it difficult for the parents to then know what issues they needed to address to safely regain guardianship of their children. Agency documentation detailed that Tina's father had been physically assaulted one evening, which "caused hospitalization and surgery to reconstruct his face. He also needed time for his ribs to heal" (Closing summary, August 15, 2002, Protection file, Agency 1). No further details regarding this incident could be found on file.

Files reviewed for this time period suggested Tina's parents' relationship ended at this time.

CFS documentation indicated that Tina's father completed an assessment through the Addictions Foundation of Manitoba, attended parenting courses, and had regular visits with his children while they were in care. Following these achievements, Tina and her sibling were returned by CFS to their father's care on November 27, 2001. The children were returned with a requirement for ongoing monitoring by Agency 1 until the temporary guardianship order expired in January 2002, at which point the CFS agency closed their file with respect to Tina and her sibling. Meanwhile, Tina's mother was noted to have not completed any courses or assessments, sporadically attended visits with the children while they were in care, and was involved in a new relationship. Given that the agency had documented- for several years- Tina's father's coercive control of Tina's mother, and his sexual exploitation of her while she was a child in care, it is concerning that the agency moved so quickly to place two children who were both under the age of three with Tina's father and then rapidly close their file without extensive monitoring and supports to ensure the children's ongoing safety.

Tina's mother, who was in a new relationship, gave birth to her fourth child. The protection file with Agency 1 regarding Tina's mother was closed on August 15, 2002. CFS case notes indicated Tina's mother and her new partner were resistant to agency involvement; however, the child appeared healthy and well cared for and there were no identified protection concerns. No formal assessments could be found on file prior to closure. At this time, Tina and her sibling were residing with their father.

Four months later, in December 2002, the CFS agency re-opened their protection file regarding Tina's mother as she was pregnant and there were a number of safety concerns which resurfaced. The agency involved was concerned about the family and intervened to ensure the safety of the children. There is no evidence that Tina or her sibling had any contact with their mother or that the agencies, while involved, took any initiative to ensure connection between the siblings living in various households at this time.

A Stabilizing Force: Tina Moves in with her Grandma

TINA AGES 3-6

Meanwhile, between 2002 and 2004, Tina (ages 3-5), her sibling, and their father moved back and forth between Winnipeg and their father's home community of Sagkeeng First Nation. A friend of Tina's father's shared a memory with our office about this time in their lives. The friend, who worked in a community-based family centre said that during this time, they would see Tina, her sibling, and their father every day as Tina's father would bring the children to the family centre to have the staff help him get the children ready for their days. The family friend said that she recalled braiding Tina's hair nearly every day during this time and that she felt that even though Tina's father had many challenges in his life, that he was determined to do his best for the two children for whom he was responsible. The family friend added that Tina's father's eventual decision to ask his paternal aunt to help him care for Tina and her younger sibling was one of the ways he tried to provide stability for the children, since he knew he was unable to do so on his own (Family friend, Interview, February 8, 2019).

In October 2004, Tina, her sibling, and their father were living in Winnipeg and concerns surrounding their father's alcohol use were again raised with Agency 1. It was also noted that he had been diagnosed with cancer and was undergoing treatment. In November 2004, Tina's paternal great-aunt, who lived in Powerview (the community adjacent to Sagkeeng First Nation), agreed to provide care for Tina (age 5) and her sibling (age 4) as their father was unable to care for them. Tina's father placed his two children with his aunt through a private guardianship arrangement.

While the woman who would raise Tina for the next decade was Tina's paternal great-aunt, Tina would come to call her "mama" or "grandma," and her great-uncle "papa" or "grandpa." In one of our interviews with the family, we asked them how they would like us to refer to them in this report, and Tina's great-aunt asked us to call them "grandma and grandpa." This is how they will appear through the rest of this report.

On December 3, 2004, Tina's grandma contacted Agency 2 indicating that she wanted to better protect the safety of Tina and her sibling by having the children continue to live with her but placing them formally in care so, "bio father will not be able to just take them – he came Tues. Nov. 30/04 drunk and demanding to take kids back" (Intake Information, December 3, 2004, Child in care file, Agency 2). Tina's grandma told the agency that Tina's father had been "beaten up badly" and that she had to call for an ambulance while he was there as he had experienced a seizure. The CFS agency agreed to the plan and Tina and her sibling were placed under apprehension on December 8, 2004 (Child information sheet, December 8, 2004, Child in care file, Agency 2). In addition to child in care files being opened regarding Tina and her sibling, a protection file

was opened under their father's name with the CFS agency on December 8, 2004.⁵ Tina and her sibling continued to live with their grandma, who was not their legal guardian in the eyes of the mainstream system, but who was the customary caregiver and daily decision-maker for the children. Although under provincial CFS standards voluntary agreements are not permitted to be used by an agency to bring children into care when there are known protection issues, the CFS agency signed a six-month Voluntary Placement Agreement (VPA) between Tina's father and the CFS agency on December 10, 2004. This practice of using VPAs was, and continues to be, common in the child and family services system.

A worker from Agency 2 spoke with Tina's grandma over the phone at the beginning of January 2005. Tina's grandma described Tina as "very hyper" and indicated she suspected that Tina might have fetal alcohol spectrum disorder. Tina's grandma requested that a referral be made to have Tina formally assessed. A letter on the CFS file from the Clinic for Alcohol and Drug Exposed Children, dated February 12, 2005, indicated that a referral had been made to have Tina assessed at the clinic, and that in order to facilitate this process, additional information was required, including the completion of several forms. There was no evidence on file that Agency 2 completed the required tasks to arrange assessment of Tina; no further mention of these assessments were located on file during our investigation.

The Voluntary Placement Agreement that had been signed in December 2004, was not renewed after expiring in June 2005, as Tina's grandma no longer felt the children's father would abscond with them. Tina's grandma indicated that Tina's dad was "...in his 3rd stage of cancer and she does not feel threatened by him anymore" (Case note, June 7, 2005, Child in care file, Agency 2). She further indicated that she had raised Tina's father when he was younger and as a result, she felt capable to raise Tina and her sibling, stating that, "the [children] are part of her life and does not want to let them go" (Case note, June 7, 2005, Child in care file, Agency 2). Tina and her sibling continued to live with their grandma and her husband through a private guardianship arrangement, which was initiated and supported by Tina's father. A note on Tina's child in care file with Agency 2, written by Tina's father, indicated that he was in support of the children living with their grandma. Tina's father's protection file with Agency 2, as well as the agency's child in care files regarding the children were all closed June 22, 2005.

TINA AGES 7-10

During the 2005-2006 school year, Tina attended Grade 1 in Sagkeeng. Tina was noted to be encountering difficulties in the first term with reading, writing, spelling, phonics, and mathematics, and was receiving extra help from a reading recovery program. Near the close of the school year, in May 2006, Tina and her family moved to Selkirk due to housing issues. Tina transferred schools and finished her Grade 1 year in Selkirk.

⁵Our office was unable to review the information contained in Tina's father's CFS files because Agency 2, a CFS agency under the Southern First Nations Network of Care (Southern First Nations Child and Family Services Authority) was unable to locate their physical files when required as a mandatory part of this review.

Tina's grandma shared with our office that after a few months living in Selkirk, her family – including Tina (age 8) and her sibling - moved back to Powerview in September 2007. Tina entered Grade 2 in Sagkeeng for the 2007-2008 school year.

Tina's report card for the 2007-2008 school year described her as quiet and soft spoken. She was noted to work consistently on independent tasks but would often not participate in class discussions. Tina was promoted to Grade 3, and the school noted:

...she may struggle in the [language arts] area if she doesn't practise her reading skills more. However she has good work habits. Her math skills are fair. Tina will need to make a big effort to listen to instructions and she should do well (Tina Fontaine cumulative record, School division).

In 2008-2009, Tina attended Grade 3 in Sagkeeng. Tina continued to be described as shy, quiet, and soft spoken. Tina's first term report card noted that with respect to language arts, "Tina tends to become lazy and then does her work quickly. She is not very attentive" (Tina Fontaine cumulative record, School division). There is no indication in her cumulative file of any assessments or supports being put in place to address these concerns. Comments on her final report card noted, "Tina needs to put more effort into her work. During this term she showed little improvement" (Tina Fontaine cumulative record, School division). Tina was not promoted to Grade 4. Tina's cumulative file did not contain any assessments or plans to address her academic needs.

Tina repeated Grade 3 for the 2009-2010 school year, and continued to reside with her sibling at their grandma's home under the private guardianship arrangement. She showed improvement in her language arts and was promoted to Grade 4 for the 2010-2011 school year. File documentation from the school does not indicate whether Tina improved on her own or if supports were put in place for her. Overall, it seemed as though Tina was doing well in school and that living with her grandma and her husband was a positive, stabilizing factor in her life. Tina's Grade 4 report card for the 2010-2011 school year had positive comments regarding Tina's efforts and improvements over the year. She was promoted to Grade 5.

The Death of Tina's Father

TINA AGES 11-12

In late October 2011, Tina's father (age 41) died as a result of a head injury he sustained from an assault. Tina's father and two other men had been drinking when there was an argument about money that escalated into the fatal assault. The two men would eventually plead guilty to manslaughter in 2014; each would be sentenced to nine years in prison.

Tina was 12 years old at the time of her father's death. Although Tina had been living with her grandma for seven years, her father had remained involved in her life. Tina's grandma shared with our office that Tina's father would come to their house for Sunday dinners and that he stayed connected to Tina and her sibling (Tina's grandma, Interview, April 12, 2018). Tina's father's death had a significant impact on her. After the death, Tina spoke of missing her father; her behaviour changed, she became increasingly withdrawn, and began using cannabis (Tina's grandma, Interview, April 12, 2018). A family member of Tina's shared with our office during this investigation that they had been very close with Tina and knew that she greatly missed her father after he died. The family member shared a number of memories with us, including one about sitting on a rooftop with Tina and that it was one of the times that Tina spoke about how much she missed her dad (Family member, Interview, February 27, 2019).

While the community of Sagkeeng is small and close-knit, there was no documentation to suggest that CFS was aware of Tina's father's death, which was likely due to there not being an open CFS file at the time. As such, there was no evidence that discussions or planning transpired to address guardianship of Tina and her sibling. Since Tina's father and Tina's mother both held legal guardianship of the two children, and since Tina's father had then placed them informally in a private arrangement, but was now deceased, Tina's mother became the sole legal guardian for Tina and her sibling after their father's death, even though she had not been involved in the lives of the two children for many years. When Tina's father died, it was an important opportunity to call everyone together to discuss the best interests of the children and make decisions about where they would live and how they would be supported through their loss and grief.

As there didn't appear to be any public services apart from education being provided to Tina at this time, according to community traditions and customs in Sagkeeng First Nation, Tina's grandma would have been recognized as the children's ongoing care provider. However, there is an inherent discord between traditional Indigenous community customs and mainstream legal processes of guardianship. In the mainstream systems, legal guardianship of children is either held by biological parents, or otherwise instructed or affirmed by court processes. As the local child and family agency for Sagkeeng First Nation recently described:

Customary Care means care provided in a way that recognizes and reflects the unique customs of a community...Historically, customary care was a way of life. Everyone was involved in raising and providing care for one another as this was the traditional way of care that is provided by the family and within [its] community. It preserves a child's cultural identity, respects the child's heritage, facilitates cross-generational connections and recognizes the role of the community in raising its children. The First Nation community is to establish the practice of customary care and to identify [its] roles within the community when raising [its] children (Sagkeeng Child and Family Services, 2018).

There are many guardianship situations for Manitoba families where there is a legal tension between the mainstream and the customary, which can create significant issues for service accessibility for families. In Tina's case, the issue would, at times, create barriers to seamless and efficient services.

Tina's grandma informed our office that on the day of Tina's father's funeral in 2011, Tina's mother contacted Tina and her sibling for the first time since 2004, when they had started living with their grandma. After Tina's father's death, Tina and her mother spoke over the phone on a weekly basis. According to Tina's grandma, this weekly contact between Tina and her mother lasted for approximately two months before it dropped off. Tina's grandma indicated that contact was lost when Tina's mother's phone number was suddenly disconnected. Tina's grandma did not talk to our team about how she viewed its impact on Tina, although it is reasonable to believe Tina would have experienced this reconnection and subsequent drop-off of contact as another traumatic loss in her life.

On November 3, 2011, a Manitoba Justice Victim Services ("victim services") worker met with Tina's paternal grandmother to offer condolences on the death of her son, and explain the role of victim services. The victim services worker and Tina's paternal grandmother completed the form for the Compensation for Victims of Crime Program. Tina's grandmother informed the worker where her son's two younger children were living. Tina's father's firstborn child continued to reside in a foster home in Winnipeg under a permanent order of guardianship. Contact information for the victim services worker was provided to Tina's paternal grandmother so it could be given to Tina's grandma.

On November 23, 2011, the victim services worker and Tina's grandma discussed counselling for Tina and her younger sibling. Victim services notes indicated, "Tina's [grandma] said she has care of the children through a written agreement with the deceased and CFS" (Victim services file, December 12, 2011). The "written agreement" was a reference to the handwritten letter from Tina's father to Agency 2 in 2005, when he had written to the agency regarding his support of Tina's grandma and her husband being the care providers for Tina and her sibling. The victim services worker indicated that they would need a copy of the letter from CFS to assist in approving the children's application for the Compensation for Victims of Crime Program. Tina's grandma indicated she would provide CFS with the authority to release that information to victim services. The victim services worker was noted to have contacted CFS on December 6, 2011, and was informed by the CFS agency that Tina's grandma had not yet contacted them (Victim services file, December 12, 2011).

Absenteeism is an Important Indicator of Risk

⁶However, as noted by our office above, the customary guardianship arrangement was not formalized legally through mainstream processes (i.e. the provincial court system). As such, in the eyes of the mainstream systems (e.g. victim services, and in time, CFS), guardianship was recognized to be held by Tina mother from the time of Tina's father's death in 2011.

Tina's cumulative file at school did not document the first term of Grade 5 while she continued to attend school in Sagkeeng. The cumulative file indicated that Tina had experienced problems with peers in Sagkeeng who would tease her and make derogatory comments about her father. In December 2011, Tina transferred to a different school located close to the community.

TINA AGE 13-14

Concerns about how her father's death was affecting her continued to grow as the criminal processes were underway regarding her father's homicide. Letters addressed to Tina's paternal grandmother and Tina's grandma were on the victim services' file dated January 17, 2012. The letters indicated that under Manitoba's *Victim's Bill of Rights* Tina's paternal grandmother and her grandma had automatically been registered to receive information about Tina's father's homicide death and the pending trial. The letters furthered indicated that the victim services worker wanted to speak with Tina's paternal grandmother and grandma about their right to file victim impact statements in court. On this same date, the victim services worker met with Tina's family and a crown attorney to discuss the crown attorney's role and the upcoming court process. The victim services file did not indicate who in Tina's family was a part of this meeting.

A letter dated May 14, 2012, on the victim services file indicated that the accused in Tina's father's homicide death entered a not guilty plea to the charge of second degree murder and that the matter was scheduled for preliminary inquiry in February 2013.

The victim services file noted that on November 23, 2012, the victim services worker, Tina's paternal grandmother, her grandma and grandpa, and other family members met with a crown attorney. The crown attorney discussed the upcoming preliminary inquiry and timelines for trial. Tina's family indicated that they wanted to attend the preliminary inquiry. However, the crown attorney informed Tina's paternal grandmother that she would not be able to attend the preliminary inquiry as she was a potential witness. Tina's grandma stated her desire to attend as she felt it was important that Tina's father be represented by family in court. The victim services file further indicated that during this meeting, Tina's grandma had inquired about counselling for Tina's sibling "who has been having a very difficult time coping." There was no mention in the documentation of the need for counselling for Tina. The victim services file noted that Tina's grandma indicated she wanted to meet with the victim services worker to complete the necessary forms. Those forms were later mailed to their home.

In March 2013, the preliminary inquiry for Tina's father's death occurred. The matter would continue to trial.

Tina made continual progress during Grade 5 and the first two terms of Grade 6 at her school. The school arranged for academic assessments to be completed for Tina in reading and math. As a result, on March 18, 2013, Tina was promoted to Grade 7 as part of a transition plan to allow her to be placed with more age-appropriate peers. Tina's principal shared with our office that Tina was a bright student who, in their view, did not struggle academically (Interview, Principal, September 20, 2018). Tina's principal indicated that Tina was capable of doing the work needed to transition and felt that it was not a stretch to transition her to the higher grade. Tina was promoted to Grade 8 for the 2013-2014 school year.

On April 9, 2013, a newly assigned victim services worker spoke with Tina's grandma over the phone, introduced herself, and arranged a meeting for the end of April 2013. Tina's grandma enquired about forms for the Compensation for Victims of Crime Program as she had not received them. The new worker committed to bringing the forms to the upcoming meeting. File documentation indicated that the meeting that had been arranged for the end of April 2013 did not occur as Tina's grandma was ill. According to victim services documentation, a rescheduled meeting was arranged on May 23, 2013. Files noted that this meeting also did not occur as Tina's grandma continued to be suffering from a health condition.

A Compensation for Victims of Crime form, completed by Tina's grandma, was found on the victim services file. It had been stamped "received May 28, 2013." At this point, according to Victim Services, the department ought to have mailed out a list of counselling resources to the family so they could begin to select the supports they needed and so arrangements could be made for victim services to cover those costs. We found no evidence that this information was communicated to Tina's family.

A letter on file dated May 31, 2013, informed Tina's grandma that she would not be receiving financial support from the program, as she "had guardianship of the children since November 3, 2002, which is long before the death of their father" (Decision letter, May 31, 2013, Victim support services file). This letter was solely in regard to support payments for dependants. As Tina's father was not working at the time of his death, financial support through loss of wages compensation would not be provided to Tina's grandma. However, this letter did not deny Tina or her grandma payment for grief therapy or other counselling services. During the course of this investigation, representatives from victim services indicated that the letter ought to have stated that although financial support was denied, the family remained eligible for counselling and other benefits offered by the program. Victim services acknowledged to our office that they had made an error in sending a letter that might not have been as clear as it ought to have been for the family. Ultimately, counselling was never provided by victim services.

A "school social work assessment," which was requested by the school in January 2013 was completed by Tina's school six months later in June 2013, and noted that Tina (age 14) had been referred for ongoing social work support due to her father's death in 2011. The assessment summarized that Tina had attended school in Sagkeeng until December 2011, and transferred to a different school in the area following her

father's death. The assessment described Tina as very soft spoken, reluctant to open up, pleasant, polite, and "profoundly affected by the murder of her father" (Social work assessment, June 2013, Tina's cumulative file). It was noted that effort had been made to connect Tina with victim services for ongoing therapy, however those efforts were not successful. No further information was provided as to who was involved and why the efforts were not successful. The stated goals from the school's assessment were to:

- continue to try to connect with Tina on a regular basis,
- continue to check in and provide support to Tina's grandma and grandpa, and
- to continue to advocate for therapy through victim services.

A letter dated July 5, 2013, on the victim services file, informed Tina's grandma of upcoming court dates for September 2013 in regard to the trial. The letter further indicated that Tina's grandma was interested in meeting with the victim services worker to complete the application for the Victims of Crime Compensation. It is not clear from documentation on file why this letter was sent to Tina's grandma when a completed Victims of Crime Compensation form had been received in May 2013.

On August 28, 2013, the victim services worker spoke with Tina's grandma over the phone in regard to the upcoming court proceedings.

Tina's first term report card for the 2013-2014 school year also reflected Tina's struggles. The report card indicated that Tina missed 9.5 days of school during the first term and that she had not completed all of her required assignments. Tina's principal and school social worker indicated that in September 2013, Tina began to "pull away" (School staff, Interview, September 20 2018). The school social worker noted that when Tina began to distance herself, that the school social worker had tried to engage with Tina who she viewed as very guarded and skeptical of the social worker's intentions. In October and November 2013, Tina (age 14) began to run away from home, further disengaged from the school, and often would not attend classes. The school social worker indicated that she connected with Tina's grandma who was at a loss as to how to help Tina. The school social worker suggested Tina's grandma contact the local child and family services office for assistance, however, Tina's grandma was reluctant to having this happen. Despite the known challenges that Tina was experiencing, and that her grandma expressed uncertainty about how to help Tina, there is no evidence that the school on their own initiative contacted CFS with any concerns about what they were seeing for Tina either.

Missing Persons Reports: Another Significant Indicator of Risk

JISSING

A Place Where it Feels Like Home: The Story of Tina Fontaine Manitoba Advocate for Children and Youth – March 2019

On the evening of November 4, 2013, Agency 4, which is the designated CFS intake agency for the Winnipeg area, received a call from Royal Canadian Mounted Police (RCMP) Powerview Detachment about a missing person by the name of Tina Fontaine (age 14). The RCMP indicated that Tina was missing from her grandma's home and was thought to be at her mother's home in Winnipeg. RCMP requested the opinion of the CFS after-hours worker in terms of allowing Tina to stay at her mother's house. The after-hours worker contacted Agency 3, as that agency continued to have involvement and an open protection file with Tina's mother because of her other children, Tina's younger siblings. Agency 3 informed Agency 4 that Tina's mother was doing better than in years past but had a history of feeling overwhelmed and relapsing. Agency 3 indicated they were in the process of trying to reunify two of Tina's mother's other children and they were unfamiliar with Tina and her needs. Agency 3 stated they were not comfortable allowing Tina to stay at the home under these circumstances. This information was relayed to the RCMP who indicated that they would be requesting Winnipeg Police Service (WPS) pick up Tina at her mother's home. Documentation reviewed for this investigation did not indicate when Tina and her mother had rekindled their relationship.

WPS went to Tina's mother's home, picked up Tina, and brought her to the Agency 4 office. WPS reported that Tina's mother had visitors at her house and was playing board games and drinking while Tina was asleep in another room. The after-hours worker contacted Tina's grandma in Powerview to advise that Tina had been located and asked her grandma to come to Winnipeg to get her. The grandma told CFS that she was unable to come to the city that night to pick her up as they had no transportation. As no other placement options were available, arrangements were made by the agency for Tina to stay at a youth shelter for the night. Information provided by the shelter for this investigation indicated that Tina's grandma told shelter staff that a 25 year old male had given Tina a ride to Winnipeg and that she had informed the RCMP of such. RCMP information was unable to confirm this information. Tina was picked up two days later from the youth shelter by her grandpa on November 6, 2013. Agency 4 forwarded their intake information to Agency 3 and closed their file on November 5, 2013. There was no further child welfare involvement involving Tina until April 2014.

On November 5, 2013, the school social worker contacted victim services and indicated that she had been in contact with the family who was looking for supports for Tina because they were concerned for Tina's safety in the community. The victim services worker explained the Victim of Crime Compensation program and indicated that applications for the program generally have to be submitted within one year of the offence. The victim services worker indicated that, "the timeline may be more lenient for a child in need of the resources" (Victim services file, November 5, 2013). When our office met with officials from Manitoba

⁷Agency 4 is a CFS agency under the umbrella of the Southern First Nations Network of Care (Southern First Nations Child and Family Services Authority).

Justice Victim Services, they informed us that while provincial legislation states applications must be made within one year, that they follow the practice of being more lenient with applications from children. The school social worker indicated that she had printed off the forms and would forward them to the family. The victim services worker advised that the family could contact her should they need help with the application. There was no acknowledgement of the previous conversations that victim services had regarding Tina over the last two years, nor that an application for services for Tina had already been received on May 28, 2013.

At the end of November 2013, Tina's youngest two siblings were reunified with their mother. Tina and her sibling continued to live in their grandma's home.

TINA AGE 15 (2014)

During the course of this investigation, Tina's grandma shared with our office that in January 2014, Tina's mother requested a visit with Tina and her sibling in Winnipeg. Grandma shared that she contacted the assigned worker for Agency 3 prior to agreeing to the visit. According to Tina's grandma, the CFS worker raised no concerns with Tina and her sibling visiting with their mother; Tina's grandma informed our office that this visit had gone well. However, when our office met with the worker, other staff, and supervisors from Agency 3, they disputed this account, saying their assigned worker had not spoken with Tina's grandma prior to the summer of 2014.

On January 30, 2014, Tina was involved in a family disagreement (Tina's grandma, Interview, September 20, 2018,). Tina expressed her anger by inflicting superficial cuts on her forearms with a pen. RCMP were contacted by the family and reported that Tina had cut her arms and locked herself in her room. Paramedics were called to the home and transported Tina to the Pine Falls Health Complex. When asked by a nurse, Tina indicated she had never self-harmed before and denied having suicidal thoughts. Tina's cuts did not require stitches, were cleaned and bandaged and she was discharged. Child welfare was not contacted by medical staff regarding this incident. Tina's grandma confirmed for our office that there had been no discussion initiated by the hospital staff about involving child and family services or the hospital social work department. When our office met with representatives from the Southern First Nations Network of Care (Southern First Nations Child and Family Services Authority) and the relevant agencies in this investigation, they collectively asserted Pine Falls Health Complex does not have a social work department, which is why no referral would have been made as a result of this incident of self-harm. However, our office contacted Pine Falls Health Complex, which confirmed that there is a rotation of social work that is provided at the complex, 2-3 times each month (Pine Falls Health Complex, Interview, March 4, 2019).

Tina's school absences continued to escalate into the second term of Grade 8 (47.5 days absent out of a possible 64 instructional days) resulting in numerous "incomplete" grades on Tina's report card. The school

social worker indicated that during this time there were numerous conversations with Tina's grandma as the family was not sure how to help Tina. There was no evidence that the school considered working with child and family services to mobilize additional local supports for Tina and the family at a time when it was evident Tina's struggles were growing. Tina was still not receiving any services from victim services.

Tina was suspended on April 16, 2014, for being under the influence of cannabis while at school. It was noted in school files that this was her second offence, although there is no record of a first offence on her cumulative file. Tina's cumulative file did not indicate the length of the suspension. In speaking with the school principal, he was unable to indicate the length of suspension and suggested to our office that according to his recollection, Tina may have stopped attending school altogether at this time.

As Risk Increases, the Family Asks for Help

On April 25, 2014, Tina's grandma contacted Agency 2 to enquire if she could place Tina in care as she was feeling unable to safely manage Tina's behaviours. Tina's grandma explained to the CFS agency that she was concerned for Tina's safety as Tina was experimenting with drugs in school and in the home, running away, and conversing with adult men on the internet. The CFS intake documentation further noted that Tina had been taken to hospital the previous month for suicidal thoughts (this is in reference to the January 2014 incident above). The CFS agency noted the following follow up was needed:

- (1)sign an Authority Determination Protocol⁸
- (2)Tina's grandma can sign a [Voluntary Placement Agreement] youth out of control
- (3) bring Tina into care
- (4) Tina needs to attend, participate, and complete a workshop on grief and loss
- (5)refer Tina to a therapist
- (6) biological mother poses risk of sexually exploiting Tina⁹
- (7)internet luring is a concern

In Manitoba, child and family services is organized by region and community, and certain CFS agencies are responsible for providing intake, or first point of contact services. As the family was residing in Powerview and Agency 2 is not the designated intake agency for Powerview, the intake information was forwarded by Agency 2 to Agency 5 for follow up, as Agency 5 is the designated intake agency for that area.¹⁰

⁸Authority Determination Protocol refers to the process used by the designated intake agency to determine the culturally appropriate authority and the authority of service for a person or family.

⁹CFS file documentation did not provide further information as to how Agency 2 determined this as a concern, or what their response would be to address this safety and protection risk.

¹⁰Agency 5 is a CFS agency mandated under the umbrella of the General Child and Family Services Authority.

An intake worker from Agency 5 contacted Tina's grandma later that same day, April 25, 2014. The intake worker was informed by grandma that Tina was currently missing and that this was not her first time running away from home. Winnipeg Police Service (WPS) information reviewed by our office indicated that RCMP requested WPS assistance in locating Tina and that WPS went to Tina's mother's home to look for Tina, but Tina was not located at that address.

That same day, the Agency 5 worker contacted Agency 3 to speak with the worker assigned to Tina's mother. Agency 3 noted that Tina's mother's two youngest children were recently reapprehended from their mother due to safety and protection concerns related to their mother's substance misuse. As such, Agency 3 informed Agency 5 that should Tina be located at her mother's home, that location should not be considered a safe place. There was no evidence on file that either Agency 5 or Agency 3 requested the assistance of Agency 4, which is the designated intake agency for Winnipeg, to attend Tina's mother's place to see if Tina was there. Asking the designated intake agency to attend to Tina's mother's home to check if Tina was there would have been reasonable as Tina had previously been found at that location and was deemed unsafe to remain with Tina's mother. Later that evening, Tina's grandma contacted Agency 5 and advised them that Tina had been safely located in Selkirk.

Three days later, the Agency 5 intake worker spoke with Tina's grandma. According to Tina's grandma, Tina had been located with extended family and was remaining there for the time being. The CFS worker met with Tina's grandma and grandpa in their home on April 29, 2014. Tina was not a part of the meeting as she had not yet returned from Selkirk. Tina's grandma was noted to have requested voluntary CFS services from Agency 5, "as she feels that there is a perceived difference in service availability" (Intake, April 29, 2014, Voluntary family services file, Agency 5). CFS file recordings included the following concerns:

- (1) Mental health issues (self-harm and mood swings). Tina would benefit from a referral to community mental health services.
- (2) Tina was acting out physically towards family members.
- (3) She was known to be using cannabis with her peers.
- (4) Tina was not attending school she had been working in the off-campus program as regular programming had become difficult for her.
- (5) Tina was conversing with adult men online and wanting to meet with them in Winnipeg. Tina's grandma informed the CFS worker that she had contacted RCMP regarding one of the men with whom Tina was conversing.¹¹
- (6) Tina was running away from home when things were not going well, including three times in the past year.

¹¹RCMP do not have a record of this contact indicated by Thelma.

(7) Tina had not received any grief counselling following her father's death.

Despite a number of the identified concerns being risk indicators of sexual exploitation, this was not explicitly mentioned as a concern. An Authority Determination Protocol was completed with Tina's grandma choosing to receive services from the General Child and Family Services Authority. Although Tina's grandma was not the legal guardian of Tina, the agency proceeded with making case plans with Tina's grandma, viewing her as Tina's customary care provider, and allowing her to make decisions on behalf of Tina. The Structured Decision Making® Probability of Future Harm was completed and assessed to be moderate. The CFS intake file was transferred for ongoing services and Agency 5 opened a Voluntary Family Service file to assist Tina's grandma with the concerns regarding Tina. The Agency 5 intake worker made a note on the file that Tina was "at HIGH RISK of coming into care should her out of control behaviour and going AWOL continue" (Intake, April 29, 2014, Voluntary family services file, Agency 5).

A CFS worker met with Tina in her home on May 6, 2014. Tina shared that she was good at math, liked to go for walks, sing, and visit with friends. Tina indicated her interest in meeting with a counsellor. File documentation stated, "Tina's issues at school were touched on as well" (Case note, May 6, 2014, Voluntary family services file, Agency 5) but did not indicate whether any of the other concerns that had been outlined in the meeting with Tina's grandma and grandpa on April 29, 2014, were discussed with Tina. It is especially concerning that the issue of internet luring and possible sexual exploitation by older men, a form of sexual abuse, was not raised during this meeting. The intake worker for the agency did record the information that Tina was conversing with men online and recommended this be further assessed. Agency 5 documented no case plan for Tina so the concerns brought forward could be addressed, and there was no indication that the agency had any direct contact or conversations with Tina after the visit on May 6, 2014.

On May 16, 2014, Tina's paternal grandmother and an aunt of Tina's met with the victim services worker as well as two crown attorneys about the trial regarding Tina's father's death. Documentation did not indicate if Tina's grandma was a part of this meeting. The crown attorneys informed the family that the two accused individuals would be entering guilty pleas to manslaughter on May 26, 2014, and that sentencing would take place in the summer or fall of 2014. Tina's family members were advised they could complete victim impact statements if they wished. A letter addressed to Tina's grandma, dated May 16, 2014, enclosed victim impact statement forms for the family to complete.

A victim services worker spoke with Tina's grandma over the phone on May 26, 2014. The victim services explained the process and the victim impact statement forms that had been mailed to the family. Documentation indicated that Tina's grandma expressed her desire to provide a victim impact statement to the court. Tina's grandma further enquired if the two additional victim impact statement forms were intended for Tina and her sibling. Tina's grandma told our office that Tina had struggled emotionally each time she began to write her statement and that Tina kepy being unable to complete expressing her thoughts

and feelings. She told her grandma, "How do I write on a piece of paper how much this has hurt me?" Tina's grandma told the victim services worker that she thought it might be best to help Tina write her statement and that Tina and her sibling could submit one statement together. The victim services worker advised that the forms are best done separately.

During the course of our investigation, we met with senior staff from victim services and we asked how often victim services met directly with Tina during the three years they had contact with Tina's family. We were informed that it is not their normal process to connect directly with children, even when those children are also identified as victims impacted by crime or the court process.

RCMP information indicated that on May 29, 2014, Tina and another youth were accused of assaulting three other female youth, but the complainant did not wish to proceed with charges. No further details were provided to our office by RCMP on this matter. Tina's school principal and Tina's grandma were able to provide further information regarding this incident and indicated that Tina and another youth had gotten into a verbal confrontation at school with three other youth which escalated into a physical fight. There is no evidence of any follow up that occurred as a result of this incident.

In June 2014, Agency 5 made a referral for Tina to attend counselling; the ongoing counselling sessions were to occur in Powerview and would start in late July 2014, but were arranged to begin on an interim basis in Beausejour, Manitoba, on an interim basis. This counselling referral was made independent of counselling that ought to have been provided by victim services. An email from the CFS agency to a potential counsellor for Tina noted an agency's concern. The worker wrote, "[Tina] will leave the home in the middle of the night in her pyjamas and go and wander the community" (Email communication, June 4, 2014, Agency 5).

On June 17, 2014, the CFS worker called Tina's grandma for an update. Tina's grandma told CFS that Tina was doing well, but continued to struggle with the death of her father. Tina's grandma informed the worker that they did not have a vehicle to attend counselling in Beausejour (75 kilometres away from Powerview) or Winnipeg (119 kilometres from Powerview). The Agency 5 file recordings noted that the worker informed Tina's grandma that if the family could find transportation to Beausejour or Winnipeg, gas vouchers would be provided by the agency.

Representatives from Agency 5 advised our office that the offer of gas vouchers in situations such as this is standard practice. However, Tina's grandma informed our office that she recalls no such offer being made to her because if the agency would have made this offer, the family would have accepted the help. Our review of the Agency 5 file revealed a notation that, "There was a recommendation for her [Tina] to be referred to local mental health services" (Case note, July 17, 2014, Voluntary family services file, Agency 5). Our office spoke with the CFS agency who indicated the plan was to arrange counselling for Tina in Powerview-Pine Falls. At that time the agency had contracted a therapist through a centre in Winnipeg to provide therapy for

its clients. The therapist was working with Agency 5 clients one day per week, primarily out of the agency's head office in Beausejour and sub-office in Powerview-Pine Falls. The therapist's schedule was unable to accommodate meeting Tina in Powerview-Pine Falls at that time and thus, the agency scheduled a meeting with the therapist to occur in Winnipeg. Representatives from Agency 5 informed our office that plan was always for Tina to eventually see a therapist in Powerview-Pine Falls once this could be arranged. Documentation presented to our office by the agency did not lend clarity as to whether this was indeed the plan for Tina.

A second social work assessment completed by the school and dated June 2014, was found on Tina's student cumulative record. The assessment noted that Tina had entered the 2013-2014 school year in Grade 8 and had started the school year well but ran away from home in October 2013. The school social worker described meeting with Tina upon her return to school. "Tina indicated that she had run away to be with her mother. Tina expressed a deep desire to live with her mother..." (School social work assessment, June 2014, Cumulative file, School division). There is no indication how long Tina was with her mother during this incident of running away, and when our office enquired with Tina's grandma on additional details, she was unable to provide further clarity about what had happened.

The school's social work assessment noted that Tina had been suspended or sent home several times during the school year. During an interview with our office, Tina's principal indicated that Tina had been sent home several times during the school year for being under the influence of cannabis. During the school year, Tina had briefly taken courses at the alternative high school, however, Tina's grandma made the decision to keep Tina home in the spring of 2014 and for the remainder of the school year to work on her emotional well-being and return to school in the fall. Tina's principal told our office that the school had offered to send work home for Tina to complete, however, Tina's grandma had declined the offer as she not want to push school work on Tina believing it was more important to work on her emotional well-being. Although Tina's struggles were becoming more pronounced and her absenteeism had increased dramatically, the school stated the same goals as the previous year's assessment from June 2013:

- Continue to try to connect with Tina on a regular basis,
- Continue to check in and provide support to Tina's grandma and grandpa, and
- Continue to advocate for therapy through victim services.

Tina's cumulative school record did not indicate that the school sought assistance from child and family services or any other local community supports to work with Tina and to re-engage her.

On June 16, 2014, the victim services worker called Tina's grandma. Tina's grandma was noted to be upset and crying throughout the phone call as she was informed the crown attorneys would be accepting a plea bargain with the accused in relation to Tina's father's death. Victim services documentation noted Tina's grandma expressed feeling angry and hurt. Tina's grandma informed the victim services worker that she

MISSING

A Place Where it Feels Like Home: The Story of Tina Fontaine Manitoba Advocate for Children and Youth – March 2019

and the family would be submitting victim impact statements. Documentation further noted that Tina's grandma informed the victim services worker "I don't want to hear from you guys ever again. You guys just keep making this too hard." The victim services worker indicated that her role was to support the family though the process. Victim services indicated they would respect Tina's grandma's wishes and would no longer contact her. When interviewed during this investigation, Tina's grandma informed our office that she got tired of hearing what victim services kept promising to do for her family because services were never provided as promised (Interview, Tina's grandma, March 6, 2019). In the nearly three years of involvement since the homicide death of Tina's father, victim services neither met directly with Tina nor did they arrange a single counselling session for her to help her manage her loss and grief.

What is needed? A place... "where she feels like its home."

Powerview RCMP information indicated that on June 27, 2014, Tina was accused of throwing a large rock through a screen door window. RCMP information did not indicate where this incident occurred or whose screen door window was broken. When asked by our office about what had happened, Tina's grandma told us that she had not been informed about this incident and was unable to provide further clarity (Tina's grandma, Interview, September 20, 2018). RCMP were unable to question Tina about this incident as Tina died before RCMP followed up.

Tina's grandma contacted the Winnipeg designated intake agency, Agency 4, on July 10, 2014, expressing concern regarding Tina. The agency was informed that Tina had recently gone on a planned visit to see her mother in Winnipeg and the grandma had received a message via Facebook from Tina's boyfriend who was concerned about Tina. The boyfriend told Tina's grandma that Tina and her mother were using crack cocaine and that Tina was being sexually exploited. Tina's grandma informed Agency 4 that she had also notified Agency 3 of the concerns, as Agency 3 continued to have open files regarding Tina's mother. During the phone call with the designated intake agency, Tina's grandma also enquired whether she would be able to place Tina in care in the event that Tina was located and brought back home. Although Agency 5 had been acknowledging Tina's grandma as the primary caregiver for Tina, Tina's grandma was informed by the CFS intake worker that as legal guardianship rested with Tina's mother, further discussions would have to happen between Agency 5 (the agency working with Tina and her grandma) and Agency 3 (the agency working with Tina's mother and her other children). The intake worker contacted the worker for Tina's mother and left a voice message expressing Tina's grandma's concerns regarding Tina. At this time, Tina's mother's addiction issues were significantly escalated and she did not have any of her children in her care.

During the course of this investigation, Tina's grandma shared with our office that Tina had worked hard to do well in school, got her grades up, and as a result, the grandma agreed to let Tina spend

a week in Winnipeg with her mother (Interview, Tina's grandma, April 16, 2018). The information that Tina had done well in school was not supported by interviews with school personnel or Tina's cumulative record as her record indicated she stopped attending school. Tina's grandma shared that when she agreed to Tina visiting her mother, she did not have any concerns as a prior visit in January had gone well (Tina's grandma, Interview, April 16, 2018). Tina's grandma indicated that Tina's sibling expressed no desire to visit with her mother and would not articulate why.

Following the grandma's call to Agency 4 on July 10, 2014, various phone calls were made that same day between the Agencies 3, 4, and 5 regarding which agency should be following up given that there was an open voluntary family service file with Agency 5, an open protection file with Agency 3, and the fact that Tina's grandma was not the recognized legal guardian of Tina.

The Agency 4 intake worker spoke with Agency 3 later that same day regarding Tina's grandma's concerns for Tina's safety. The Agency 3 worker indicated that she had directed Tina's grandma to file a missing person's report with RCMP and contact the designated intake agency for Winnipeg. The Agency 3 worker further indicated that they did not feel their agency would be responsible for follow up for Tina. They further noted that although Tina's grandma had not been granted legal guardianship of Tina through the courts, she was in receipt of child tax benefits for Tina. The Agency 3 worker acknowledged to the intake worker at the designated intake agency for Winnipeg (Agency 4) that it was unclear who Tina's legal guardian was and whether Tina's mother would, by default, be the legal guardian. Tina's mother's worker requested workers from Agency 4 attend Tina's mother's last known address and apprehend Tina if she was found to be at that location.

After-hours workers from the designated intake agency in Winnipeg attended Tina's mother's last known address on the evening of July 10, 2014. The occupant in the upper suite indicated that Tina's mother had been evicted and no longer resided at that address. CFS case notes dated June 25, 2014, indicated that Tina's mother was residing with a family member. There was no documented information on CFS files as to why Tina's mother had been evicted.

On July 11, 2014, the Southern First Nations Network of Care Child and Family Services Authority ("Southern Authority"), which is one of four governing CFS authorities in Manitoba, and responsible for oversight of Agency 2, Agency 3, and Agency 4, directed their agencies that Agency 3 would be responsible for follow up on Tina. Conclusions and recommendations noted in the Agency 4 intake report reiterated the concerns about Tina being sexually exploited and using substances. Intake files noted that because Tina was with her mother, Agency 3 was required to follow up. The intake recommended that, "in the event Tina does return to Tina's [grandma's] care, it is recommended that further permanency planning take place with respect to the children

and that the agency ensures that both Tina and her sibling [name omitted] have a legal guardian" (Intake, July 2014, Agency 4). The intake was forwarded to Agency 3 and Agency 4 closed their file.

Tina's grandma shared with our office that during this time in Winnipeg, Tina had been in contact with her sibling via text message and sent pictures of herself with a black eye that Tina said had come from their mother. Tina's grandma told our office that she contacted Agency 2 four times regarding these pictures and asked for help for Tina (Interview, Tina's grandma, March 6, 2019). The pictures were not provided to Agency 2 as Tina's sibling had deleted them from her phone. There was no record of this information being reported to child welfare and thus no investigation into this issue occurred.

Tina (age 15) was picked up by Winnipeg Police Service (WPS) on July 17, 2014, not because she was missing and had been located, but because WPS received a call that Tina was screaming for help as she was being dragged by an older male down Selkirk Avenue by her arm. When WPS arrived at the scene, Tina and the adult male (age 18) were found to be intoxicated. WPS detained Tina and the other individual for public intoxication under the provincial *Intoxicated Persons Detention Act*. The male was taken to a local adult detox resource, and Tina was taken to a different short-term detox resource for youth.

Tina was admitted to the short-term detox resource in Winnipeg during the early morning hours of July 17, 2014. Upon admission, a nurse assessed Tina for visible injuries, assessed her vital signs, and conducted a breathalyzer. Tina's blood alcohol concentration was measured as 0.109%, which would have meant she was significantly intoxicated. Tina informed the nursing staff that she had consumed 15-20 beers and "chugged a litre" prior to the intervention by police. Staff from the short-term detox resource also spoke with Tina about the individual she had been with. Tina indicated that she was not in a sexual relationship with the 18 year old male, however, admitted that she did consensually "hook up" with a 16 year old male. Tina would later tell her CFS worker that she was involved in a sexual relationship with the 18 year old male, who she indicated was her boyfriend. Tina was issued a ticket by WPS for possession/consumption of liquor by a minor. Tina went to sleep and was monitored regularly by detox staff. Upon waking up later that morning, Tina told the staff that in addition to using alcohol the prior night, she had been high on pills. Tina indicated that she only used pills when she consumed alcohol and that in addition, she used cannabis daily. There was no further information as to what kind of pills Tina had consumed. It is concerning that there was no further discussion around the large amount of alcohol that had been consumed by Tina, and no evidence of any inquiry as to how Tina obtained the alcohol and pills. Additionally, there was no discussion around why she was being dragged down the street by an 18 year old male or further exploration around her relationship with this male.

¹²Agency 2 file information later referred to this individual as being Tina's boyfriend, although the man involved in this incident was a different male than the one who was referred to as Tina's boyfriend who had reported the concerns of Tina's substance use and sexual exploitation to Tina's grandma earlier in July.

The short-term detox resource contacted Agency 3 to advise that Tina was in their care. File documentation noted that Tina had also provided the detox resource staff with her mother's phone number. Tina's mother's CFS worker contacted the CFS worker for Tina's grandma on July 17, 2014, indicating that Tina was at short-term detox and that Tina's mother was planning on picking her up upon discharge, but that this was problematic as Agency 3 had active protection concerns with Tina's mother. The CFS worker for Tina's mother wanted to speak with the grandma to have her pick up Tina instead, and if it was not possible for grandma to pick up Tina, the worker asked if Agency 5 intervene in the situation. Agency 5 indicated that since legal guardianship of Tina had not been addressed at the time of Tina's father's death, Tina's mother was Tina's legal guardian, and because there was an open protection file with Agency 3, and protection concerns with Tina's mother, that it would be most appropriate for Agency 3 to apprehend Tina. CFS spoke with Tina's grandma who indicated that she was no longer able to care for Tina due to her behaviours. The voluntary family services file was closed for Tina's grandma on July 17, 2014, as Tina was no longer living in that home.

On the afternoon of July 17, 2014, Tina was discharged from the short-term detox resource to Agency 3. During her short stay in detox, Tina was provided a pamphlet about available voluntary services. Tina's stay at the detox facility was essentially long enough for her to sober up before being discharged. No discharge planning occurred, nor were further resources or support offered. The CFS worker apprehended Tina and placed her at a local motel as no other placement was available. No planning, assessment, or support occurred at this time, when both her risk and her drug use were escalating. The CFS worker was informed

the following day, on July 18, 2014, that Tina was missing and had been discharged from her motel placement. Agency file recordings did not indicate who informed the worker that Tina was absent or who had decided to discharge Tina from her placement.

The CFS worker contacted Tina's mother and grandma to check if either of them had seen Tina. Neither one knew where Tina was at that time. The CFS worker then contacted the missing persons unit of the Winnipeg Police Services. The missing persons report indicated Tina was suspected to be sexually exploited and was last seen at a specific motel location in Winnipeg.

On July 18, 2014, in an attempt to locate Tina, WPS contacted Tina's mother who stated she did not know where Tina was. WPS attempted to contact another relative of Tina's but received a busy signal. The CFS agency spoke with Tina's mother and then with Tina's grandma over the phone, neither knew where Tina was. An after-hours request for assistance was submitted to the designated intake agency for Winnipeg by Tina's CFS worker, which requested Tina be placed in a shelter if she was successfully located.

On July 21, 2014, WPS missing persons unit left messages with Tina's CFS worker and attempted to contact Tina's grandma, however, there was no answer.

On July 22, 2014, WPS again attempted to contact Tina's grandma to see if she had heard from Tina, however, there was no answer. The WPS missing persons unit contacted Tina's CFS worker on the same day. The CFS worker indicated that she had spoken to members of Tina's family who denied knowing where she was and indicated that they believed she was with her boyfriend. The WPS missing persons unit contacted family members of Tina's boyfriend who indicated to police that they had not had contact with him for a long time. An attempt was made by the WPS missing persons unit to contact additional family members, however, there was no answer.

Tina reached out to her CFS worker on July 22, 2014, via her mother's cell phone. She indicated that she was okay and was with family and her boyfriend. The CFS worker asked Tina to attend the office as the worker needed to locate a placement for her, and Tina agreed to attend the office. The CFS worker requested placement through the agency's foster department, however, no placements were available. The agency worker contacted shelters trying to secure a placement for Tina, however, no placements were available at those locations either.

On July 23, 2014, Tina attended the CFS agency office with her 18 year old boyfriend, the same individual who in the weeks prior had been found by WPS dragging Tina down the street; Tina spoke to her CFS worker's supervisor. File documentation did not indicate if Tina's boyfriend was present in the room with her while she spoke with the CFS supervisor. Tina presented with a number of "hickeys" on her neck, which she indicated were from her boyfriend. The supervisor asked Tina about her mother to which she replied, "I like her she's cool. I think she's funny and she tells me cool stories about her life" (Case note, July 23, 2014, Child in care file, Agency 3). The supervisor asked Tina about her substance use and indicated that they had heard Tina used crack cocaine with her mother; Tina replied, "I did crack with her about 3 weeks ago." Tina admitted to using substances often and stated she, "used to drink a lot." There is no indication that anyone spoke with Tina's mother regarding the concerns. When the supervisor asked how long ago Tina was using substances so frequently, Tina responded "last week." Although this was the first contact Agency 3 had with Tina after her discharge from the short-term detox resource where she had been severely intoxicated, there was no evidence that the agency supervisor raised concerns about this with Tina during this conversation. The supervisor spoke to Tina about where she would like to live and Tina indicated that she wished to live with her paternal grandmother. The CFS supervisor safety planned with Tina and "informed her running the street was not a great plan." Tina was noted to agree and said she would "stay put for awhile." Tina and the supervisor reviewed Tina's safe people to which she identified her grandfather. Tina was placed by CFS at a temporary youth shelter on July 23, 2014. The missing person's report was cancelled that same day.

On July 25, 2014, a staff member at the youth shelter contacted Tina's CFS worker and was informed that a request had been made to the provincial placement desk for a specialized foster home/treatment home for Tina. During this investigation, our Investigators asked the provincial placement desk about whether this referral had been made. We were informed that they were unable to find evidence of a formal referral having been made; however, they further stated, "it does not negate that consultation and/or discussion regarding placement had

The Provincial Placement Desk is centrally located at the Child and Family Services Division and is responsible for matching children in care with appropriate specialized placement resources in Manitoba. Referrals to the Provincial Placement Desk are received from CFS agencies throughout the province.

not transpired with the prior PPD [Provincial Placement Desk] Specialist at that time" (E-mail communication, February 27, 2019, Provincial placement desk).

Tina remained at the youth shelter until July 26, 2014, when she ran away from the placement. Staff at the shelter called hospitals in Winnipeg to see if Tina had been admitted in the past 24 hours, filed a missing persons report (July 27, 2014), and contacted Tina's guardian CFS agency and the Child and Family Services Division. The missing persons report noted:

- (1) Tina was not high risk
- (2) she was not a chronic runaway
- (3) her main mode of transportation was by foot or bus (had tickets in her possession)
- (4) she had a history of suicidal ideations or attempts, was not currently suicidal; had "hesitation marks" on both wrists
- (5) she was known to use drugs, mainly cannabis and alcohol

Tina returned to the youth shelter on July 27, 2014, and stayed for approximately one hour and then left. She returned again to her shelter placement on the afternoon of July 28, 2014, and the WPS missing persons report was cancelled.

A handwritten case note on the youth shelter's file dated July 30, 2014, indicates that Tina had been absent the previous night, and upon return informed a staff member that she had "spent the [previous] night in jigtown...and is going back there and not returning." Tina was informed by shelter staff that she was at risk

of losing her placement. Tina left her placement and did not return. Staff called hospitals in Winnipeg to see if Tina had been admitted in the past 24 hours, filed a missing persons report (July 31, 2014), contacted Tina's CFS agency, and notified the Child and Family Services Division. The missing persons report filed by the shelter contained different information than in the previous missing persons report from just days prior, and that Tina was being sexually exploited by adults was not included. The new report noted:

- (1) Tina was not suicidal
- (2) She was known to abuse both drugs and alcohol

- (3) She was not prescribed medication and did not suffer from any medical conditions
- (4) She did not have access to money
- (5) She travelled by bus and foot

On July 30, 2014, Tina's CFS worker received a call from Tina's grandma indicating that one of her grandchildren had seen nude photos of Tina on social media. Tina's grandma was advised to contact WPS missing persons unit and inform them of what was found. There is no record of a call from the grandma to the missing persons unit to inform them of the photos. In an attempt to locate Tina, who was missing again, the CFS worker tried to contact Tina's mother on her cell phone, however, her phone was off. The CFS worker was noted to have also tried to locate Tina at her boyfriend's home.

The following day, on July 31, 2014, Tina's CFS worker spoke with WPS missing persons unit about the report of nude photos online. WPS missing persons unit indicated that they had searched social media and did not find any posts containing nude photos of Tina. The CFS worker attempted to contact Tina's mother on her cell phone once again, however, her phone remained off. CFS also attempted to contact Tina's grandma but was unsuccessful as the phone had been disconnected. Again, no referral was made to the StreetReach program at this time.

StreetReach Program

StreetReach is a direct service program within the Child and Family Service Division. StreetReach uses mandated child welfare legislation in collaboration with non-governmental partners and law enforcement to provide a coordinated and rapid response to address the safety of high risk, missing and exploited/trafficked children and youth in Winnipeg.

StreetReach also works in collaboration with law enforcement services around the province, including the Royal Canadian Mounted Police and Brandon Police Service in an effort to strengthen partnerships to address missing and exploited youth, and to successfully identify offenders connected to these youth.

The priorities of StreetReach include:

- Actively investigate youths' disappearance to locate as quickly as possible and return to place of safety;
- Conduct comprehensive risk assessments;
- Work collaboratively within a multidisciplinary team (comprised of law enforcement, community partners, and CFS agencies) to develop tailored interventions to reduce at risk behavior; and
- Through investigative methods, identify offenders and hold them accountable, thereby reducing future risk to vulnerable youth.

(Email communication, February 28, 2019, Child and Family Services Division)

On August 1, 2014, a staff member from the youth shelter contacted Tina's CFS worker and informed that they would be discharging Tina as she was missing and that they would be contacting another youth shelter to see if that resource had space available for Tina. The shelter staff was informed that the other shelter was full, but was encouraged to try calling again later. Tina and her 18 year old boyfriend showed up at the youth shelter later that day. The shelter staff spoke with Tina who indicated she would be staying at her uncle's place. The shelter staff encouraged Tina to call later if she needed a bed as a spot might become available later on. The shelter staff contacted both the other shelter and Tina's CFS agency to advise them of the situation. Tina continued to have an open missing persons report with WPS. In reviewing WPS information provided to our office, there is no evidence to suggest that WPS were actively searching for Tina at this time. Following the missing persons report being filed on July 31, 2014, there is no documentation on the WPS file until August 7, 2014. Our office met with representatives from WPS during this investigation and discussed this period of time; and no further evidence was provided to us that indicated WPS were actively searching for Tina while she was missing from August 1 – August 7, 2014.

On August 1, 2014, Tina's CFS worker attended Tina's boyfriend's house looking for her. The boyfriend's father indicated that his son and Tina had been there at his house the previous day. The CFS worker explained to the boyfriend's father that Tina was currently missing and needed to contact her worker to check in. The father agreed to have Tina contact her worker if he were to see her. Following speaking to the father, the CFS worker contacted missing persons to provide an update. The CFS worker then attempted to contact Tina's mother; however, Tina's mother's phone had been disconnected and her address was unknown as she had been evicted from her previous residence. The worker contacted the boyfriend of Tina's mother who indicated he had spoken with Tina's mother a few days prior and would have Tina's mother contact the worker if he spoke with her again.

The two local youth shelters spoke with each other on August 1, 2014, regarding possible beds for Tina if she were to be located. Tina arrived at one of the youth shelters with her boyfriend on the evening of August 1, 2014, however, Tina was advised by shelter staff that no bed was available. Tina indicated that she was planning on staying at a relative's home that night.

On August 2, 2014, Tina contacted her CFS worker. Tina indicated she had been staying with her boyfriend for a few days and disclosed being at an unknown address on Furby Street. Tina indicated that she wanted to be placed somewhere "where she feels like its home." As no homes were available, Tina was informed that a bed had been secured for her at one of the youth shelters and Tina told her worker that she would ride her bike to the shelter. The worker explained to Tina how important is was for Tina to make sure she got to the shelter as previously, a bed had been

held and Tina had not shown up. There is no indication we found on file that the agency worked to confirm Tina's location so that Tina could be picked up and transported safely to placement. Given the situation and the known risks to Tina, this is concerning. Instead, Tina was left to make her own way to the shelter for the night. There is no evidence on either the CFS file or the shelter file that Tina arrived at the shelter that night. Tina's CFS worker was noted to be looking at the possibility of placing Tina with an aunt and uncle who were open to having Tina live with them. When the worker spoke with the uncle, the worker indicated that File information also referenced a possible placement in Selkirk, which the CFS worker intended to follow up on the next day. There was no further information on CFS files regarding this possible placement.

Information from the youth shelter indicated that on August 3, 2014, Tina contacted them by phone asking for the phone number to the other youth shelter as she needed a place to stay that night. The shelter staff member indicated that all beds were currently being held for other youth. The staff member encouraged Tina to come to the shelter and that they could assist her in contacting the CFS designated intake agency for Winnipeg, who would help. Tina told the shelter staff that she had stayed at her uncle's home the previous night. Tina did not contact CFS about needing a placement. It is inappropriate that any child in care facing the risks Tina was facing was having to manage arranging her own placements.

On the evening of August 5, 2014, Tina's CFS worker contacted the youth shelter to arrange placement for Tina. Tina's CFS worker indicated that Tina was not with her at the moment and that she would encourage Tina to go to the shelter if she could be found. The CFS designated intake agency after-hours program was called by the youth shelter on August 5, 2014, indicating that Tina was expected to arrive at the centre that evening but had not shown up. The CFS after-hours workers attended an address where Tina was suspected to be but were unable to get inside the building as it was locked and the buzzer system was not working. There is no evidence that the CFS agency (the designated intake agency for Winnipeg) contacted police to assist in getting inside the building to look for Tina. Instead, the CFS workers abandoned their search. Once again, no referral was made by CFS to the StreetReach program, which has significant access to information and specializes in locating missing and exploited children and youth, and other young high-risk victims. Tina did not show up at the youth shelter that night.

The following day, August 6, 2014, Tina's CFS worker attempted to contact Tina's uncle by phone to enquire about Tina's whereabouts, but was unable to reach him. The worker also contacted the WPS missing persons unit to update them with the known addresses Tina had attended, however, CFS file documentation did not list those addresses which were provided by CFS to WPS. WPS information reviewed for this investigation did not indicate what steps were being taken by police to locate Tina.

WPS information indicated that on August 7, 2014, WPS contacted the youth shelter regarding the missing persons report which had been filed eight days earlier, on July 31, 2014. WPS enquired if Tina had been located. The shelter staff member indicated they did not know if Tina had returned. WPS left a voice message for Tina's CFS worker requesting an update.

August 8, 2014: The Last Day Tina is Seen by Service Providers

In the early morning hours (2:20 a.m.) on August 8, 2014, Tina and a female friend arrived at the youth shelter. Tina used an alias of "Tessa Guimond" and indicated that she lived with her mom, "Robin," that she had not been home in a week, and had no involvement with child and family services. Tina was noted by shelter staff to present with a swollen lower lip and several scratches on her knee. She indicated that she had tripped over a skateboard and had landed on a table. Tina's friend spoke with a staff member in private and indicated:

that her friend's "...real name is Tina Fontaine...she told me she was going to tell you guys her name was Tessa Dumas but then changed it to Guimond...I saw her get out of a john's car and she smoked weed laced with cocaine."

The shelter staff spoke with Tina who denied using an alias and insisted her name was Tessa. The staff contacted the CFS designated intake agency after-hours unit and explained the situation. CFS informed the shelter they had no bulletins or notices regarding Tina, however, there is no indication to suggest that the CFS agency called WPS to enquire if the child was currently missing. CFS then spoke with Tina/Tessa over the phone, who continued to deny using an alias. Tina and her friend left the shelter at 3:30 a.m. Neither the youth shelter, nor the CFS after-hours agency were aware that Tina was subject of a missing persons report, which is explainable only as there was no evidence to suggest that Tina's CFS worker updated the Child and Family Services Application system to indicate that Tina was missing.¹³

Two hours later, at 5:15 a.m. on the morning of August 8, 2014, WPS pulled over a vehicle in central Winnipeg, as the individual had failed to use proper signals. WPS record checks revealed that the individual driving the vehicle had a suspended license. Upon WPS approaching the vehicle, officers smelled alcohol on the driver's breath and the driver became argumentative. Officers noticed a young female in the vehicle who gave an alias name of Tessa Twoheart and

¹³"The Child and Family Services Application and Intake Module data provide information concerning children in care and families receiving...services from CFS. Cases are entered into the province-wide file management system...Details include case category, case status, and data fields related to each category. Health, well-being, school, and maltreatment/injury indicators are also included." From:

http://umanitoba.ca/faculties/health_sciences/medicine/units/chs/departmental_units/mchp/resources/repository/descriptions.html?ds=CFS

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A Place Where it Feels Like Home: The Story of Tina Fontaine Manitoba Advocate for Children and Youth – March 2019

then later identified herself as Tina Fontaine. The driver's vehicle was impounded and Tina was let go despite being the subject of a missing persons report. When interviewed for this investigation, WPS acknowledged to our office that the WPS members involved in this incident disregarded their training, acted in a way that contravened proper procedures and as a result, were disciplined and are no longer officers. As a missing person and a child in care, WPS policy required officers to return Tina to her approved placement. WPS information did not indicate if the driver of the vehicle was charged. One of the officers would later testify in court that he did not ask Tina if she had been sexually exploited by the driver of the vehicle. The intoxicated driver of the car would himself later testify that indeed this was not the first time he had sexually exploited females and on that morning he was looking for "a girl to hang out with" as he had got into a fight with his girlfriend.

A few hours later that morning, on August 8, 2014, at approximately 10:00 a.m., six and a half hours after leaving the youth shelter, two individuals found Tina unconscious in a back alley near the University of Winnipeg, a known area for sexual exploitation. They reported this to University of Winnipeg security. Tina was unable to be woken up. University of Winnipeg security noted that Tina was not fully clothed from the waist down. 911 was called by University of Winnipeg security. Paramedics responded and were able to wake her. She was taken to the Health Sciences Centre by ambulance and told paramedics that she had been with a man and had been consuming alcohol, cannabis, and other drugs. She presented as confused and had blisters and burns on her lip. Tina admitted to using alcohol, cannabis, pills, and gabapentin. Tina tested positive for amphetamines, cannabinoids, and cocaine metabolite. A pregnancy test was negative. The doctor spoke with Tina about sexual activity (voluntary and involuntary) to which she denied any sexual activity. The doctor asked Tina about sexually transmitted infections (Tina's sexually transmitted infection results came back negative) and expressed concern that Tina had been sexually assaulted or "sexually exploited in some way." Tina denied being sexually assaulted and refused a gynaecological examination to look for trauma. Tina was medically cleared for discharge.

While in hospital, a CFS worker from Agency 3 stayed with Tina until she was discharged. Tina spoke of wanting to get a bike as she had lost hers and indicated that a friend of hers, Sebastian (a.k.a. Frenchy, Raymond Cormier) was going to find one for her. The worker further enquired about Sebastian. Tina shared that he was a 62 year old methamphetamine user and that she liked to "just chill" with him. Although Tina tested positive for amphetamines, she denied using methamphetamine with him.

¹⁴Following Tina's death, when the information came to light that two officer's had let Tina go despite her being the subject of a missing persons report WPS launched an internal investigation. Both officers were disciplined and are no longer working in the police force.

On August 8, 2014, Tina's CFS agency contacted WPS to advise that in regard to the open missing persons report from July 31, 2014, Tina had been located and was currently at the hospital. The missing persons report was cancelled. WPS information did not indicate further involvement surrounding this incident. Follow up to the WPS child abuse unit could have been initiated by the hospital, the CFS agency, or internally by the missing persons unit of the WPS, as there was sufficient evidence known by each of these groups to warrant a request for involvement by the child abuse unit of Winnipeg Police.

Later on that same day, Tina's CFS agency requested after-hours approval for a hotel placement from the designated intake agency for Winnipeg as Tina was being discharged from hospital and required an emergency placement. Approval to place Tina in a hotel was granted. Tina was discharged from hospital and brought to the hotel by her CFS worker around 5:00 p.m. Tina told her worker that she wanted to meet up with friends. The CFS worker told Tina that this was not a good idea as Tina had admitted to not sleeping for days and needed to rest. Tina indicated that she would return by midnight. The CFS agency worker responded by telling Tina that she "shouldn't be going out but if she did she should be back by 11" (Case note, August 8, 2014, Child in care file, Agency 3). The CFS agency worker left the hotel. A general home care worker contracted by CFS was left to supervise Tina.

Tina left the hotel shortly afterwards.

Events Prior to the Death of Tina Fontaine

On August 9, 2014, Tina continued to remain absent from placement and a missing person's report was filed. WPS issued a city wide "BOLO" ("be on look out") to all officers to look out for Tina.

Tina's CFS agency file documentation did not indicate what steps, if any, were being taken by the agency over the weekend of August 9-10, 2014, to locate Tina; nor did the file indicate what steps, if any, the agency took to locate Tina on August 11, 2014. Other than issuing a BOLO on August 9, 2014, WPS file information did not indicate what steps, if any, were being taken by police to locate Tina over that same weekend, between August 9 - 11, 2014.

WPS received text messages on August 11, 2014, from an individual refusing to provide their name. The individual reported they had seen Tina on Ellice Avenue around 4 a.m. on Saturday, August 9, 2014. The individual indicated that they had observed Tina walking down the street with a male. The unidentified individual sending texts could not provide further information about seeing Tina, as it had been dark. Despite having a phone number attached to the text messages, WPS information did not indicate WPS response to this information. WPS contacted a family member of Tina's on Monday, August 11, 2014, to enquire if they had seen Tina. The family

member indicated that they had not seen her. WPS was also in contact with Tina's CFS worker and the paramedics who had responded to Tina on Friday, August 8, 2014.

On August 11, 2014, WPS contacted the manager of StreetReach advising that Tina would be a good candidate for future consideration for their limited high risk victim list. This list prioritizes youth at imminent risk of harm for the targeted deployment of CFS-police resources and to conduct intensive searches (including address searches) for the youth when they are missing and connect them to resources. StreetReach contacted Tina's CFS worker requesting a referral to their team for Tina as well as further information from the agency about Tina. It would be another four days before the agency would complete the referral for Tina to StreetReach. Still, between August 11 and August 14, StreetReach moved ahead and compiled information from CFS files. StreetReach specifically worked to identify known indicators for sexual exploitation to assist in determining Tina's specific areas of risk, and in addition, StreetReach gathered information to assist in locating Tina.

Tina's CFS worker contacted various members of Tina's family inquiring about her whereabouts on August 12, 2014. No one was able to provide any information as to Tina's location. WPS issued a city wide BOLO to all officers to look out for Tina. A media release was sent out to the public on August 13, 2014. WPS continued to issue city wide BOLOs and was in contact with the MissingKids.ca program, through the Canadian Centre for Child Protection. A family member who participated in this investigation told our office that they had been disturbed in the photos of Tina from this time. One photo in particular, the one used in the media release, in which Tina's hair is cut short struck the family member as shocking as Tina had always been so proud of her long hair and had prided herself in its care. The family member told our team that this image was significant to them as it represented for them how drastically Tina's life had changed since she had been in Winnipeg (Family member, Interview, February 27, 2019).

Following the media release, WPS received information from an anonymous caller on August 14, 2014, that Tina had been seen entering a house in central Winnipeg and that the individual believed Tina was "working the streets." WPS file information did not indicate whether this information was followed up on. WPS were noted to have spoken with family, Tina's boyfriend's family, and Tina's mother's boyfriend about her whereabouts. No one was able to provide information as to Tina's location. WPS continued to issue city wide BOLOs.

Tina's CFS worker met with Tina's mother on August 14, 2014, at the agency office. Tina's mother was unaware of Tina's whereabouts and indicated that she had last spoken to Tina approximately two weeks prior. The CFS worker enquired if Tina's mother knew of addresses where Tina might have been. Tina's mother provided an address of someone they knew. The worker relayed this

information to the WPS missing persons unit for follow up. WPS followed up with this information, attending the address the following day. The CFS worker began preparing a warrant for Tina to be placed at a short-term detox resource should she be located.

On August 14, 2014, the StreetReach manager emailed WPS missing persons unit to advise that Tina had informally been added to their consideration list and that the StreetReach team would be searching for Tina. In their email, the StreetReach manager wrote:

...looking into this case and it looks like it is a jurisdictional nightmare with a bunch of different agencies playing hot potato, it's your case not ours...bottom line is there have been numerous concerns documented in our [CFS] system that this child is being exploited...We will be actively looking for her as she is a very high risk child from what I can see from my quick look this afternoon. Outreach will start looking for her tomorrow so if there is any information you have that I haven't got can you please let us know and we will get on it" (Email communication, August 14, 2014, Winnipeg Police Services).

Further information received via text message by WPS on August 15, 2014, indicated that an anonymous individual had seen Tina on Saturday, August 9, 2014, with a "john." The text message described the individual as a male, short hair, in their 20s, wearing blue jeans and a vest. The anonymous individual further indicated that they had seen Tina at the youth shelter the previous Friday, August 8, 2014, and that Tina had "tried to bullshit them with a fake name and everything." Police noted that attempts to track down information regarding the subscriber information for the text messages were unsuccessful.

On August 15, 2014, WPS went to the additional address that had been provided by Tina's mother. The resident indicated that they had not seen Tina recently, and when WPS searched the house, they did not find anything. WPS spoke with the youth shelter staff who indicated that Tina had been at the shelter for about an hour on the evening of August 8, 2014, using the alias of "Tessa Guimond." WPS information indicated that shelter staff had informed them that other youth staying at their shelter had seen Tina getting in and out of "john's" vehicles. On the same day, WPS spoke with the supervisor at Tina's CFS agency, and spoke with Tina's uncle who indicated he had not heard from Tina. WPS spoke with the University of Winnipeg security staff member in regards to the August 8, 2014, incident and forwarded the media release to the staff member to circulate to university staff. WPS continued to issue city wide BOLOs to its officers.

On August 15, 2014, WPS spoke with staff at the youth shelter, and to Tina's aunt. No one was able to provide information on Tina's location.

Four days after StreetReach had asked Tina's CFS agency to refer her to their program so Tina could be prioritized for their specialized services, the CFS agency completed the referral to StreetReach. It was August 15, 2014, and the CFS agency referral noted that they suspected that Tina was being sexually exploited as she was known to associate with older men "who feed her addiction" and would often have new clothing and not be able to explain how she had money for new clothes or where they clothes were coming from. The referral form noted that Tina had been seen getting in a vehicle with an individual known to target and sexually exploit young girls. Local media, as well as Winnipeg Police Service, were also assisting in locating Tina. StreetReach began to conduct searches for Tina. The StreetReach manager contacted local resources requesting information on Tina's mother to assist them in locating Tina. The StreetReach team attended an address in central Winnipeg and spoke with Tina's uncle who had not seen or heard from Tina.

Tina's CFS worker contacted Tina's mother on August 15, 2014. Tina's mother indicated that she still had not heard from Tina. The worker asked for a specific sibling's address. Tina's mother was reluctant to provide the address as she felt "her [sibling] wouldn't like it" (Case note, August 15, 2014, Child in care file, Agency 3). The worker explained to Tina's mother that they were extremely concerned for Tina's safety and that every known address needed to be checked. Tina's worker further emphasized that if family members were to speak to Tina or have any contact with her that WPS needed to be informed immediately. CFS case notes indicated that the worker searched the north end neighbourhoods of Winnipeg looking for Tina and was in regular contact with the WPS missing persons unit who was searching all possible known whereabouts provided by the agency. Case notes further indicated that the CFS worker contacted everyone who had been identified as possibly knowing where Tina was. Tina continued to be missing and her whereabouts unknown. There was no information on file to indicate whether the agency's search efforts continued into the weekend or whether an after-hours request was made to look for Tina.

On August 16, 2014, WPS attended the additional address provided by Tina's mother in Winnipeg in an attempt to locate Tina. They searched the residence but did not find Tina. WPS continued to issue city wide BOLOs.

On August 17, 2014, following a tip from a passerby, police recovered Tina's body from the Red River near the Alexander Docks. She had been wrapped in a blanket with multiple rocks enclosed.

Events After the Death of Tina Fontaine

An autopsy was conducted by a pathologist from the Chief Medical Examiner's office on August 18, 2014, and in the presence of members of the Winnipeg Police Services, who seized several pieces of evidence immediately following the autopsy. The autopsy noted that Tina was 160 cm (5'3") and 33 kg (72.7 lbs) at

the time of the examination. The pathologist documented that there was no evidence of physical trauma to Tina's body, although there was moderate decomposition; positive identification occurred through Tina's dental records. Due to the condition of Tina's body, the autopsy was unable to conclusively determine an anatomical cause of death. Toxicology reporting showed the presence of ethyl alcohol, however, the toxicologist indicated they were unable to determine whether the levels of ethyl alcohol were due to ingestion prior to death, or if the levels had been affected naturally due to the location and condition of Tina's body, as ethyl alcohol can be produced in the body after death through decomposition. Toxicology

also reported the presence of cannabis and cannabis metabolite; however, again, further conclusions were not possible as drug levels can vary based on a number of factors, including the length of time between death and toxicological analysis. While the pathologist who conducted the autopsy concluded that the way in which Tina's body was found was certainly "highly suspicious," due to the condition of the body, they were unable to determine a cause of death. As such, Tina's manner of death was, and remains, listed as "Undetermined" by the Office of the Chief Medical Examiner (Office of the Chief Medical Examiner, 2014).

Tina's death sparked action and outrage both locally and globally. Following Tina's death, the province's use

<u>What is an "undetermined" death?</u>

The Office of the Chief Medical Examiner determines the manner of death of each child according to an established protocol. All deaths are assigned one of five manners: Natural, Accidental, Suicide, Homicide, or Undetermined.

When the Chief Medical Examiner's investigation is unable to determine how the death occurred, the manner of death is categorized as undetermined, even if the physical cause is known. This category also includes sudden unexplained infant death and sudden infant death syndrome.

of hotels as placements for children in care received intense scrutiny. In November 2014, the then-Minister of Family Services announced that the province would be overhauling the CFS emergency-placement program in an effort to reduce the numbers of children placed by CFS in hotels. However, at the beginning of April 2015, a different 15 year old girl was severely assaulted in downtown Winnipeg. She had been placed in the same hotel as Tina and while absent from her placement, she was attacked by another youth who was also placed at a downtown hotel. Following this incident, the provincial CFS system vowed to end hotel placements altogether, stating that as of June 1, 2015, hotels would no longer be used. A new provincial minimum CFS standard was added to the service manual that CFS workers are required to follow. Provincial Child and Family Services Standard 1.4.3 *Use of Hotels*, effective June 1, 2015, specifies:

1. Hotel Use

Hotels (including motels) **will not** be used as placements for children by agencies of the child and family services system. This applies even with respect to emergency and/or temporary placements for children. No agency or authority may designate a hotel (including motels) as a place of safety [emphasis in the original].

2. Children Travelling with Care Providers

The use of hotels does not apply to children in care who are travelling with an agency care provider such as a foster parent, place-of-safety parent, agency staff or hired escort for a specific purpose such as a family visit, medical appointment, pre-placement visit or vacation.

All child care workers hired or contracted to provide child care for children in care who are traveling undergo criminal record, child abuse and adult abuse registry checks. At least two positive character references are also obtained.

A surge in local grassroots leadership emerged following Tina's death. This included the start of Drag the Red, a group of volunteers who search the local river bottom with ropes and hooks for bodies or any

evidence that may help solve missing persons or homicide cases. Tina's death also brought about the resurgence of the Bear Clan Patrol, a group of dedicated community members who regularly patrol Winnipeg's North End neighbourhoods and promote safety, conflict resolution, and crime prevention, and whose resurgence has prompted similar groups to be started in many neighbourhoods within Manitoba and outside our province.

Strong Hearted Buffalo Women Crisis Stabilization Unit, known as Stronghearts CSU, was launched in the fall of 2015 in direct response to Tina's death.

Stronghearts CSU is a semi-secure, Level V

#TinaFontaine #LoveForTina

Daughter to Us All, image by Christi Belcourt, used with permission from the artist

short-term crisis intervention program for females of all nations aged 12-17 years old who are assessed by StreetReach as at risk of sexual exploitation. The six-bed unit program is Indigenous-led and offers a safe, nurturing, non-punitive environment for sexually exploited youth who are in crisis.

In December 2015, Raymond Cormier was arrested and charged with second-degree murder in the death of Tina Fontaine. Originally from New Brunswick, Mr. Cormier had lived in Winnipeg for several years but was apprehended by police in the Vancouver area. WPS reported that Tina and Mr. Cormier knew each other, and were connected by a specific address location in Winnipeg (CBC, 2015). CFS files confirmed that Tina knew Mr. Cormier, whom she called "Sebastian."

Following Tina's death, numerous rallies, marches, and vigils were held across Canada in Tina's name, and long-echoing calls for a national inquiry into missing and murdered Indigenous women and girls grew louder. In September 2016, the federal government launched the *National Inquiry into Missing and Murdered Indigenous Women and Girls* under the federal *Inquiries Act*.

Mr. Cormier's trial for second-degree murder began at the end of January 2018. Following the conclusion of the trial, our office reviewed audio transcripts of the trial proceedings. Evidence against Mr. Cormier was largely circumstantial and informed by witness testimonies. Witnesses reported that Tina and her then-boyfriend met Mr. Cormier in the summer of 2014. A piece of evidence submitted by the Crown was the duvet cover found wrapped around Tina's body when it was pulled from the Red River. Witnesses suggested it was the same duvet Mr. Cormier had bought at Costco, although this could not be conclusively verified during the criminal investigation.

The trial was affected by the fact that forensic analysis of Tina's body was nearly impossible, due to the effects of water and decomposition. Foreign fibres from the duvet wrapped around Tina's body and fibre and cigarette butts from Mr. Cormier's residence were analysed by the RCMP but no DNA evidence was found linking Mr. Cormier to Tina. In addition, and as noted above, medical examiners were unable to determine the exact cause of Tina's death (Office of the Chief Medical Examiner, 2014; Malone, 2018; MacLean, 2018). At the end of February 2018, Mr. Cormier was acquitted of the second-degree murder of Tina Fontaine. The conclusion of that criminal process then allowed our office to broaden the scope of our work and to complete our investigation.

In March 2018, the federal government announced that Ndinawemaaganag Endaawaad Inc ("Ndinawe") in Winnipeg would receive \$350,000 to add a 24/7 safe space to their building on Selkirk Avenue where youth can seek shelter, resources, and support at any time day or night. *Tina's Safe Haven* was opened on November 5, 2018, and named in Tina's memory.

In March 2018, the *National Inquiry into Missing and Murdered Indigenous Women and Girls* requested a 2 year extension to complete hearings and write their report. The federal government granted a shorter extension with its final report due back to the federal government by the end of April 2019.



Mural and butterflies created by Tina's cousins and friends for the four-year memorial feast in her honour held in August 2018. Image used with permission from Tina's family.

Findings, Analysis, and Recommendations

A Call to Action for Early Intervention and Prevention

Throughout her life, Tina Fontaine needed an array of services from child and family, education, victim support, law enforcement, health, and mental health systems. At times, particularly in the final months of her life, some of these services were unavailable, not easily accessible, or ill-coordinated, failing to provide the supports and interventions she desperately needed.

While tragic deaths like Tina's enrage us and can leave us feeling hopeless as we look for who is to blame, as members of society, it is imperative that instead respond assertively to this call to action. Tina's story was her own, and yet, her experiences mirror those of many other young people in our communities. As advocates for children and youth, we hear from and work with young people every day who are facing the same battles, the same inabilities to access appropriate support services or placements that can meet their individual needs. Their families struggle to find resources, and desperately needed publicly-funded services are too-frequently unavailable, unresponsive, or ineffective. What happened to Tina is what is happening — and will continue to happen — to other youth if we keep only looking for short-term crisis responses to structural deficiencies and intergenerational traumas.

We know that in publicly sharing details of Tina's life and some of the details of those who were around her, we risk allowing readers and onlookers to wilfully ignore the deeper systemic issues and this could lead to casting blame on individuals. In fact, we <u>all</u> share responsibility that there are peoples in our province and our country who continue to be ignored and disadvantaged by the structural barriers that have been established and reinforced because we do not unanimously demand their improvement.

When Tina was born, she was part of a family that carried the legacies of residential schools and other structural inequities they were forced to endure through generations. Tina's paternal grandfather was a survivor of residential schools, as were others in their community, and these experiences left lasting impacts. According to the family, her grandfather coped with his trauma as best as he could, and in the absence of healthier supports, alcohol and violence marred his relationships. In turn, Tina's father experienced his parent's trauma that had not been resolved and eventually, Tina's father went to live with his auntie, the woman who would also eventually raise Tina. Tina's birth happened at a time when her parents were struggling with some of the very issues she herself would eventually face: loss, grief, addiction, exploitation, and violence.

If readers emerge from this story blaming individual people or specific organizations, they have missed the broader view of Tina's story and what her legacy must become for those many additional young people and their families who continue to face the same barriers four years after Tina's death.

The story we share with you today is tethered tightly to the formal findings and recommendations made by the Manitoba Advocate, which, when implemented, carry the possibility of altering the trajectories of many young people and greatly improving not only the individual stories of children still alive today, but these recommendations can help shift our province's focus towards a vision of a safe and healthy society that hears, includes, values, and protects all children, youth, and young adults.

The evidence gathered by our office demonstrates a number of gaps across these public systems, and that they remain reactive rather than proactive. There were a number of missed opportunities for service providers and public systems in Tina's life. For example, trauma-informed counselling services, which Tina was entitled to after the death of her father were never provided. Further, service providers did not appropriately assess and interpret the indicators of the high risk nature of the appalling sexual exploitation to which Tina was being subjected, nor did they understand that Tina's status as a missing person and as a sexually exploited youth left her at very high risk of harm and death. In the month prior to Tina's life what she needed most was immediate access to appropriate placements and resources that would have met her individual needs.

Even more concerning, as the previous section of this special report establishes, at different times these systems interacted and some documented Tina's deepening crisis after her father's death, but never intervened to truly mitigate potential harm or take action in a way that made a difference for her. With the benefit of hindsight, Tina would have benefited, for example, from the school working closely with the family to mobilize resources from the local community by way of a multi-system meeting in late 2013 or early 2014 to provide her with cross-departmental, child-centred supports, and coordinated interventions (for example, a model like Healthy Child Manitoba's High Fidelity Wraparound Program) when Tina was clearly in crisis.

Service providers did not focus on the sources of her emotional pain while they were seeing her increasingly absent from school, frequently missing from home, not receiving needed counselling services, being sexually exploited by adults, and living with a growing addiction. Public services involved in her life did not engage Tina 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 Tina was known to and interacting with several public service systems and yet these professionals and organizations were unable to intervene or have access to culturally-informed, effective, and secure resources that would have helped Tina.

Children and youth, like Tina Fontaine, 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 rights about protection, provision, and participation. As advocates for children and youth, our office views the UNCRC as a cornerstone to all of the work that we do alongside and on behalf of all young people that we have the responsibility and 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.

The objectives of this special report are to tell Tina's story, describe which public services were involved, what specific services were delivered to the family, and whether those public services were responding appropriately to the family's needs. As described in provincial law under *The Advocate for Children and Youth Act*, the Manitoba Advocate is empowered to undertake these investigations and to publish special reports to help public systems improve their effectiveness for Manitoba families. Through a commitment to ongoing quality improvement, provincial public services can improve their effectiveness and responsiveness and aim to prevent tragedies like this one from being repeated in the future.



Memorial rose for Tina welded by two Winnipeg youth. Image included by permission from its creators.

Education

Children in Manitoba have the right to education, and the province has a corresponding responsibility to ensure that children indeed attend school. According to Section 1.1 of *The Public Schools Act* (The PSA), school attendance is compulsory for children between the ages of seven and 18 years old in Manitoba. Internationally, Article 28 of the *United Nations Convention on the Rights of the Child* (UNCRC) recognized all state signatories, including Canada, must, "take measures to encourage regular attendance at schools and the reduction of drop-out rates."

Absenteeism and Suspension

FINDING: After her father's death by homicide, Tina's absenteeism increased significantly. However, there were no documented responses by the school to address her chronic absenteeism or a coordinated plan to address her escalating behaviours. Following a suspension in April 2014, Tina did not return to school.

School absenteeism is the legitimate or illegitimate absence of a student from school or class. Chronic absenteeism, defined as missing 10% of a single school year, is a serious public health issue (Dube & Orpinas, 2009; Balfanz & Byrnes, 2013). Severe chronic absenteeism is a designation used when absenteeism exceeds 20% (Balfanz & Byrnes, 2013). Absenteeism is an early warning sign that a student might be struggling. The reasons for chronic absenteeism are varied but can include: poor health, poor mental health, family and work responsibilities, transportation, bullying, homelessness, and undiagnosed cognitive vulnerabilities (Rafa, 2017). It might also indicate struggles in the family and community, including separation and divorce, mental health and substance misuse problems, or in the case of Tina, the death of a parent and the subsequent loss of both parental relationships.

Students need to attend school to be healthy and succeed. Having a sense of belonging in school and being engaged in school activities is a protective factor for children and youth; however absences and suspensions have detrimental effects (O'Connell, Boat, & Warner, 2009). In the short-term, lack of attendance leads to challenges in learning and achievement (Carroll, 2010; Christle, Jolivette, & Nelson, 2007, in Maynard et al., 2018). Over time, school absenteeism and suspensions may increase the risk of dropout by 37% and 68%, respectively (Cabus and De Witte, 2014; Suh, Suh & Houston, 2007). Absenteeism and suspensions are also associated with an increased risk of violence, injury, substance misuse, psychiatric disorders, and economic deprivation (Dube & Orpinas, 2009).

Attendance and Suspension

On average, Tina's attendance record from Grade 1 (2004-2005) and until Grade 4 (2010-2011) was borderline at 91% (Table 1). While she struggled with language arts, Tina excelled at math and was repeatedly described as "quiet" and "polite." Her final Grade 1 report card stated:

It has been an absolute delight to have her in the classroom this year as she has an enthusiasm for learning that is wonderful to see!...I am going to miss her beautiful, beaming smile every day! Have a fantastic summer Tina, I am so glad I had the opportunity to be your teacher!

Analysis of Tina's school file revealed that school attendance decreased significantly beginning in the 2011-2012 school year, and directly following the death by homicide of her father (Table 1). In December 2011, she transferred to a different school. Overall, during the 2011-2012 academic year, she was *severely absent*, missing 26% of school days.

Tina continued to be chronically absent the following school year (2012-2013), missing 17% of school days, or more than one out of every six days of school. Her attendance was noted in her final term report card in 2012-2013: "Tina needs to be in class everyday and on time to stay on top of her responsibilities as a student."

Chronic **Absenteeism** Severe **Absenteeism** 2004-2005-2006-2007-2008-2009-2010-2011-2012-2013-2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 95 92 89 91 74 Percentage

Table 1 – Tina Fontaine's Attendance Rates, by Percentage of Total School Days (2004-2014)

The following year (2013-2014), Tina was no longer attending school on a regular basis, meeting the definition of *severely absent*. During the first and second term of Grade 8, she missed 57 days of school. The report card noted:

When Tina completes her assignments it is apparent she has a good understanding of concepts taught this term. In second term, Tina is encouraged to attend class more regularly and complete missed work when she is away.

Tina was suspended on April 16, 2014, for being under the influence of cannabis while at school. The school record includes a "Letter of Level 3- suspension" and described that this was her second offence. A social work assessment dated June 2014, also suggests that there were previous suspensions, stating:

Tina continued to have a difficult year this year, and was suspended or sent home several times. Tina was briefly taking courses with [name] at the alternative high school program, however it was decided by [her grandma and grandpa] to keep Tina home for the remainder of the school year to work on her emotional well-being, and to return in the fall.

The cumulative record contained no documentation about any other suspensions or details on the alternative high school program referenced in the file. Further, the suspension letter stated, "Tina will need to attend a meeting with the [school division] Suspension Review Team prior to returning to school." There was no documentation in the cumulative record of such a meeting subsequently occurring. In fact, there was no record of Tina returning to school following the suspension on April 16, 2014. During an interview with our office, the principal was unable to recall the length of suspension and suggested that Tina may have stopped attending school at this time (Principal, Interview, September 20, 2018).

The pattern observed beginning with chronic absenteeism, followed by an escalation in harmful behaviours and suspensions is indicative of student disengagement and isolation, and predictive of school dropout. In October 2018, the Manitoba Advocate for Children and Youth (MACY) published *Documenting the Decline*, a report on the death of a young Indigenous boy named Circling Star (Manitoba Advocate, 2018a). Much like Tina, Circling Star was suspended from school, an event that contributed to his disengagement from school and consequent exacerbation of harmful behaviours. In that 2018 report, the Manitoba Advocate made a recommendation to address the use of suspensions given evidence of their harm. In light of findings of this report, the Manitoba Advocate continues to see the importance of her recent recommendation that Manitoba Education and Training review the use of suspensions and expulsions, and develop a province-wide strategy that better supports student success.

Measuring Absenteeism

School absenteeism is a key early warning sign that a student requires additional support, and signals a serious risk of academic dropout. As Table 1 shows, descriptive analysis of absenteeism records reflected struggles in the lives of Tina and her family. Unfortunately, this trend was not immediately obvious from reviewing the school records because attendance was measured differently between schools, there were

mistakes and omissions in the manual summary calculation of absenteeism, and there was no analysis of a trend in absenteeism. The lack of a common measurement standard of absenteeism and the lack of systematic data collection and analysis of attendance records resulted in a missed opportunity to recognize the early warning signs that Tina needed extra help to remain engaged in her school environment.

Lack of Documentation

There was no documented response to Tina's chronic and severe absenteeism in her cumulative record, despite legislated requirements outlined in The PSA. According to The PSA, parents or legal guardians have the right to be informed regularly of their child's attendance (Section 58.6 (a)). In turn, principals must report the absence to the child's parent or legal guardian; and inform them of their obligation to ensure that the child attends school (Section 266(2)). If the child continues to be absent, principals must report the absence to school attendance officers (Section 266(4)).

In one interview with our office, Tina's grandma reported being unaware of the extent of Tina's absenteeism (Interview, Tina's grandma, March 6, 2019). However, over the course of our investigation, the school reported to us that they viewed communication to have been regular and ongoing with Tina's grandma. There was no documentation in the school records, however, confirming that the school informed grandma of Tina's growing absenteeism. Further, there was no evidence in the school records that an attendance officer was contacted.

A request for social worker services was filed by the school more than a year after Tina's father died, on January 29, 2013. The request cited concerns including issues with peer relationships and the death of her father. The assessment was completed six months after the request, in June 2013. The assessment stated that the social worker became involved in January 2013 and that "Tina meets with the behaviour resource and school counsellor." The goals of the assessment were to "continue to try to connect with Tina regularly, continue to check in a provide support to Tina's [grandma and grandpa], continue to advocate for therapy through victims services." However, there was no documentation of any sustained involvement of the social worker, behaviour resource, or school counsellor in the school file or if any supports were provided to the family.

The next social work assessment on file was conducted a year later in June 2014. This assessment documented the escalation of her harmful behaviour including: two instances of running away, "high-risk behaviours online," and being suspended "several times" during the school year. Although her both her challenges and her absenteeism had escalated, the school set the same goals as they had 12 months earlier, to "continue to try to connect with Tina regularly, continue to check in a [sic] provide support to

Tina's [grandma] and [grandpa], continue to advocate for therapy through victim services." This was the last recorded entry in Tina's school records.

Lack of Coordination

During the course of this investigation, the school social worker reported suggesting to Tina's grandma that she contact child and family services for assistance (School social worker, Interview, September 20, 2018). Despite being aware of the risk of harm that Tina was experiencing, and the desperation of Tina's grandma, there was no evidence in the school records or the child welfare records that the school independently contacted CFS with any concerns, nor did it appear the school worked to mobilize other community resources which may have assisted.

Tina's absenteeism and escalating harmful behaviours, including misusing substances at school and peer conflicts were preventing her from meeting learning outcomes. Our office found no evidence in the school records that a coordinated strategy to address those struggles, such as a positive behaviour plan or an Individual Education Plan (IEP), was considered. IEPs are written documents developed and implemented by a collaborative team outlining a plan to address the unique needs of students that struggle to meet learning outcomes. IEPs can involve the student, student's parent or guardian, the classroom teacher, and additional supports such as school counsellors and social workers. Tina's behaviours documented in her school records indicate that she was entitled to receive coordinated support services; however, these supports were not provided. The collaborative approach and mobilization of resources required by an IEP could have supported Tina and improved coordination among her support network. In the case of Tina, the educational system had an opportunity to identify her struggles early and coordinate resources to ensure her well-being and potential. While there was clear evidence that Tina encountered wonderful educators in her life, overall, the educational system missed opportunities to provide supports and engage in meaningful ways that may have kept her in school.

In October 2018, the Manitoba Advocate released her first special report after a child death investigation. *Documenting the Decline: The Dangerous Space Between Good Intentions and Meaningful Interventions* included significant data and other research regarding the effects of exclusionary practices in schools. In that report, the Manitoba Advocate made a formal recommendation that the Department of Education and Training conduct an urgent review of the use of out-of-school suspensions and expulsions in light of the growing evidence of their detrimental effects on youth.

On January 23, 2019, the Manitoba government announced it was establishing a commission to conduct a review of kindergarten to Grade 12 education in the province. In addition to a sitting MLA, the commission consists of eight individuals, "who will lead public consultation and stakeholder engagement" (Manitoba News Releases, 2019, para. 4). One of the co-chairs for the commission noted that the "focus will be on student outcomes, long-term sustainability and enhanced public confidence" (ibid., para. 7). The education commission is expected to provide the Minister of Education and Training with a report, including key findings and recommendations by February 2020. Given the long-established and growing evidence concerning the detrimental impact of absenteeism and suspensions, these are essential issues for the *Manitoba Commission on Kindergarten to Grade 12 Education* to examine and report on publicly.

RECOMMENDATION ONE: The Manitoba Advocate for Children and Youth recommends that Manitoba Education and Training ensure its recently established Commission on Kindergarten to Grade 12 Education review the measurement of and response to absenteeism across Manitoba. It is further recommended that the Commission review the use of out-of-school suspensions and expulsions, with the goal of developing 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 practices that are in line with the best interests of the child and respect the right to education for children and youth.

Details:

- The Commission to identify how school divisions can be resourced with the
 capacity to measure, assess, and respond to the underlying causes of school
 absenteeism. Building and sustaining relationships with students who are
 experiencing absenteeism and their families.
- Manitoba Education and Training continue efforts to improve student attendance by increasing public awareness of the right to education, identifying improvements to communication with parents and guardians around absenteeism, and to provide transparent information to the public about suspensions and expulsions.

¹⁵For more, see: https://news.gov.mb.ca/news/index.html?item=44959&posted=2019-01-23

Mental Health

Childhood Bereavement

FINDING: The death of Tina's father was a profoundly traumatic event that occurred at an especially vulnerable stage in her development, Tina's transition from childhood to adolescence. Timely, easily-accessible, and culturally-safe bereavement services and grief counselling ought to have been made available to Tina and her family.

Despite any other challenges and the ways in which he was able to maintain consistency in her life, Tina's father's death had a deep impact on Tina. While Tina's father was unable to provide a stable environment where he himself could be a consistent and reliable parent for Tina and her sibling, Tina's father made positive choices insofar as he arranged for Tina's grandma to care for the children from the time they were young. In this way, he acted protectively towards the children and was able to remain involved in their lives as they grew.

Many experts suggest that the death of a parent during childhood is a unique and overwhelming event that may have potentially traumatic consequences over time (Cerniglia, Cimino, Ballarotto & Monniello, 2014). Of note, research shows that the trajectory of children's grief is not linear; as was the experience of Tina following the death of her father. For example, the Child Bereavement Study (Worden cited in Cerniglia, Cimino, Ballarotto & Monniello, 2014) indicates that 15-20% of parentally bereaved children present with significant emotional and behavioral difficulties two years following the death of their parent, even after showing an initial adjustment to the loss. Moreover, negative outcomes are significantly influenced by the developmental stage of a child or youth at the time of the loss.

As was the case for Tina, the transition from childhood to adolescence is an especially vulnerable stage in development to lose a parent (Stroebe cited in Cerniglia, Cimino, Ballarotto & Monniello, 2014). Serious bereavement complications common in adolescents who have lost a parent include anxiety, social withdrawal, social skills deficits, and lower self-esteem (Biank & Werner-Lin, 2011). For example, one study showed that 9.8% of bereaved children met the criteria for major depression compared to 1.3% in a matched control group (Gersten, Beals and Kallgren cited in Wolchik, Tein, Sandler & Ayers, 2006).

In an essay about how to help children deal with the loss of a parent, Wolfelt (2016) notes:

With the exception of infancy, no developmental period is so filled with change as adolescence. Leaving the security of childhood, the adolescent begins the process of separation from parents. The death of a parent or sibling, then, can be a particularly devastating experience during this already difficult period (para. 5).

Loss of a parent is tragic, and this impact for children is understandably amplified when the death occurs suddenly or in traumatic circumstances, such as with Tina's father's death by homicide. As one resource notes, "While grief is a normal reaction to loss, feelings of anxiety or sadness may be intense and long-lasting...Sometimes...children keep grief inside until they can't manage it by themselves anymore" (Children and grief, n.d., para. 4).

In 2016, our office published a special report, *Don't Call Me Resilient: What Loss and Grief Look Like for Children and Youth in Care*. The report reflects the voices of young people who described their experiences of loss and grief and further, the report reflects best practices of how to support and assist children who are grieving. As noted in that report, grief for young people can be complex and difficult to unpack. Its affects are compounded with each additional loss or traumatic event, and:

Expressions of grief are often missed or misunderstood. Sadness, anger, guilt, relief, powerlessness, loneliness, abandonment and fear may look like crying, nightmares, anxiety, appetite changes, bedwetting, tantrums, overcompensation, acting out, difficulty learning, lack of attachment, headaches, fatigue, and risk taking behaviours (Office of the Children's Advocate, 2016, p. 10).

Our objective throughout the above report was to challenge commonly held beliefs that children are naturally resilient. In fact, resilience is a skill that is learned through managing difficult or challenging events, and this emotional and practical navigation can be more difficult for children and youth who may not yet have the skills to move through the impact of their grief. As further noted in the above referenced report:

Adults often make the assumption that children are resilient because they are young and assume they should be able to adapt to new situations quickly. However, research on trauma and resilience shows that coping with trauma can be especially difficult for children (Office of the Children's Advocate, 2016, p. 5).

From an early age, Tina's relationship with her father – with each of her parents – was impacted by the family's experiences of addiction, abuse, violence, unstable housing and other structural challenges. That she witnessed her father live for many years with cancer would have been difficult, especially as she also saw him live with the many other challenges previously described in this report. It is understandable that his sudden and violent death could have profoundly impacted Tina and shaken her understanding of the world and her place within it. The emotional struggles that Tina experienced as a result of the sudden and tragic death of her father are consistent with these literature findings, and would have been expected by her service providers, educators, family members, and social supports.

Access to Children's Mental Health Supports

FINDING: Mental health counselling supports were recommended several times for Tina, but were never provided.

As will be described in the next chapter on Victim Services, that branch of the provincial Justice department became involved in Tina's family immediately after the death of Tina's father. Over the months and years that followed, there were a growing number of recommendations and a common acknowledgement that Tina needed mental health supports. The first documented discussion noted in this review occurred on November 23, 2011, when Tina was 12 years old. On that day, the victim services worker spoke with Tina's grandma about counselling for Tina and her younger sibling. In fact, counselling supports would never be arranged through victim services, as is described in the following chapter.

Child and family services had also assessed on more than one occasion that Tina required counselling supports. Recommendations included that Tina needed to attend, participate, and complete a workshop on loss and grief, and a recognition that Tina had not received any grief counselling following her father's death.

As many Manitobans are aware, the provincial government hired a consultant group to review Manitoba's mental health and addiction services. The final report, known often as the *Virgo report* (2018), looked at mental health and addiction service delivery for children, youth, and adults in the province; that report was released to the public in May 2018. Our office carefully reviewed the 279-page final report and it validated what Manitobans have long felt: these systems are under-funded, the resources are spread too thin, and prevention-focused efforts are often overshadowed by the ever-growing need for crisis interventions.

Of particular interest to our office, is, of course, the Virgo report's priority focus on the mental wellness of Manitoba's children and youth. In our review of the province's report, we agree with the Virgo team's assessment that Manitoba's youth mental health and addictions system is marked by inadequate funding for services, insufficient early intervention services, and the need for universal prevention resources and supports for all children and youth. Sadly, in the time since that report was made public, the province has remained silent on its implementation plan to address what should absolutely be its priority focus: the early mental health intervention for children and youth. Early intervention is shown time and again to be of key value to individuals who can receive early support for their health needs, and early intervention also provides considerable fiscal benefit: early treatment is infinitely more cost-effective than emergent, crisis-driven responses.

These issues cannot be discussed without acknowledging that Indigenous communities and families experience the weight of the trauma and grief more acutely. Indigenous children and youth today carry with them the burdens of colonization and residential schools. The overrepresentation of Indigenous children in today's social service systems must be understood for what it is: these are the legacies of a shameful history. The Virgo report (2018) included specific recommendations for the Manitoba government aimed to redress certain deficiencies of the provincial mental health and addiction services and to aim them towards becoming more culturally-informed.

It is our responsibility to walk in reconciliation and that means that the federal and provincial governments must pay special attention to ensuring that the services that Indigenous government leaders and communities require to treat and heal their children and their families must be provided in a seamless and meaningful way. Indeed, funding should be targeted and prioritized where the need is greatest, and in Manitoba, those priorities are children and youth in rural and remote locations, many of whom are Indigenous.

As an overarching conclusion, the Virgo team stated that the broad provincial mental health and addiction system will not improve significantly in terms of access or coordination without a concerted and sustained effort to better meet the needs of Manitoba's Indigenous peoples. During its extensive review, the government's experts identified clear evidence of access and service challenges for Indigenous peoples, combined with the discovery that for almost every service encountered, the largest percentage of people being served were of Indigenous background. Two key challenges facing services for Indigenous peoples were identified:

- 1. The need for more culturally informed services (land-based programs, use of customary languages) and,
- 2. The "jurisdictional issue" (conflict between provincial/federal services and responsibilities).

In all, the government's Virgo report expressed that the strategic priorities should open new doors and pave the way for significant progress in resolving long-standing perceived and real jurisdictional challenges with respect to mental health and addiction services and supports. In describing their commissioned report as the path to setting out a "bold plan to address long-standing service gaps," (Manitoba government, 2018, para. 1), Manitoba Health promised the release of its implementation plan by the fall of 2018. To date, and nearly ten months since its strategy was released, Manitobans continue to wait on the provincial government to make the necessary changes and investments to overhaul the child and youth mental health system, an area where the "limitations were most evident" (ibid., para. 10).

Through a meaningful understanding of trauma, including both childhood and historical trauma, it becomes clear that the way toward healing for Indigenous youth must reflect the tenets of Canada's Truth and Reconciliation Commission (2015) and include the role of culture in healing (Marsh, Cote-Meek, Young, Najavits & Toulouse, 2016). Extending from this, Indigenous researchers and practitioners have called for a treatment model for trauma that encompasses both psychological and social aspects of healing, including the valued role of culture in healing (Gone, 2013; Marsh, Cote-Meek, Young, Najavits & Toulouse, 2016; O'Neill, Fraser, Kitchenham & McDonald, 2018).

For example, the First Nations Mental Wellness Continuum Framework (Health Canada, 2015) recognizes culture as an important social determinant of health and calls for a "culture as intervention" (p. 4) model that reflects many different Indigenous cultures. Importantly, the framework recognizes the need for trauma-informed care, an approach that ensures service providers have a meaningful understanding of the unique needs and vulnerabilities of Indigenous peoples due to historical trauma. In trauma-informed care, the service provider views trauma as an injury and places a priority on healing based on principles of compassion, choice, safety, and control (Health Canada, 2015). The framework provides comprehensive recommendations for redressing the harmful impact of colonization and residential schools. Adopting a strength-based lens, the framework defines mental wellness as:

...a balance of the mental, physical, spiritual, and emotional. This balance is enriched as individuals have: purpose in their daily lives whether it is through education, employment, caregiving activities, or cultural ways of being and doing; hope for their future and those of their families that is grounded in a sense of identity, unique Indigenous values, and having a belief in spirit; a sense of belonging and connectedness within their families, to community, and to culture; and finally a sense of meaning and an understanding of how their lives and those of their families and communities are part of creation and a rich history (Health Canada, 2015, p. i).

Perhaps one of the most significant treatment models to address historical trauma is the Circle of Courage® identified in the seminal book, *Reclaiming Youth at Risk* (Brendtro, Brokenleg & Van Bockern, 1990). Dr. Martin Brokenleg describes the Circle of Courage® as a synthesis of research on tribal wisdom, and its teachings are centred on the following values:

- Belonging,
- · Mastery,
- Independence, and
- · Generosity.

Belonging is described as the antithesis of alienation. In the pursuit of belonging, young people are returning to their communities in search of place and identity. Wastery refers to the competence of young people, as measured by their progress relative to past performance—not by comparison to

others. Independence refers to the power young people exert over their lives. Generosity is the measure of virtue, where relationships are valued as more important than possessions (Brokenleg, 1996). Through his academic lens, Dr. Brokenleg demonstrates the parallels of these traditional values, rooted in ancient wisdom, to the values of modern psychology, which include: attachment, achievement, autonomy, and altruism (Brokenleg, 1999).

However, while modalities of treatment are important to discuss, what comes before is the ability for children and youth to simply gain access to needed mental health supports. In September 2018, the Manitoba Advocate issued a Statement of Concern, entitled, *A Call to Action: A Mental Health and Addictions System to Meet the Needs of Children and Youth* (Manitoba Advocate, 2018b). The statement was issued by the Manitoba Advocate in light of the fact that Manitoba did not have a stated implementation plan to redress the many significant gaps in the youth mental health system, which were examined and described in the Virgo Report (2018), and which continue to leave too many children and youth unable to access mental health and addiction supports in our province. In that statement, the Manitoba Advocate noted:

What we need here in Manitoba is 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 (Manitoba Advocate, 2018b, para. 4).

The Manitoba Health, Seniors, and Active Living website includes a frequently asked questions page, which explains the government's rationale for having undertaken the wide-scale mental health and addictions review, beginning in 2017. Overall, the government's impetus in undertaking the review was to "improve access to and coordination of mental health and addiction services in the province" (Manitoba Health, n.d., para. 1). Further, the government indicates in their online literature that they were motivated to conduct the provincial review partly in acknowledgement that:

- 70% of mental health problems and illness have their onset in childhood or adolescence (Manitoba Health, n.d.).
- Between 2011/2012 and 2015/2016, 25.6% of Manitobans age 10 and older received medical care for at least one of the following mental illnesses: depression, anxiety, substance abuse, personality disorder, or schizophrenia (Manitoba Health, n.d.).
- From 2011/2012 to 2015/2016, there were 55,281 Manitoba residents treated for substance abuse, representing 5.0% of Manitoba residents age 10 and older (Manitoba Health, n.d.).

As advocates for children and youth across our province, we agree with the provincial government that mental illness and addiction issues are critical systems to address, and that proper interventions need to begin in childhood if there is to be hope for improved long-term outcomes. While it is unknown what mental health problems might have followed Tina into her later teen and adult years, what is known is that Tina experienced some of the above described challenges in her early, formative years, and was unable to access recommended supports.

As of the writing of this current special report on Tina's life, which comes six months after the Manitoba Advocate issued her Statement of Concern, and ten months after the release of Manitoba's Virgo report, Manitoba is still without an articulated mental health and addiction strategy for children and youth.

<u>RECOMMENDATION TWO</u>: The Manitoba Advocate for Children and Youth recommends that Manitoba Health, Seniors and Active Living expedite the public release of a clear implementation plan to address the child and youth-specific recommendations contained in the report on *Improving Access and Coordination of Mental Health and Addiction Services: A Provincial Strategy for all Manitobans* ("Virgo Report").

- Details: Manitoba Health, Seniors and Active Living's plan must ensure that resources are prioritized in rural and remote locations to ensure equitable service levels for children and youth regardless of where they are living.
- The implementation plan must reflect the client populations who require them and must, therefore, be culturally-informed, and be developed in ways that reflect the voices and preferences of Indigenous health experts, Indigenous leadership, children and youth, and others with lived experiences.

Victim Services

Manitoba's Victim Bill of Rights

Tina's father's homicide in late October 2011, was a turning point in Tina's life. After his death, Tina's behaviour changed and she became increasingly withdrawn (Tina's grandma, Interview, April 12, 2018). The victim services program through Manitoba Justice had the responsibility to support Tina as a victim of crime and offer victim services at the time of her father's fatal assault and throughout the trial. Yet, those interventions were inaccessible to Tina as a child, were too court-focused rather than child-centred, and were prohibitive in terms of time and eligibility parameters in providing support to Tina. Furthermore, the lack of clarity and consistency in the information and services provided to Tina's family as victims of crime, suggests an absence of quality control in the management of victim service cases.

Manitoba's *Victims' Bill of Rights* defines a "victim" as an individual or an entity "against whom an offence is committed or is alleged to have been committed," and which includes individuals who are "the victim's nearest relative." As confirmed by a representative from the Compensation for Victims of Crime (VOCC) Program, a *victim* can be a direct victim, a witness of a crime, or an immediate relative of a direct victim. Tina would therefore have fit this definition of victim, as children are included first in the victim services' definitions in *The Victims' Bill of Rights*. In Part 5 of the legislation pertaining to Compensation for Victims of Crime, the definition of *child* includes a child to whom a victim stands *in loco parentis*, meaning a person who has the legal responsibility to take on the function and responsibilities of a parent, such as a guardian. Further, section 48(1)(b) outlines that a child of the victim is "entitled, in accordance with the regulations, to ... compensation for related counselling services." According to a representative from the VOCC Program, a child does not have to be financially dependent on a parent who is a direct victim to be able to access counselling; counselling is available to all immediate family members.

Quality Assurance Measures are Needed to Ensure Service Delivery is Consistent and Child Centred

FINDING: Tina was not invited to participate directly in the process of accessing victim services; these decisions were deferred to adults in her life.

FINDING: Following the death of Tina's father, victim services did not provide Tina the counselling to which she was entitled. Had the process been streamlined and the quality of services consistent, Tina might have been able to access timely compensation benefits, primarily in the form of counselling.

According to the victim services' file, which contains information on various points of contact between the Manitoba Justice Victim Services branch and Tina's family following the death of her father, not once did a worker meet with Tina directly. Representatives from victim services have confirmed with our office that it is not general practice for victim services to be in direct contact with a child affected by a crime, as usually it is that child's caregiver or guardian who acts as the spokesperson. Furthermore, while parents and children of a deceased victim are afforded the same informational rights, Victim Services' policies only refer to children of the deceased who are over 18 years old. This eligibility distinction excludes minor children of victims from being able have a direct point of contact with Victim Services. As a result, information was shared only with the adults in Tina's life, and in all cases, adults made all of the decisions about what supports she might need rather than inviting the opinions and participation of Tina herself.

The initial meeting between Tina's grandma and the victim services worker took place on November 23, 2011. During this meeting, Tina's grandma discussed counselling for Tina. She also explained that she had care of the children through a written agreement with Tina's father and CFS. The victim services worker explained that VOCC required a copy of the written agreement for the children's VOCC application. In our review of their files and other evidence provided during this investigation, we found no explanation why victim services would have required formal confirmation of legal guardianship, given that eligibility criteria were satisfied based on the fact Tina was his child.

In May and October of 2012, victim services was in touch with adults in Tina's family to notify them of the accused's plea and details about the time and location of court dates. The victim services worker assigned to the family met with adult family members in person and liaised with the crown attorney to coordinate meetings between their office and the family. There were no discussions about counselling services for Tina were documented on the file at this time.

On November 23, 2012, one year after her first request, Tina's grandma again asked victim services about counselling for Tina and her sibling. Arrangements were made for a meeting in December 2012, for a victim services worker to assist Tina's grandma in completing the VOCC application forms for Tina and her sibling to access services and benefits through the VOCC Program. However, there was no documentation in the victim services file that this meeting actually took place. There are two letters from that month in the victim services file: one dated December 6, 2012 notifying her family on the details of

an upcoming preliminary inquiry, and another dated December 13, 2012, which indicates the letter accompanied an information guide and application form for the VOCC Program. There was no indication on file that the victim services worker attempted to follow up with Tina's grandma to complete the required forms for the requested counselling.

In April 2013, a new victim services worker was assigned to Tina's family; Tina's grandma reported to the new worker that she had not received any forms. Case notes in the victim services file revealed that a meeting was planned with Tina's grandma on April 25, 2013, and May 23, 2013, at which time the worker would bring the forms, these meetings were cancelled, due to Tina's grandma's health issues.

The victim services file included a copy of Tina and her sibling's Victims of Crime Compensation application form, as completed by Tina's grandma, which victim services received on May 28, 2013. Compensation benefits can include recovering costs related to items lost during a crime, counselling, travel for counselling, or lost wages. According to a representative from victim services, once a VOCC form is completed, if a victim articulates that they want counselling, information is then sent out to the victim indicating that counselling and travel for counselling is approved. A list of counsellors and Elders is also shared and the victim can select whomever they wish to see from the list, or can identify other counsellors. There was no indication on file that this was ever done for Tina.

In the file there was a letter addressed to Tina's grandma from VOCC, dated May 31, 2013, which communicated that "there will be no financial support by our program for the children of the late [Tina's father]," as "child benefits are only paid in situations where the parent who is deceased, was providing financial support to his children at the time of his death." Tina and her sibling were in the care of Tina's grandma since November 3, 2003, "long before the death of their father..." While there is a distinction between *child benefits* and *counselling*, both services are available to victims of crime under the VOCC Program. It is important to note that this letter did not clarify this distinction, nor that counselling services were still available for Tina and her sibling. According to victim services' policies, victim services workers must ensure that parents and children of a deceased victim are provided with the same information as a registered person. There was no documentation in Tina's file that the victim services worker communicated to Tina's family the eligibility restriction that this provision only pertains to adult children. Although Tina was still eligible to access counselling through the VOCC Program, this letter denying child benefits through the VOCC Program may have understandably been interpreted as a full denial of her application to the program.

Victim services continued to be in touch with Tina's family over the spring and summer months in 2013, specifically in May, July and August, responding to questions about court processes, request by the family about smudging in court, liaising with the crown attorney's office to arrange meetings with the family, and providing updates on the rescheduling or cancellation of court dates. It should be noted that

during this time period, there was no mention of counselling or follow through for counselling for Tina and her sibling.

In June 2013, following a social work assessment done at Tina's school, Tina was referred for counselling support to cope with her father's death. The social worker at Tina's school made efforts to connect with victim services to secure therapy services for Tina, but was not successful. During the next school year, in November 2013, the school social worker once again reached out to victim services regarding supports for Tina out of concern for what was identified as increasingly concerning behaviour. This time, while the attempt to contact victim services was successful, no confirmation was communicated to the teacher as to whether Tina already had a file with victim services or if any claims to access the VOCC Program had been approved or denied. As such, the school social worker printed off VOCC forms and shared them with Tina's family. It is concerning this did not prompt the victim services worker to follow through on the past requests for counselling. Tina had still not received the therapeutic supports to which she was entitled.

In late May 2014, Tina's grandma received information on the process of completing victim impact statements. During the course of this investigation, Tina's grandma shared with our office that Tina had begun – several times – to write a victim impact statement on her experience following the loss of her father. Tina's grandma asked the victim services worker if the family could submit a combined statement for both Tina and herself, as Tina was having too difficult of a time writing it on her own. Unfortunately, Tina's grandma was advised that the process required each person to complete their own statement. For Tina, the overall process was not mindful of her unique experience as a child victim and her preferences. Further, she was never included or consulted, as per her right to express her opinion or be heard by adults in the *United Nations Convention on the Rights of the Child* (Article 12).

On June 16, 2014, after learning that the accused in Tina's father's case would be accepting a plea bargain on a lesser charge, Tina's grandma indicated to victim services that she and the family would be submitting victim impact statements. She also expressed her dissatisfaction with her experience with the justice system, particularly her disappointment in the quality of support services she and her family received as victims of crime, advising, "I don't want to hear from you guys ever again. You guys just keep making this too hard" (Communication note, victim services file, June 16, 2014). As a result, respecting Tina's grandma's wishes to no longer be contacted, victim services de-registered Tina's grandma from the program on this date. Reflecting on her de-registration, Tina's grandma explained further how she viewed her family's experience with victim services, and that they kept promising services with no follow-through: "they kept saying they'd help and never did" (Tina's grandma, Interview, March 6, 2019).

According to the Victim services policy and procedures manual, victim services workers are expected to document every contact with a client, regardless of method (phone, letter, or in person). Victim services

workers must also document any contacts with collaterals, or individuals relevant to a victim's file. Our office's review of the victim services file found a general lack of clarity in what was being communicated regarding what supports Tina was eligible for, what tasks were completed, and how to properly navigate and complete application processes to access these supports. Given the documentation the in file it is not a surprise that the services provided to Tina and her family did not transpire in the manner that would have provided Tina with the necessary counselling following the murder of her father.

<u>RECOMMENDATION THREE:</u> The Manitoba Advocate for Children and Youth recommends that Manitoba Justice evaluate the continuum of Victim Support Services for children and develop quality control measures to ensure that services are childcentred and provided in a timely manner.

Details:

- Manitoba Justice to examine the criteria regarding how child benefits are approved or denied and subsequently clarify and distributed to victim applicants.
- Manitoba Justice to clarify current legislation and policies that are contradictory related to access to compensation services and benefits.

Child and Family Services

Fractured Families

FINDING: Starting in Tina's early years, child and family services did not reflect a commitment to preserving, supporting, and protecting Tina's family unit, in accordance with the Declaration of Principles within *The Child and Family Services Act*. Instead, Tina's family experienced multiple fractures to its structure while receiving child and family services.

The Child and Family Services Act (CFSA) legislates and governs all activities of the child and family services system. The CFSA opens with 11 principles articulated as its basic foundation. Included is Principle 7: Families are entitled to receive preventative and supportive services directed to preserving the family unit. This requires that child and family services (CFS) agencies are required to provide services to families that prioritize early intervention, assist in restoring health to family units, and ensure — wherever possible — that children are secured within a safe family context. However, as advocates for children and youth, we see daily reminders in our work that too often, an apprehension model is practiced in our province. Concerns within a family are allowed to grow to the point of crisis, and then apprehensions occur to protect the safety of children, when earlier assessments, planning, interventions, and support networks might have prevented the breakdown of the family unit.

Tina's family experienced such fractures at a number of critical times. Setting aside, for now, the historical opportunities CFS had in the lives of Tina's parents before they started their own family, CFS witnessed the struggles for Tina's parents and focused on crisis responses at the expense of family preservation and family growth. Tina's mother gave birth to her first child, Tina's eldest sibling, when she was a 14 year-old child in care of Agency 1. The agency had been documenting their concerns with Tina's mother's drug and alcohol use, the violence she was experiencing, and the coercive relationship Tina's father had with her, which included him profiting financially through sexual exploitation.

It is concerning that Agency 1 documented their knowledge of protection issues, including sexual exploitation — a form of child abuse — and did not intervene to protect Tina's mother from those who preyed upon her. As she was then unable to demonstrate an ability to parent her first child safely, the child was apprehended at birth and the agency was granted a permanent order within seven months of the child's birth. A later request by Tina's mother to explore the possibility of rescinding that permanent order and to reunify with her oldest child was stalled partly because the assigned worker from one agency was unable to reach a worker from another agency on the phone to discuss the request. And so, the family was allowed to fracture even further and Tina's oldest sibling was rarely mentioned from that point forward. The case notes did not reflect any effort by the agency to attempt to maintain the bond

or attachment by way of allowing or arranging visits between Tina's mom and her firstborn child. During the course of this investigation, Tina's grandma shared that she had not known that the oldest sibling existed for many years, and expressed that she wished she had known the sibling had been placed into care as she would have also offered the child a home (Tina's grandma, Interview, March 6, 2019).

CFS apprehended Tina and her younger sibling on two occasions in their early years due to safety issues brought about by parental addiction and violence. After an apprehension in 2001, when Tina was two years old, Tina's parents separated and her mother had little contact with her sibling and her from that point on, and until the death of Tina's father in 2011. While Tina's family continued to grow and several additional siblings were born, there was no evidence that the multiple agencies involved viewed sibling connections for each of the children as important to the health and development of their senses of wellbeing and belonging. While some visits happened between some of the children, Tina was not included in those plans.

In 2016, our office released a report, *Don't Call Me Resilient: What Loss and Grief Look Like for Children and Youth in Care.* The report emerged from the stories and voices of youth who attended a focus group held by our office where the topics of family wellbeing and belonging were explored. Youth emphasized the importance of siblings, and many of the youth shared stories of having been separated from siblings as a regular and expected part of being involved with the CFS system. It is sad to hear how often children and youth feel like they are being punished as they enter care. Even when parents are unable to provide safe care, service providers must commit to protecting and nurturing the relationships between siblings. Youth told us that they want the CFS system to demonstrate an improved understanding that sibling relationships are a vital element of their personal wellbeing and those relationships help them understand their place within family and community contexts. Due to the early and ongoing fractures in her family dynamic, Tina was only given the opportunity to develop a consistent relationship with one of her seven siblings. It is easy to imagine how this loss of family relations could have contributed to her seeking belonging elsewhere, and why she was left vulnerable to adult predators.

Embracing Customary Care

FINDING: Legal guardianship is often recognized, practiced, and understood differently by mainstream government systems and Indigenous communities. In Tina's case, government service providers and some child and family service agencies did not acknowledge customary practices as legitimate. This contributed to service delivery confusion for Tina and her family.

Customary Care means care provided in a way that recognizes and reflects the unique customs of a community...Historically, customary care was a way of life. Everyone was involved in raising and providing care for one another as this was the traditional way of care

that is provided by the family and within [its] community. It preserves a child's cultural identity, respects the child's heritage, facilitates cross-generational connections and recognizes the role of the community in raising its children. The First Nation community is to establish the practice of customary care and to identify [its] roles within the community when raising [its] children (Sagkeeng Child and Family Services, 2018).

Clarity surrounding a child's guardianship and the legitimacy of customary care arrangements is of vital importance. In nearly every aspect of a child's life, important decisions are made under the authority of the child's legal guardian. Since minor children are rarely afforded the opportunity to make life-impacting decisions from a vantage of autonomy, who holds the legal guardianship of a child is often important to mainstream services. Further, considering that Indigenous children are over represented in Manitoba in almost all child support serving sectors, Manitoba must move forward to recognize the cultures and custom of the children they serve.

For Tina, the lack of clarity around her guardianship and legal status created problems with respect to service delivery, safety planning, and her ability to access programming and supports. This could have been resolved with a recognition that Tina's grandma had been her primary caregiver for 10 years, and she had been responsible for making decisions on Tina's behalf during that time.

In Tina's earliest years, her parents held her guardianship, save for the two times she was apprehended for safety reasons. After the first apprehension, Tina and her sibling were returned to their parents' care, and after the second time, following the breakdown of her parents' relationship, Tina and her sibling were returned by CFS to the care of their father. While both parents would have retained legal guardianship of Tina, her father would become the primary care provider and decision maker.

Tina's guardianship remained legally with both of her parents for the next several years. However, Tina's grandma was the primary caregiver and decision maker for Tina from the age of five until she was 14 years old. The community they lived in recognized and supported this customary arrangement; however, most mainstream services did not formally recognize it. This fact became problematic after the death of Tina's father in 2011. At this time, legal guardianship of Tina and her sibling rested solely with their mother, despite the fact that Tina's mother had not been involved with them, virtually since 2001. In spite of the fact that Tina's grandma was her customary caregiver, when she attempted to access Victim Support services for Tina in November 2011, she was initially and erroneously advised that she would have to show written proof from the agency of their support of her being Tina's recognized guardian.

In the time after her father's death, Tina struggled in a number of ways, and according to Tina's grandma, was profoundly affected by the loss of her father. This was a critical time during which Tina needed security and belonging, as she faced the shifting reality of her family dynamic. Tina's behaviour

escalated to a point that grandma had to reach out to CFS in April 2014, recognizing that she was no longer able to safely care for Tina on her own and that she need support. Agency 5, recognizing Tina's grandma as the customary guardian for Tina, opened a voluntary services file and began working with grandma to support Tina.

When we interviewed Agency 5 during this investigation, they expressed that they work with many families where private care arrangements have been in place, especially when they provide services to Indigenous families (Agency 5, Interview, February 21, 2019). As an agency, they told us their practice is to work in the least intrusive way within a definition of family that goes beyond legal relationships. The agency noted that children are not apprehended in the absence of an immediate safety concern. While our office agrees with this stated position, we also note that Tina's grandma and grandpa reported not feeling recognized as Tina's guardians, most particularly at the times when Tina went missing from home, when there were multiple agencies involved, and when they sought out updates for what was happening for Tina.

Three months later, guardianship was again an issue. In July 2014, when Tina was missing and believed to be in Winnipeg. Tina's grandma called Agency 4, the designated intake agency for Winnipeg. Tina's grandma asked for assistance and enquired about placing Tina in care when Tina was found. This request was denied by Agency 4, as the agency did not recognize Tina's grandma as the legal guardian for Tina, noting Tina's mother still held legal guardianship. In contrast, Agency 5 had opened a file recognizing her as the customary care provider. This could understandably have created a sense of confusion and powerlessness for Tina's grandma because she had been the key decision maker and protector for Tina for nearly a decade. One of the outcomes of the ongoing jurisdictional disagreement regarding guardianship and which agency would assist the family, is that from July 10 – 17, when Tina was missing, no one was looking for her in order to bring her safely back home.

A week later, when Tina stayed an overnight at a short-term detox resource, guardianship remained a complicating issue. The detox resource called Agency 3 to advise Tina had been admitted and was detoxing overnight and Agency 3 called Agency 5 to arrange for Tina's grandma to pick up Tina from the detox resource as Agency 3 had protection concerns regarding Tina's mother. It was Agency 5, pivoting from their earlier position of recognizing the customary care arrangement that then advised Agency 3 the appropriate course of action - according to CFS provincial standards and policies - would be for Agency 3 to apprehend Tina for protection reasons, as guardianship had not been properly addressed at the time of Tina's father's death.

In one of the interviews we held with Tina's grandma, she shared with our team that she was upset with the CFS agencies who were involved at this time, as those organizations did not recognize her as Tina's caregiver. She shared that she had to contact the agency and police to be provided with information

about plans for Tina after her apprehension and to learn what was happening in the weeks before Tina's death. She said, "I was the one up at night with her when her father died and when she was sick." Tina's grandma indicated to us that, in her view, better service from the system would have seen CFS recognize her as Tina's caregiver and guardian, in line with customary care practices.

There are many children in Manitoba who are well cared for and loved by extended family, as Tina was by her grandma and grandpa. And yet, Indigenous customs of caring for children by extended family is often not recognized within mainstream systems. Families who rely on customary care arrangements in Manitoba find that they cannot access government services in their totalities (e.g. child welfare, education, health, mental health, victim support, housing, child tax benefits, and other financial supports) if they have not gone through the legal process to formally transfer guardianship through the courts.

While more agencies are working towards changing practices and policies in order to recognize customary arrangements, other agencies continue to adhere to legal guardianship practices that have colonial, Euro-centric origins. Given that Indigenous children are overrepresented in child support services delivered in Manitoba, our province ought to move towards recognizing and legitimizing customary care providers so that all Manitobans who require public services can access them efficiently and within the community and care structures that work best for their families.

The Family Tries to Find Help from Several Systems

While CFS had been involved with Tina in her first years of life, Tina then experienced nearly eight years of relative stability living with her grandma and grandpa. Following the homicide death of her father, after which she did not receive counselling, despite repeated discussions of its need and the struggles she had been having, she began to noticeably struggle. Tina's absenteeism from school grew. She began using cannabis and was suspended for being high at school more than once. By November 2013, two years after her father's death, and nine months before her own death, Tina (age 14) went missing and was believed to be in Winnipeg. RCMP, Winnipeg Police Services (WPS), Agency 4, and Agency 3 were all involved to find her. Tina was located at her mother's home by WPS and was assessed as not safe to remain at that location. Tina's grandma was contacted by Agency 4 to drive to Winnipeg to pick up Tina, but Tina's grandma informed the CFS worker that she did not have transportation to Winnipeg. What ought to have happened at that point was for CFS and RCMP to work together to drive Tina back to her home in Powerview, as this was where she was reported missing from, and where she had a safe home. Instead, Agency 4 placed 14-year-old Tina in a Winnipeg shelter, transferred the intake to Agency 3 and Agency 4 closed their file. It took the family two days to secure transportation to Winnipeg to pick her up and take her home. It is concerning that the choice was made to have Tina stay in a shelter for two days when transportation could have easily been secured by the systems involved for Tina to return to her

home in Powerview. This is even further concerning given Tina was known to be struggling in many ways and was vulnerable to exploitation by adults. Her grandma had informed the youth shelter where Tina was placed that it had been a 25 year-old man who had taken Tina from her home community to Winnipeg when she first went missing. There is no evidence in the files we reviewed that the youth shelter reported this important information to Agency 4, potentially leaving Tina even more at risk of harm.

At this time, there was no other CFS agency involvement for Tina. Tina's family tried to find help for her. Tina's grandma spoke with Tina's school, who tried on behalf of the family to mobilize counselling for Tina through victim services. Unfortunately, victim services explained that (a) the onus would be on Tina's family to reach out to victim services to access counselling, and (b) they typically had a window of one year to provide assistance and therefore Tina might not be eligible.

Tina's family also had contact with medical personnel in January 2014, seven months before Tina's death, after Tina was transported to Pine Falls Health Complex by ambulance following an incident of self-harm, where she inflicted cuts on her arms after a family disagreement. Medical personnel ought to have created a plan for follow up or information about resources the family could access, and also reported the incident to CFS. However, there is no evidence that either of these steps were taken. Tina's family was left to follow up and manage the crisis on their own.

During the spring of 2014, four months before her death, Tina's grades and attendance at school dropped severely and she was suspended for the final time in April 2014; she would never return to school.

The Problem with Silos and Jurisdictions

FINDING: In her final months of life, and with multiple child and family service agencies involved, Tina did not receive the child and family service interventions and resources she required to support her through her addictions and to protect her from the adults who were exploiting her.

In April 2014, Tina's grandma called Agency 2 asking if she could place Tina in care because she felt unable to protect her. Tina's grandma explained to CFS that Tina was running away to Winnipeg and currently missing, that she was concerned about the possibility of Tina being sexually exploited by adults, that Tina was being groomed and lured online by adults, and that the environments Tina was frequenting while in Winnipeg placed her at great risk. The request to place Tina in care was forwarded by Agency 2 to Agency 5 as the designated CFS intake agency for the area. Agency 5 called Agency 3, which was the agency working with Tina's mother, and were advised that Tina's mother's home was not safe for Tina. Agency 5 did not place Tina in care, choosing instead to open a voluntary services file for

Tina's grandma. What was also missing from the documentation and other evidence our office reviewed was any acknowledgement by CFS of Tina's increasing absenteeism from school, and which had been increasing since her father's death in late 2011.

When Agency 5 met with Tina's grandma and grandpa, they did not address the many safety concerns identified by the family. After the initial meeting – in which Tina was not present as she had not yet returned from where she had been located - CFS summarized in their case notes that their concerns included Tina's:

- mental health,
- anger and physical aggression towards members of the family,
- drug use,
- ongoing absenteeism from school,
- risk of being exploited by adult men,
- frequent running away, and
- ongoing need for grief counselling.

When Agency 5 met with Tina a week later in early May 2014, agency notes documented no case planning and no discussion about a number of the concerns identified by the family, only that they had talked about what subjects Tina liked at school, that she liked taking walks, and that she was agreeable to counselling. It is concerning that the agency worker did not appear to recognize that the list of concerns were all indicators of sexual exploitation. It is further concerning that the issue of sexual exploitation, a form of child sexual abuse, was not discussed with Tina at this meeting. When asked about this meeting during our investigation, Agency 5 indicated they felt it was important to have their worker establish a relationship with Tina prior to raising some of these emergent issues. They stated that they viewed having gotten Tina to agree to attend counselling was sufficient for this first meeting. However, given the critical safety issues present at that time, Agency 5 had an obligation to speak with Tina about the issues of which the agency was fully aware.

Agency 3 expressed concern during the course of this special report that at the time of transfer of Tina's file they were not given all of the necessary information from Agency 5 about the family and the identified concerns. Agency 3 stated that as a result of the previous file being a voluntary services file (VSF), important information was held back when the file was transferred to them. According to section 76(12) of *The Child and Family Services Act* (CFSA), an agency who holds a voluntary services file should not share the contents of that file. However, the CFSA provides that when an agency has reasonable grounds to believe that a child is in need of protection, as was the case with Tina, information can be shared. Both Agency 3 and Agency 5 had a shared responsibility to act in Tina's best interests and ensure the necessary information was exchanged. Working collaboratively would have allowed the CFS agencies to best plan for Tina and her family.

In her final two months of life, Tina's high risk behaviour rapidly escalated. She increasingly went missing, was homeless, and was known to be struggling with significant drug misuse. During this time, Tina's grandma had frequent contact with various CFS agencies (Agency 3, Agency 4, and Agency 5), and with RCMP as she was greatly worried about Tina and feared for Tina's safety. It was only when Tina was admitted to the short-term detox resource on July 17, 2014, Tina's final month alive, that Agency 3 brought her into care. By then, Tina's grandma, knowing she was unable to keep Tina safe at home, informed the agency that they would have to find a different placement for Tina. Families ought to be supported long before they face situations where crisis have been escalating to a point where they don't feel able to care for their own children. Preventative services must be the priority, and an early one.

Safe and Secure Placement Resources Are Needed for Children in Imminent Danger

FINDING: Manitoba continues to lack safe and secure placement resources for children who are at risk of imminent harm or death.

Manitoba does not have a continuum of care for sexually exploited youth who are experiencing life-threatening addictions. What was evident in our review of all of the organizations and systems involved, was that Tina was presenting with increasingly high levels of risk. Apart from conducting address searches for her and waiting for Tina to make contact when she needed a place to stay or a meal, public services were unable to help her because nearly all placements and services in Manitoba are voluntary and children who are in crisis can opt to leave or to run from placement. The evidence in our investigation revealed a lack of resources, including an absence of safe and secure placements for Tina. This is despite a decade of completed child death reports from this office and calls from many CFS workers and community service providers requesting the Child and Family Services Division support their creation.

Notwithstanding this lack of a continuum of care, it is unacceptable that a child who was frequently missing, known to be sexually exploited by adults, misusing drugs and alcohol, and unable to explain physical injuries would be encouraged to find her own way to placements when she called her guardian agency. Given the situation and the known risks to Tina, Agency 3 ought to have ascertained the location where Tina was, picked her up, and transported her to her placement, this was not the arrangement made by the agency. Instead, the result of the phone conversation was that Tina indicated she would ride her bike over to the youth shelter. CFS file information did not indicate if Tina ever arrived at the shelter, and the shelter files reviewed by our office did not support that Tina successfully arrived at the shelter at this time.

When youth facing these dangers in our communities make contact with organizations or mandated agencies, youth should never have to receive the message that there are no beds or there is no room for

them. As advocates for young people, we know this would be a difficult thing for a youth worker at a shelter to communicate and likewise, it is concerning that any professional ever needs to tell a youth there is no room for them. The responsibility to fund a continuum of resources rests squarely with the government, through the Child and Family Services Division. For Tina, more than once in a matter of weeks she was told there were no beds available for her, which essentially left her homeless and responsible to find her own place to stay. For youth who are exploited, this means they may likely be forced towards exploitation in order to have their most basic needs met, as it is an old and true adage that *nothing comes for free*. When systems have contact with youth who have been missing and are being exploited, each opportunity for contact must be seen as a critical chance to intervene, but in order to intervene effectively, organizations needs placement options, and frontline workers need to develop expertise in understanding, at a minimum, addiction, mental health, and sexual exploitation.

When Tina showed up at the Agency 3 office in late July 2014, the CFS agency did not demonstrate an understanding of the risks of sexual exploitation. An agency supervisor spoke with Tina that day about reports Tina had been using crack cocaine. Tina confirmed these reports and indicated that she was using with her mother. At that point, Tina was the subject of an active missing persons report and had arrived at the CFS agency office with a young adult man who witnesses had previously observed physically assaulting Tina, and whom Tina referred to as her "boyfriend." With no evidence that the CFS agency enquired about this relationship, nor that they followed up with Tina's mother about using crack cocaine with Tina, the supervisor informed Tina that, "running the streets was not a great plan." This was an important but missed opportunity for safety planning and intervention related to Tina's high-risk substance misuse, homelessness, and ongoing sexual exploitation.

A couple weeks later, in early August 2014, the lack of resource options and intervention played out again when Tina was found unconscious, only partially dressed, and possibly the victim of a sexual assault. While being treated at hospital Tina disclosed to her CFS agency that she liked to "chill" with a 62 year old meth-using man. She was believed to possibly have been sexually assaulted, but refused a gynaecological exam, and she tested positive for a number of substances, including amphetamines. Following this traumatic event, the CFS agency should never have simply dropped Tina off with contracted care workers at a hotel. Unfortunately, this was the only placement option available. As previously described, Tina walked away from the hotel placement for the final time shortly after her CFS worker dropped her off and left.

Since Tina's death, Manitoba's lack of resources for children experiencing sexual exploitation continues to be extremely limited. With the exception of a few semi-secure crisis stabilization beds for high risk victims, there are no additional options for CFS workers when children who present with these lifethreatening indicators urgently need placement.

When children surface looking for a safe place to stay and they are sent to a shelter, the message that gives to them is that they are not valuable. They need and deserve a place where they belong and call home. We must develop a continuum of resources to ensure youth understand that violence against their bodies and spirits in the forms of physical assaults and sexual exploitation *is not normal*. These are egregious violations. When they happen, children and youth must receive the clear and unshakeable message that adults will do what is needed to protect them and to help them so they can heal and recover.

While it is a difficult topic, discussion is desperately needed in Manitoba about a full continuum of services for children and youth, including a safe and secure detox and treatment facility. Further, families, care providers, parents, and guardians urgently need places they can access when their child is at imminent risk of harm or death.

In December 2018, the Manitoba Advocate published another child death investigation, *In Need of Protection: Angel's Story*. In that report, our office profiled seven youth who are presently at risk of significant harm or death. Like Tina, the seven youth profiled are being sexually exploited by adults in our province, are addicted to drugs, and are unable to keep themselves safe. These children surface for short periods of time, but are unable to remain connected to helping resources, because some of them are forced back into exploitation by the adults who coerce and control them, some are unable to resist the pull of drug addiction, and each of them are at significant risk of harm or death. Each day our office is working with and supporting youth who are in these dire and desperate situations.

At the writing of this special report, our office is actively advocating for and working with 17 Manitoba youth who are at imminent risk of harm and death and who require safe and secure detox and treatment.

Families need appropriate options. While involuntary and secure treatment may not be appropriate for most youth, there are young people in our province who require caring adults to intervene decisively when the other option is significant harm, or death. Emerging research on involuntary interventions suggests safe and secure treatment ought to be part of the continuum of options for children and youth struggling with life-threatening addictions. Importantly, "secure facilities" do not need to be institutions. They can be secured via adequate staffing, geographic locations, and be holistic and culturally-based home-like settings.

¹⁶See http://manitobaadvocate.ca/wp-content/uploads/In-Need-Of-Protection-Angels-Story-Dec-2018.pdf, pp. 91-93.

What is needed here in Manitoba is careful analysis of how other jurisdictions outside of Manitoba are managing the responsibility of involuntary care resources. One such example is the province of Alberta, which has developed a legislative framework that provides for youth at imminent risk to be apprehended and held in treatment resources immediately for 5 days, and then the system may apply to the court for up to two further periods of safe and secure treatment of up to 21 days each, based on the needs of the youth – much longer than the seven days of involuntary treatment currently available to families in Manitoba. This extended period would provide time for stabilization of the youth, further assessment, and allow for culturally appropriate interventions by clinicians and other specialized supports. The youth could have access to detox and mental health counselling, psychological services, medical supports, education, and life-skills support during this time of safe stabilization.

Unanimous agreement does not exist in our province that involuntary detox and treatment for youth is needed. Understandably, when questions of personal autonomy and restrictions on liberty are being considered, there is a range of positions and the discussion can become passionate and charged. As advocates for children and youth, we uphold and promote the United Nations Convention on the Rights of the Child (UNCRC), and believe that youth have clear and vital rights to express their views, to be included in decision-making, and to have their opinions and preferences considered seriously (UNCRC Articles 3 and 12). Youth also have the right to privacy and to be protected from unreasonable measures that would limit their personal freedoms as individuals (UNCRC Article 16). At the same time, we acknowledge that youth require special protections and considerations owing to their inherently amplified vulnerability within communities and because, as minors, there are reasonable limits on their abilities to be self-determining. One thing we know to be true and have heard in our work is that parents who have lost a child to the harms associated with sexual exploitation, drug addiction, mental health, and other dangers have told us that they would trade anything to have another chance to save their child. Parents and care providers who struggle to support a child through spiralling addiction know that all of the love and good intentions in the world are sometimes not enough to keep their child safe and alive. When youth are unable to make safe choices for themselves, parents, care providers, and guardians need options that will allow them to step in and place their child – involuntarily, if needed – into a resource that can provide appropriate supports and give them the chance to save their child's life.

As noted above, safe and secure placements need not look like jails. They can be secured by a well-trained and well-resourced staff compliment, they can be geographically secure, and be filled with highly-skilled people such as Elders and clinicians, individualized supports, culturally appropriate and innovative programs that will wrap around the child with all-encompassing love and holistic support.

On August 2, 2014, six days before she would go missing for the final time, Tina spoke with her Agency 3 worker and indicated she wanted a more stable placement that could meet her needs. She said she wanted to be placed somewhere "where she feels like its home." Unfortunately, the only option

available to Tina at that time was a temporary shelter. This arrangement did not meet Tina's known needs; she remained on the street and missing.

The need for safe and secure placements for youth was recommended recently in a public inquest, which looked at the 2013 death of a youth in custody (Manitoba Justice, 2018). In that final report, Associate Chief Justice Hewitt-Michta made a recommendation for, "a review of the number and availability of secure foster placements in Manitoba for high-risk youth in crisis, recognizing that the *Youth Criminal Justice Act* prohibits the use of incarceration as a substitute for appropriate child welfare measures" (p. 64).

Emerging research with young adults who were sexually exploited as children further supports the creation of a safe and secure setting outside of the context of jail or criminal custody settings. Indeed, with the benefit of hindsight, "the young adults who were exploited/trafficked as children identified that a specialized secure setting would decrease risk and further exploitation" (Richardson, 2018, p. 65). Richardson found that "the lack of a secure setting was undoubtedly one of the factors that caused the young adults interviewed to be further abused as children and the service providers and guardians/parents to not effectively intervene" (ibid., 2018, p. 108).

Our systems are overwhelmed as they try to manage growing – and changing – needs of populations where large numbers of young people are in urgent need of intervention. While on the face of it, it may look like a mental health and addiction crisis, or an increase in violent incidents being reported, or more youth who are being exploited by adults, what we need to focus on is that what we are seeing is the effects of *a trauma crisis*, and there is an urgent need for a full continuum of services here in our province. We need options for young people who are hurting and need early support, all the way to those youth who are at imminent risk. Along that continuum is education, early intervention, and safe and secure healing and treatment centres. Evidence-informed harm reduction approaches - including clean needle exchanges and overdose prevention sites that support youth and young adults - are considered best practice by mental health experts across the country. For our office, the issue is clear and confirmed with every youth we hear from and work with who is struggling under the weight of their addiction and who is asking the adults in this province for real change and meaningful help.

The solutions lie upstream. If our focus of resources and interventions keep our eyes locked on the results of trauma, then we will ignore the reasons that cause the trauma and our province will continue to see ballooning numbers of youth involved in child and family services, youth justice, and who are in need of emergency detox and treatment.

When the Manitoba Advocate released *In Need of Protection: Angel's Story* (Manitoba Advocate, 2018c), she emphasized the need for a full continuum of resources. Angel's story and many others in our

province reveal that children who are struggling with trauma-related addictions require immediate intervention to mitigate the extreme risk they face.

While the number of children abusing substances, including methamphetamine is increasing at an alarming rate, there are no involuntary, safe and secure, or long-term treatment options in Manitoba to address addictions and exploitation issues. At present, many youth in Manitoba, including sexually exploited youth like Tina, and like we described in the story of Angel, are not voluntarily willing or able to enter treatment.

Manitobans need to know where to turn to get addiction and mental health services. However, parents and others who contact our office continue to share the belief that when they seek to access these services on their own, their child will be placed on a waitlist. There is the perception of more availability of services and treatment within the CFS system. As such, some parents feel they have to place their children in care voluntarily in order to access the trauma-based services their children require. Just before Tina would begin her significant and rapid spiral downwards, her grandma told CFS she was no longer able to care safely for Tina; she felt powerless to meet Tina's needs. When Tina entered care on July 17, 2014, this was exactly one month before her body would be recovered. While sometimes the danger to young people happens slowly and steadily over time, this was not the case for Tina. That she was in such danger was only just recognized before she would go missing for the final time. If the mobilizing of resources to help Tina would have begun in 2011, after the death of her father, there is a strong likelihood that what happened to her in her final weeks of life might never have transpired.

As a province, we have a responsibility to ensure emergency supports are in place for children and youth at imminent risk, but we need to insist on and require of our public systems that early intervention options are also available so youth never reach a critical state. This is a trauma crisis, which only becomes a missing persons/youth justice/sexual exploitation/mental illness/addiction crisis when those underlying traumas are not addressed.

Manitoba has a population of youth who are in desperate need of intervention and treatment. Some of those youth are unable to make decisions that keep themselves safe, and in the absence of innovative and systemic action, some of these youth may not survive. In these situations, parents and guardians have an obligation and the right to intervene and direct the plan in the youth's best interests. As noted, our province currently does not have the mechanisms or placements that parents or guardians need to support their children when those children are severely addicted, are being sexually exploited, or are being harmed in other ways in the community. When children and youth are at imminent risk, parents, care providers, and guardians need to be able to access safe and secure detox and treatment options as they work to save their child's life.

RECOMMENDATION FOUR: The Manitoba Advocate for Children and Youth recommends that the Manitoba government, through its Deputy Ministers of Health and Social Policy and Priorities (DMHSPP) committee, work with the government's Legislation and Strategic Policy Branch to analyse the province of Alberta's *Protection of Sexually Exploited Children Act* and Alberta's *Drug-Endangered Children Act* to determine how safe and secure treatment facilities can be introduced in Manitoba. It is further recommended that the DMHSPP committee develop a plan to ensure the continuum of services for children and youth includes safe, secure, home-like settings for treatment and programming when children and youth are at imminent risk of harm or death.

Details:

- The continuum of services plan developed by the DMHSPP committee must define imminent risk, ensuring the definition contemplates issues of homelessness, addiction, and sexual exploitation.
- The development of a plan for safe and secure treatment facilities must include consultation with subject matter experts, persons with lived experience, and community stakeholders to ensure the treatment settings are safe, secure, therapeutic, effective, and culturally informed.

Sexual Exploitation

It is a heartbreaking and desperate truth that here in Manitoba, adults actively lure, demand, and routinely purchase sex from children and youth, a crime that violates their human rights and dignity.

As you read this, hundreds of children and youth are falling through the cracks of our society's safety net, just like Tina. These children and youth are preyed upon across our province and beyond by adults who sexually abuse and exploit them for their own sexual gratification.

As described in Manitoba's provincial Child and Family Services Standard 1.3.5, Child Sexual Exploitation, 17 child sexual exploitation is when anyone under the age of 18 is, "...coerced, lured or

engaged into a sexual act, exploited through the sex trade or pornography (also known as child sexual abuse images), with or without their consent, in exchange for money, drugs, shelter, food protection or other necessities or rewards" (Manitoba Families, n.d., emphasis added).

According to *Tracia's Trust: Manitoba's Sexual* Exploitation Strategy, there are five main forms of sexual exploitation of children and youth in Manitoba:

- 1. Sexual exploitation in the sex trade/industry;
- 2. Child abuse images (child pornography);
- 3. Internet luring;
- 4. Child sex trafficking; and
- 5. Child sex tourism.

(SEY) in Manitoba have been outdated.

Notwithstanding, it was known that children and

Until recently, statistics on sexually exploited youth

youth in Manitoba are being exploited as early as 8 or 9 years old, approximately 70% are Indigenous, approximately 80% are female; and the vast majority have experienced previous physical/sexual abuse, live in situations of poverty, family violence and addictions, and have been involved with the justice system as well as child and family services (New Directions, 2005; Manitoba Families, 2019).

Language matters.

When discussing the sexual exploitation of children and youth, it is important that we recognize that certain terms can reflect our compassion or our judgment of young people who have been victimized by others. The use of terms like "prostitute" or suggesting that "youth exploit themselves" in relation to children and youth who are being sexually exploited are examples of terminology that can reveal a lack of understanding of the power imbalances and dysfunction at play when adults profit (financially or by other means) from the sexual exploitation of children and youth (Office of the Children's Advocate, 2016).

¹⁷ See https://gov.mb.ca/fs/cfsmanual/1.3.5.html

Approximately 80% of SEY are exploited in an invisible manner (i.e. not on the streets) and approximately 20% are exploited in a visible manner (i.e. on the streets). However, the exploitation of children has become increasingly more internet-based, with estimates of up to 90% of exploitation occurring online, meaning only approximately 10% of sexual exploitation takes place on the streets (Berry, Runner, Hallick, Rocke & Scheirich, 2018). Online exploitation remains largely invisible. With the exception of law enforcement personnel, service providers working in the area of counter sexual exploitation, and those preying on children to sexually abuse them, the vast majority of the general population is unaware of the websites where online sexual exploitation occurs. As such, this concerning societal issue impacting children and youth often goes unrecognized and unacknowledged (Berry, Runner, Hallick, Rocke & Scheirich, 2018).

Notwithstanding the hidden nature of sexual exploitation today, service providers, persons with experiential knowledge, and experts all agree that existing estimates represent only the tip of the iceberg. Recent statistics by Manitoba's New Directions' Transition, Education and Resources for Females (TERF) Program are telling (see the boxes below). Indeed, all of the 56 SEY participants in the TERF programs for which statistics were gathered over a two year period (from January 2017 to January 2019) had one or more co-occurring challenges involving CFS, mental health and addictions, justice, and education (New Directions, *Demographic Data*, 2019).

Sexually Exploited Youth Demographics (N=56)

Age Range During Data Collection: 13 to 18 years old

Gender: 96% female | 4% LGBT2SQ+

Ethnicity: 89% Indigenous | 4% Newcomers | 7% Unknown

Age First Exploited: 53%: 12-14 years old | 32%: 15-17 years old | 11%: 9-12 years old | 4%:

Unknown

Exploited By: 34%: Friend | 20%: Family Member | 16%: Other/Unknown | 11%: Boyfriend/Girlfriend

| 11%: Sexual Offender | 5%: Drug Dealer | 3%: Gang Member

Age Majority First Ran Away: 12 years old

Ran Away 51 Times or More: 24%

Area Grew Up In: 66% urban settings | 30% both urban and rural settings | 2% rural settings | 2%

unknown

History of Sexual Abuse: 66% History of Physical Abuse: 59% Diagnosed Disabilities: 38%

Not Attending School at Point of Intake: Vast Majority

Source: Transition, Education and Resources for Females Program of New Directions, *Demographic Data*, February 2019.

Sexually Exploited Youth Involved in Provincial Systems (N=56)

Child and Family Services:

- 88% of SEY had current involvement
- 91% had past involvement
- 40% had more than 7-10 past CFS placements
- 6% had more than 51 past placements

Education

- Highest grade completed: 39% (Grade 8), 25% (Grade 9), 16% (Unknown), 7% (Grade 10),
 7% (Grade 7), 6% (Grade 6)
- There were 34 diagnosed learning disabilities among 38% of SEY

Mental Health and Addictions

- 72% had seen a mental health professional
- 57% self-harmed
- 41% attempted suicide
- 98% used drugs or alcohol
- First use of drugs or alcohol took place as early as 8 years old or younger
- The top drug of choice was cannabis, followed by alcohol and crystal methamphetamine
- 20% received treatment for substance abuse

Justice

- 30% of SEY spent time on probation
- 48% had justice related charges
- 52% spent time in youth corrections
- 18% had past gang involvement
- 22% had gang involved family members
- 55% had gang involved friends

Source: Transition, Education and Resources for Females Program of New Directions, Demographic Data, February 2019.

These alarming statistics highlight the urgent need for wraparound supports for youth in general, and SEY in particular across systems. This includes the urgent need for proactive intervention and detection of sexual exploitation.

A Missed Opportunity: the Need for Early Detection of Sexual Exploitation

FINDING: Indicators of sexual exploitation were not detected early enough for Tina to allow for proactive intervention and her protection across multiple public service systems.

As noted in the Manitoba Advocate's recent special report, *In Need of Protection: Angel's Story* (Manitoba Advocate, 2018c), it is alarming that the sexual exploitation of youth in Manitoba is being detected years after it begins, if at all. During her final years of life, Tina presented with many of the most commonly identified risk factors predictive of sexual exploitation, including intergenerational sexual exploitation within her family. Yet, our office's investigation reveals that service providers did not properly assess, respond to, or intervene through a response plan based on well-known indicators of sexual exploitation when Tina was in danger and transitioning into the sex trade, especially during the final weeks of her life (see stages of exploitation summarized in the box below).

Stages of Sexual Exploitation

At-risk: traumatic event, runaway and/or homeless, numerous child welfare placements, if family/friends involved in sex trade, abused or bullied, isolated and/or spending lots of time on the computer, family breakdown and/or instability, cognitive vulnerability, legacy of colonization for Indigenous youth and barriers they have to overcome, poverty (e.g. lack of food or place to stay).

<u>Transitioning In:</u> have all/most of the at-risk factors above, identify more with culture of sex trade/ gangs, truant from school, do not see the negatives of sex trade, increase drug/alcohol use, violence increase, using language of sex trade, decreased connection with family and mainstream friends, and begin hanging out with entrenched youth.

<u>Entrenched</u>: complete adoption of cultural components of sex trade, able to see/acknowledge the negatives of sex trade but accept them as "normal," drug/alcohol use increases to daily, everyone they socialize with is from the sex trade, complete rejection of family, level of violence increases (to them or by them) – very explosive quickly, immediate gratification of needs, connect to resources associated with sex trade, and always have money or objects they can't explain.

<u>Transitioning Away:</u> see negatives of sex trade and can start to internalize/discuss them, start to emotionally move away from the sex trade, reconnection with culture and family of origin, drug/alcohol use decreases, violence decreases, participate in programming to address their needs, and acquire money through visible and legitimate jobs (chores/work).

(Berry, Runner, Hallick, Rocke & Scheirich, 2005)

Research has identified several risk factors for sexual exploitation (Gorkoff & Runner, 2003; Berry, Runner, Hallick, Rocke & Scheirich, 2003; Coy, 2009; Twill, Green & Traylor, 2010; Lloyd, 2011; Reid, 2011; Pearce, 2011; Kubasek & Herrera, 2015; Ontario Native Women's Association, 2016). The most common indicators, in no particular order, are as follows:

- 1) Childhood sexual/physical abuse
- 2) Being female
- 3) Cognitive and/or developmental disabilities
- 4) Mental health issues
- 5) Family violence/instability
- 6) Physical health issues
- 7) Parental drug/alcohol misuse
- 8) Neglect
- 9) Difficulties in school
- 10) Parental involvement in the sex trade/intergenerational exploitation
- 11) Lack of belonging/self-esteem
- 12) Poverty
- 13) Systemic issues (being a racialized person, involvement with child welfare, being a member of a group that is over-represented in the justice system, etc.)
- 14) Substance/alcohol misuse
- 15) Chronically reported missing

In the months before her death, Tina demonstrated 14 of these risk factors. Had police and child welfare workers shared and had access to this information, they would have had what they needed to prioritize a response. At the time of Tina's death, specialized extensive training to help detect the indicators of sexual exploitation had existed in Manitoba for nine years. This training was offered to police and child welfare staff multiple times throughout the year, every year since 2005, when Tina was six years old. 18

According to senior representatives from Winnipeg Police Services (WPS), all members receive police academy and service training on missing persons and identifying children in need of protection, including sexually exploited children (Written correspondence, Winnipeg Police Services legal counsel, February 21, 2019). In light of this training all members receive, it is concerning that two Winnipeg Police Service members did not appropriately respond to a missing 15-year-old child when she was located on August 8, 2014, in a high sex trade area, with an older, intoxicated man who was not known to her, and at five in the morning. During our investigation, WPS informed us that the officers involved in this incident disregarded their training, violated WPS policies, and were subsequently disciplined for their actions. When they encountered her, the officers sent Tina on her way and allowed the man who had been

¹⁸ A core training course on understanding and working with sexually exploited youth is offered in Manitoba through New Directions for Children, Youth, Adults and Families' Transition, Education & Resources for Females (TERF) program. For more information, see http://newdirections.mb.ca/training-education-programs/terf-transitioneducation-resources-for-females/. New Directions also offers The Kappapako Miikiwaap Lodge Teachings Training Course focused on preventing the sexual exploitation of children and youth. Additional training is offered by the Winnipeg Police Service, the Canadian Centre for Child Protection, and a number of community agencies.

drinking and driving, and intending to sexually exploit Tina to sleep and sober up at the intoxicated persons detention unit for a few hours.

What is also important for Manitobans to note in the above interaction is the lens through which Tina was viewed by this adult predator. This man, as he would later testify in court, had a fight with his girlfriend and his response to that fight was to drive to Winnipeg's West End neighbourhood, a well-known site for commercial sexual exploitation, so he could buy sex from a child. This man testified in court that he was unaware of Tina's age when he picked her up. Notwithstanding this individual's claim, given Tina's very young appearance and that she weighed less than 80lbs, it is hard to believe this man was not fully aware he was sexually exploiting a child. There is an inherent and disturbing level of entitlement and abusive privilege that is revealed by a person who feels that the way to get over a fight in his personal relationship is to buy sex from a young, Indigenous girl.

The Link Between Missing Persons and Sexual Exploitation

FINDING: Manitoba has the highest prevalence rate of missing children and youth in Canada; Tina's frequent periods of going missing from home were another indicator for sexual exploitation.

As was the case for Tina, one of the most significant indicators of sexual exploitation is when a child or youth is repeatedly going missing. Further, as established by numerous reports over more than three decades, including *Our Women and Girls are Sacred* (National Inquiry, 2017), there is a link between sexual exploitation and Indigenous women and girls, in particular, who are missing and who are murdered.

In Manitoba, the designated intake agency for the Winnipeg area receives an average of 600 missing persons reports for children each month (Interview, Executive Director, Agency 4, February 25, 2019.) It is important that service providers distinguish between a child that is absent (but whose whereabouts are known) versus a child that is missing, and respond accordingly. Police and social workers need to work closely together throughout the province in urban, rural, and remote settings alike. It is important that ongoing joint collaborative responses between law enforcement and child welfare, including the CFS designated intake agency, be created based on each community's unique needs. This will allow key stakeholders to share information regarding risk factors of missing children that will inform their responses and interventions.

From November 2013, and from that point on, when Tina started going missing more frequently, Tina's grandma reported Tina missing to RCMP, who were then in contact with CFS and WPS. While established procedure would suggest WPS might have had access to important information about Tina, it is unknown

by our office what information was shared by RCMP. However, WPS responded, and transported Tina to the designated CFS intake agency for Winnipeg, per their standard procedure.

The information contained in missing persons reports are also of concern. Information in some of these missing persons reports was incorrect, and it is unclear whether the inconsistent information was a result of WPS not receiving complete information, not issuing complete information, or if the information itself was unknown at the time of the reports being made. Tina's missing persons reports, which were made by shelter staff on July 27, 2014, and again on July 31, 2014, included some information, but the reports were not a full reflection of the danger present in Tina life. For example, information that Tina was being sexually exploited by adults was absent and the July 27, 2014, report described Tina as "not high risk."

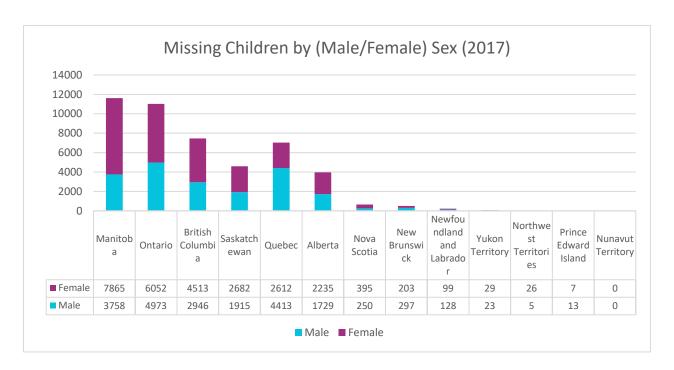
July 27, 2014 report	July 31, 2014 report
Was not high risk,	Tina was not suicidal
Was not a chronic runaway,Mostly travelled by bus and foot,	 She was known to abuse both drugs and alcohol
 Had a history of suicidal ideation and attempts, and Was known to use drugs and alcohol. 	 She was not prescribed medication and did not suffer from any medical conditions She did not have access to money She travelled by bus and foot

When we met with representatives from WPS during this investigation, they noted that information accuracy was an issue at a number of points along the case. They informed our office that they responded to the information they were being provided as it came to their attention, and that information, in retrospect, was not always complete (Interview, Winnipeg Police Services, February 27, 2019). Indeed, information sharing and information accuracy impacted responses by WPS, by shelter staff, by the CFS agency, and later by StreetReach, which did not receive the necessary information to flag Tina as being at high risk in the community until the final days of Tina's life. Overall, information sharing required improvements because when a child is at imminent risk, there should be no real or perceived barriers to exchanging full and accurate information from any organization that may be involved.

As the graph below shows, the problems are significant in Manitoba with respect to children who are missing and the dangers that exist for those children. The graph below is based on data from Canada's National Centre for Missing Persons and Unidentified Remains (2017). It reveals that:

- Manitoba had the highest number of missing children in Canada, with 11,623 children.
- 68% of missing children in Manitoba were female, with the majority thought to be runaways.

 Manitoba had the highest number of children presumed dead, with 23. Of children presumed dead, 17 (74%) were female.



In light of the fact that Manitoba has the largest number of missing children in Canada, response plans and protocols are urgently needed for missing youth at imminent risk of harm in general, and sexually exploited youth like Tina in particular. In order to provide the most effective and preventative services, these response plans need to include risk information related to each missing child.

From April 1, 2016, to March 31, 2017, StreetReach workers encountered or provided services to 321 different children and youth between the ages of 9 and 19, including 3,078 address checks for missing children and youth (Manitoba Families, 2019). The StreetReach program operates Monday to Friday and receives a list from WPS every weekday of missing youth, including those who are being sexually exploited. Designated CFS intake agencies and police need to be able to access specialized resources, during evenings and weekends, in Winnipeg and wherever needed, in rural and remote locations in order to search for missing children and youth who are in danger.

The 50 Manitoba Youth with the Highest Numbers of			
Missing Persons Reports (MPRs)			
MPR Per Youth, Per Year			
2014 # of Reports Time missing over the year			
Average MPR	32	13.55%	

Max MPR	107	107 44.96%			
	2015				
Average MPR	50	20.02%			
Max MPR	110	43.82%			
	2016				
Average MPR	46	18.51%			
Max MPR	135	53.78%			
2014-2016					
Average MPR	43	17.42%			
Max MPR	135	54.73%			

(Manitoba Families, 2019, p. 31)

Alarmingly, as the data in the table above reveals, some youth in the group of 50 that were missing most frequently were missing for over 50% of the year. Given that Manitoba has the highest numbers of children and youth who go missing, our province could aim to be a leader in best practices, ensuring highly integrated and coordinated responses between CFS, law enforcement, and the broader community. Manitoba can also look to other jurisdictions such as British Columbia and Alberta. Additionally, the Dallas model has informed the approach in Manitoba to addressing sexual exploitation. These models can continue to help our province advance and refine our approaches to ensure responses to children in need of protection are rapid and seamless.

A recent report by Manitoba Families titled, *Collaboration and Best Practices to End Human Trafficking and Sexual Exploitation in Manitoba* (2019), reveals that:

Out of 282 confirmed cases of Sexually Exploited Youth (SEY), 9,402 Missing Persons Reports (MPRs) were recorded over a three-year period. Not all of these youth were active during these specific years. Some aged out of care upon which time they were considered missing adults (even if they are on extensions of care), some youth were placed outside of Winnipeg, and some youth were residing in locations where missing person reports were not consistently being filed (p. 31).

The above referenced report released by the Manitoba government further demonstrates that there is a link between the number of placements within the child welfare system and future homelessness (Manitoba Families, 2019). Indeed, as youth who are being sexually exploited experience growing trauma and increasingly search for a sense of belonging, as was evident in Tina's case, they do not return to their placement and are, in essence, homeless. Being homeless further increases a youth's vulnerability to predators, as they may be forced into sexual exploitation in exchange for basic necessities like food and shelter.

Research in the field of maltreatment confirms that youth involved in the child welfare and justice

systems are more at-risk of sexual exploitation and highlights the need for a response that involves cross-system collaboration (Dierkhising, Geiger, Hurst, Panlilio, & Schelbe, 2015). Given Tina's absenteeism from school, her known substance misuse, homelessness when missing, risk level for sexual abuse, exploitation, and violence, Tina ought to have come to the heightened attention of the systems from which she was receiving services sooner.

High Risk Victim

A high risk victim is a child that has been assessed by the StreetReach Team as requiring an immediate response from all systems due to the likelihood that the child will be victimized through the sex trade when missing from their home/placement. Once a child has been deemed a high risk victim, there is a multisystem high risk victim Response Plan Meeting held to develop a coordinated effort to return the child to safety as quickly as possible and to assess their immediate needs. Some indicators used to assess level of risk include:

- Chronically missing
- Prior victimization
- Harmful alcohol/drug use
- Mental health issues

(Manitoba Families, unpublished a), p. 4)

Need for Increased
Collaboration and an Improved
Joint Response between Justice and Child Welfare

What is extremely concerning is that the findings in this special report about Tina Fontaine are not new in Manitoba. In 2009, shortly after the deaths of Cherisse Houle and Hillary Wilson, the Manitoba government launched the StreetReach Program, which is a collaborative, rapid response initiative between justice and child welfare to serve the needs of youth who are being sexually exploited. In 2009, data indicated that sexual offenders were sexually abusing and harming children, and at times this abuse turned lethal. The then-Minister of Family Services and Housing stated, "We are in a constant race to keep at-risk youths out of the clutches of sexual predators and street gangs" (Manitoba, 2009, para. 2). The Minister further stated that, "A critical foundation of StreetReach will be the development of protocols to create an efficient working relationship among service providers including child-welfare agencies, health-care agencies, mental-health agencies and law enforcement" (ibid., para 7). Protocols along these lines were well established in the years following. As noted, every week day, StreetReach receives a list of missing youth from WPS, including those who are being sexually exploited.

As the timeline below reveals, response by CFS and WPS were mobilized each time Tina was missing. The exception was with the WPS between August 1-6, 2014. Our investigation revealed that there were no responses from the missing persons unit of the WPS during this week while Tina was officially reported missing. What our investigation did not examine were what other priorities WPS might have had during this time.

The protocols, which had the stated objective of efficiency, were tested when Tina went missing for the final time on August 8, 2014. At that point, the evidence was clear that Tina was being exploited by adults, was experiencing severe violence, was living with an addiction, was essentially homeless, and overall was at imminent risk of harm. CFS and police were both involved over those final days before Tina's body would be found.

On August 11, 2014, WPS requested that the StreetReach manager add Tina to their priority list. The StreetReach list included children that the team would seek when missing if assessed to be high enough risk to need a specialized team of social workers, police, and community outreach representatives looking for them, coordinating resources, and returning children to safety.

	reports were also made on: November 4, 2013, A		
Date July 18, 2014	Phone contact with family members.	CFS (Agency #2)	
Missing Person Report Filed		Phone contact with family members. Submits after-hours service request.	
,	Attacase and a base a contact with CCC	Submits after-flours service request.	
July 21, 2014	Attempted phone contact with CFS		
Indu 22, 2014	agency and family members.	Dhana contact with family mambar	
July 22, 2014	Successful and attempted phone	Phone contact with family member. Phone contact with Tina.	
	contact with family members, CFS	Phone contact with Tina.	
	agency, and other relevant persons.		
July 23, 2014	Missing Person Report cancelled.	Agency attends address to search for	
		Tina. Tina attends agency office.	
July 27, 2014			
Missing Person Report Filed	81		
July 28, 2014	Phone contact with youth shelter,		
	advised Tina had returned. Missing		
	Person Report cancelled.		
July 31, 2014			
Missing Person Report Filed			
August 1, 2014		Agency attends address to search for	
		Tina. Agency attempts phone contact	
		with family members. Contact between	
		two youth shelters regarding a bed for	
		Tina. Tina attends a shelter, but does	
		not stay.	
August 2, 2014		Agency receives call from Tina.	
		Shelter bed is arranged, but Tina does	
		not attend.	
August 6, 2014		Attempted phone contact with family	
		member.	
August 7, 2014	Phone contact with staff at youth		
	shelter.		
August 8, 2014	Police have in-person contact with Tina,	Tina attends a youth shelter, and leaves	
	and she is permitted to leave. Police	shortly after. CFS agency places Tina in a	
	informed of Tina being located on Ellice	hotel following her discharge from	
		hospital.	

	Avenue, and treated by paramedics.	
	Missing Person Report cancelled.	
August 9, 2014	BOLO Issued	
Missing Person Report Filed	BOLO Issued	
	Dhana and a traith CFC and a family	Dhana and at with MADC
August 11, 2014	Phone contact with CFS agency, family	Phone contact with WPS.
	member, and paramedics.	StreetReach begins involvement.
	Received text message indicating Tina	Agency prepares media release.
	was seen on August 9 th .	
August 12, 2014	Phone contact with CFS agency.	Phone contact with family members.
	BOLO Issued	
August 13, 2014	BOLO Issued	
	Media Release Issued	
August 14, 2014	Phone contact with anonymous caller,	Phone contact with WPS, advise of
	paramedics, CFS agency, RCMP and	recent address search for Tina.
	other relevant individuals. Police attend	StreetReach team continues to gather
	an address to search for Tina. BOLO	information on Tina. CFS agency
	Issued.	prepares warrant for Tina's potential
		admission to YASU.
August 15, 2014	Received anonymous messages about	StreetReach referral forwarded to CFS
	Tina being seen on August 9 th .	agency worker. StreetReach attends
	Phone contact with youth shelter staff,	address to search for Tina. Phone
	UofW security, CFS agency supervisor,	contact with WPS and family. CFS
	and family member. Attended an	agency workers search neighbourhoods
	address to search for Tina. BOLO Issued.	for Tina.
August 16, 2014	Attended an address to search for Tina.	TOT TITIG.
August 16, 2014		
	BOLO Issued.	
August 17, 2014	Tina's body recovered.	

On average, approximately 60-70 children are on StreetReach's referral list for service. Due to the limited program resources and staff, only the highest risk children can be added to StreetReach's list of high-risk victim.

In Tina's case, missing persons reports were filed on November 4, 2013, April 25, 2014, July 10, 2014, July 18, 2014, July 27, 2014, July 31, 2014, and August 9, 2014, after she went missing on August 8, 2014, for the final time. While indicators of sexual exploitation existed, StreetReach was not contacted until August 11, 2014, when an earlier referral was warranted at the end of July.

It should be noted that there has long been a need – and calls from community based organizations and mandated agencies that specialized resources need to be accessible and active on duty 24 hours a day, seven days a week, in both rural and urban communities. Had such hours been in place on the weekend of August 9 and 10, 2014, then WPS or the CFS agency might have connected with StreetReach immediately, as soon as concerns were reported on August 8, 2014. Tina's story reveals that this immediate team intervention was needed. Indeed, children and youth need joint child welfare, justice, or specialized services at any time of day or night.

As soon as the August 11, 2014 concern from WPS was received by StreetReach, the next step in the process was for the legal guardian – in this case, Agency 3 – to complete a referral to StreetReach. Our review of CFS files indicated that while StreetReach requested a referral from the guardian agency that same day on August 11, 2014, it took four days for Agency 3 to complete the form, while Tina was known to be missing and considered to be at high risk of harm. An urgent referral to StreetReach, after the incidents from August 8, 2014, would have been helpful so that specialized resources could have been dedicated to looking for her.

When it was first developed, the StreetReach team worked in close collaboration with the WPS missing persons unit. Typically, they would work together as teams on the streets of Winnipeg, locating missing and exploited children and identifying suspected offenders. As police are able to share information with mandated CFS workers, and StreetReach was staffed with mandated CFS workers with the ability to enter a residence when there is suspected interference with a child in care (Section 52 of the CFS Act), critical safety information was shared and case plans were developed in collaboration with the child's guardian and police. The officers in the missing persons unit were assigned five high-risk children each and each child would be assigned a StreetReach worker, with the professionals spending time getting to know each child, an approach that ensured these children did not fall through the cracks of either the justice or CFS systems (Former StreetReach manager, Interview, January 25, 2019).

Cross-system collaboration and wrap-around interventions like StreetReach, which includes a community non-governmental organization component, are considered best practices to ensure that the needs of children and youth who are sexually exploited are met through programs that offer healthy supports and a sense of belonging through culturally appropriate services and interventions.

In 2016, our office released a special report that highlighted what must be done in our province to redress some of the specific ways in which Indigenous girls in our communities are targeted by predators who give them a false sense of belonging and acceptance (Office of the Children's Advocate, 2016). Community experts were interviewed and spoke about the importance of a child's sense of belonging as a hedge against those who would inflict harms on them. One interviewee in that 2016 report emphasized an important takeaway for Manitoba's Sexual Exploitation Strategy to address:

...many Indigenous girls are dealing with a loss of identity that in return results in a loss of spirit...They need to be nurtured in developing their identities and need assistance in returning to their cultural roots in order to strengthen their identities as people and protect them from exploitation (p. 37).

In 2017-2018, Manitoba Families funded 8.2 million dollars worth of prevention and intervention initiatives under *Tracia's Trust: Manitoba Sexual Exploitation Strategy* ("the Strategy"). ¹⁹ In spite of this Strategy which has existed since 2002, this report reveals considerable gaps in service and challenges for youth who are sexually exploited in Manitoba. Like Tina, hundreds of children and youth are falling through the cracks of our society's safety net, and being sexually exploited every year in Manitoba.

In 2018, the Manitoba Advocate made recommendations to improve the province's response to prevent sexual exploitation. Given the vital importance of these recommendations for children, youth, young adults, and their families in our communities who are impacted by this egregious violation of basic human rights, we are once again highlighting these recommendations:

- Expand StreetReach, the Winnipeg Outreach Network, and culturally appropriate services for youth who are sexually exploited in/from First Nations, rural and remote communities;
- Conduct an independent evaluation of Tracia's Trust: Manitoba's Sexual Exploitation Strategy;
- Pilot the Transition, Education and Resources for Females Sexual Exploitation Risk Assessment
 Tool in collaboration with the four Child and Family Services Authorities across all child and
 family services agencies in Manitoba to increase earlier detection and prevention of sexual
 exploitation.
- Update *Tracia's Trust: Manitoba's Sexual Exploitation Strategy* based on findings of the independent evaluation; and
- Carry out ongoing public education via awareness campaigns that
 - o (a) denounce the sexual exploitation of children and youth and
 - (b) raise awareness about the ongoing demand for purchasing sex and/or sexually exploiting children and youth in Manitoba (Manitoba Advocate, 2018c).

Based on our findings, it is clear that Manitoba needs a 24/7 continuum of services for sexually exploited youth that is relevant to the realities that SEY face in 2019. This includes safe and secure treatment for sexually exploited youth, like Tina, who are struggling with substance misuse in an attempt to cope with trauma and abuse. At present, the vast majority of SEY who are admitted to Project Neecheewam's Stronghearts CSU are detoxing as a result of methamphetamine consumption without medical support. Since 2011, Manitoba has seen a major increase in methamphetamine and intravenous drug use among SEY (Manitoba Families, 2019).

There remains a lack of viable 24/7 treatment options for children and youth with life-threatening addictions. As the issue of safe and secure treatment crosses many department responsibilities and requires the participation of customary care providers and legal guardians, please refer to the chapter in

¹⁹This total of 8.2 million dollars excludes initiatives by other departments and additional expenditures per child/youth billed to child maintenance by CFS agencies.

this report examining child and family services (see page 89) for the formal recommendation being made by the Manitoba Advocate on this issue.

An Examination of the Socio-Economic Implications of Sexual Exploitation.

While it may be uncomfortable to examine the issue of sexual exploitation from a socio-economic perspective, it is important for Manitobans to understand why there is such an aggressive demand by adult predators to coerce and force children and youth into commercial sexual exploitation. Law enforcement sources estimate that traffickers can profit from several hundreds to over \$1,000 daily per exploited child and an average of \$280,000 per year per sexually exploited youth (Criminal Intelligence Service Canada, 2008; Western Centre for Research & Education Learning Network, 2012).

These numbers about the socio-economic costs and demand side that is fueling the sexual exploitation of youth like Tina should be a chilling concern to the public and to government, when considering prevention strategies to reduce the numbers of children who are being forced into commercial sexual exploitation. The fiscal costs of child sexual exploitation are concerning, but more importantly are the personal costs, to the children, their families, and to all of us in society while a population of adult sexual predators are active in our communities in their abuse of children.

Evidence over the last 30 years has demonstrated the need to prevent and intervene early with respect to child sexual exploitation. The majority of scholars who have studied harm reduction have discussed this as being the most effective measure to reduce and eliminate sexual exploitation from our society. Further research has discussed children and youth who are in care of the CFS system being at a high risk for offenders to target due to not having the same familial and other protections as children and youth who reside with their families and communities.

This special report has demonstrated several instances where there was a lack of awareness and lack of early intervention and prevention efforts to protect Tina. It is clear that early intervention and prevention makes sense. The cost to fund prevention initiatives for youth who are sexually exploited are substantively less than lifetime costs associated with health care, the justice system/corrections, housing, and a broad range of other community support services.

For instance, a 2005 study analyzed the incremental fiscal costs on society's institutions over a life cycle in the event that a youth is sexually exploited in the sex trade in Manitoba. It found that, "Although for many youth, involvement in the sex trade is a temporary life experience (average 10.1 years in this study) it results in a permanent impact on government and community support services and a lifelong impact on the individuals involved" (Buckle, 2005, p. 5).

It was estimated that for each youth who becomes sexually exploited, the direct fiscal cost is \$236,195 dollars (Buckle, 2005). When looking more broadly, the estimated societal and fiscal costs total \$446,026 per child over their lifetime (Buckle, 2005). In 2016-2017, StreetReach was made aware of 321 sexually exploited youth. If we apply the \$236,195 direct fiscal estimate from 2005 to StreetReach's data (which is based in large part on Winnipeg – excluding the rest of the province), a conservative fiscal estimate of the cost of sexual exploitation to Manitoba tax payers (\$236,195 x 321 children) for 2016-2017 was \$75,818,595 million dollars. If we total the societal and fiscal costs related to the sexual exploitation of these children and youth over their lifetime, the total cost of sexual exploitation is \$143,174,346 million dollars (\$446,026 x 321 children).

In reviewing StreetReach's data for the last five years, an average of 300 different children are being exploited in Winnipeg each year. Recall that, on average, \$280,000 per year of illicit profit can be made per sexually exploited youth. Based on these figures ($300 \times $280,000$), a low estimate would mean that an average of **84 million dollars a year is flowing into the hands of human traffickers, gangs, and drug dealers as a result of the commercial sexual exploitation of children and youth**. These offenders, that are most often also involved in other types of criminal offenses have come to learn that trafficking children is a low-risk, high-profit offense for which arrests are not common.

Early prevention, detection, and intervention are critical. Reactive policies are not fiscally responsible, nor humanly responsible to children and their families. What is also not fiscally responsible is neglecting to provide these children with adequate resources to prevent the continued trauma and abuse they are experiencing, particularly when they are missing.

As this special report about Tina reveals, it is urgent that our province act immediately to:

- prevent and detect sexual exploitation earlier, as per evidence-informed best practices and indicators that were missed in Tina's case in spite of training received by police and service providers;
- respond more quickly and effectively when sexually exploited youth like Tina are missing and in situations that pose a high probability of harm;
- improve the existing child welfare and law enforcement joint response; and
- curb the persistent demand by adults for sex with kids, the socio-economic impacts of sexual abuse, and profits made by organized crime networks from the avails of sexual exploitation.

RECOMMENDATION FIVE: The Manitoba Advocate for Children and Youth recommends that Manitoba Families, in consultation with other government departments and relevant stakeholders, create a new protocol to ensure that response

plans are created for missing youth in general, and sexually exploited youth in particular who are at risk of imminent harm.

Details:

- Manitoba Families to ensure that this protocol:
 - Distinguishes between absent and missing youth.
 - Require that plans are initiated the first time a child goes missing, and that there is a further requirement to ensure the response plan is consistently reflective of the harm and dangers that are present in the individual child's life.
 - Provide timelines for when service providers must report missing children and act to locate them as quickly as possible, including when their whereabouts are known, when and how to report their absence to police.
 - Include clear components for response plans and include any known addresses where the youth may be located or is know to frequent.
 - Include 24/7 provisions for a joint child welfare and justice response in Winnipeg and ongoing capacity for a joint child welfare and justice response for missing and sexually exploited youth in rural areas.
 - Includes consultation with persons with lived experience, community members, and relevant stakeholders.

A Note about Recommendations

With the proclamation of the Advocate's new mandate provided by *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 and family services, 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.

APPENDIX A - FINDINGS AND RECOMMENDATIONS SUMMARY

	FINDINGS		RECOMMENDATIONS		
	Education Education				
1.	After her father's death by homicide, Tina's absenteeism increased significantly. However, there were no documented responses by the school to address her chronic absenteeism or a coordinated plan to address her escalating behaviours. Following a suspension in April of 2014, Tina did not return to school.	1.	The Manitoba Advocate for Children and Youth recommends that Manitoba Education and Training ensure its recently established <i>Commission on Kindergarten to Grade 12 Education</i> review the measurement of and response to absenteeism across Manitoba. It is further recommended that the Commission review the use of out-of-school suspensions and expulsions, with the goal of developing 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 practices that are in line with the best interests of the child and respect the right to education for children and youth.		
	Mental I	leal	th		
3.	The death of Tina's father was a profoundly traumatic event that occurred at an especially vulnerable stage in her development, Tina's transition from childhood to adolescence. Timely, easily-accessible, and culturally-safe bereavement services and grief counselling ought to have been made available to Tina and her family. Mental health counselling supports were recommended several times for Tina, but were never provided.	2.	The Manitoba Advocate for Children and Youth recommends that Manitoba Health, Seniors and Active Living expedite the public release of a clear implementation plan to address the child and youth-specific recommendations contained in the report on Improving Access and Coordination of Mental Health and Addiction Services: A Provincial Strategy for all Manitobans ("Virgo Report").		
	Victim Se	ervic	es		
4.	Tina was not invited to participate directly in the process of accessing	3.	The Manitoba Advocate for Children and Youth recommends that		
5.	victim services; these decisions were deferred to adults in her life. Following the death of Tina's father, victim services did not provide Tina the counselling to which she was entitled. Had the process been streamlined and the quality of services consistent, Tina might have been able to access timely compensation benefits, primarily in the form of counselling.		Manitoba Justice evaluate the continuum of victim support services for children, and develop quality control measures to ensure that services are child-centred and provided in a timely manner.		
	Child and Fam	ily S	Services		
 7. 8. 9. 	Starting in Tina's early years, child and family services did not reflect a commitment to preserving, supporting, and protecting Tina's family unit, in accordance with the Declaration of Principles within <i>The Child and Family Services Act</i> . Instead, Tina's family experienced multiple fractures to its structure while receiving child and family services. Legal guardianship is often recognized, practiced, and understood differently by mainstream government systems and Indigenous communities. In Tina's case, government service providers and some child and family service agencies did not acknowledge customary practices as legitimate. This contributed to service delivery confusion for Tina and her family. In her final months of life, and with multiple child and family service agencies involved, Tina did not receive the child and family service interventions and resources she required to support her through her addictions and to protect her from the adults who were exploiting her. Manitoba continues to lack safe and secure placement resources for children who are at risk of imminent harm or death.	4.	The Manitoba Advocate for Children and Youth recommends that the Manitoba government, through its Deputy Ministers of Health and Social Policy and Priorities (DMHSPP) committee, work with the government's Legislation and Strategic Policy Branch to analyse the province of Alberta's <i>Protection of Sexually Exploited Children Act</i> and Alberta's <i>Drug-Endangered Children Act</i> to determine how safe and secure treatment facilities can be introduced in Manitoba. It is further recommended that the DMHSPP committee develop a plan to ensure the continuum of services for children and youth includes safe, secure, home-like settings for treatment and programming when children and youth are at imminent risk of harm or death.		
	Sexual Exp	loita	ation		
10.	Indicators of sexual exploitation were not detected early enough for Tina to allow for proactive intervention and her protection across multiple public service systems. Manitoba has the highest prevalence rate of missing children and youth in Canada. Tina's frequent periods of going missing from home were another indicator for sexual exploitation.	5.	The Manitoba Advocate for Children and Youth recommends that Manitoba Families, in consultation with other government departments and relevant stakeholders, create a new protocol to ensure that response plans are created for missing youth in general, and sexually exploited youth in particular who are at risk of imminent harm.		

APPENDIX B - 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 C - REFERENCES

Primary Sources

Child Welfare Files Reviewed

Agency 1 (Historical CFS agency of record)

Tina's father	Protection file
Tina's mother	Child in care file
	Protection file
Tina Fontaine	Child in care file

Agency 2

Tina's father	Protection file *Tina's father Fontaine's protection file was requested for review, however, Agency 2 was unable to locate the file.
Tina Fontaine	Child in care file

Agency 3

Tina Fontaine	Child in care file
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Agency 5

Tina's grandma	Voluntary Family Services file
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Other

Tina Fontaine	Short-term addiction detox centre Youth Shelter 1
	Youth Shelter 2
	Southern First Nations Network of Care Child and Family Services Authority StreetReach Program
	Child and Family Services Application

Education Files Reviewed

Tina Fontaine	School division cumulative record
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Victim services Files Reviewed

Tina Fontaine	Tina Fontaine victim services record
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Interviews (One or more interviews with the following):

- Executive director, Youth shelter
- Chief and Council Sagkeeng First Nation
- Tina's grandma and grandpa
- School principal and school social worker
- Agency 1

- Agency 2
- Agency 3
- Agency 4
- Agency 5
- Former manager, StreetReach
- Winnipeg Police Services
- Family members/cousins

Other Sources of Information

Tina Fontaine	Office of the Chief Medical Examiner – Autopsy and report of the medical
	examiner
	Former Manager - StreetReach
	Health Sciences Centre – Medical Records
	Royal Canadian Mounted Police
	Sagkeeng Chief and Council
	Winnipeg Police Services

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