Q1999-90

Ontario

Ministry of the Solicitor General / Ministère du Solliciteur général

Office of the Chief Coroner / Bureau du coroner en chef

Verdict of Coroner's Jury/ Verdict du jury du coroner

We / Nous soussignés

of / de Kingfisher Lake, ON

of / de City of Thunder Bay, ON

of / de City of Thunder Bay, ON

of / de City of Thunder Bay, ON

of / de City of Thunder Bay, ON

the jury serving on the inquest into the death of / dûment assermentés, formant le jury dans l'enquête sure le décès de:

Surname / Nom de famile: SAKANEE

Given names / Prénom: Selena

Aged / âgé(e) de: 15

held at / qui a été menée à: *the Ontario Government Bldg – 189 Red River Rd., Thunder Bay, Ontario P7B 6G9*

on the / le: Nov 29th to Dec 10

day(s) of / (du/au): November/December

by / par: Dr. Dr. David A. Legge, Coroner for Ontario / coroner pour l'Ontario.

having been duly sworn, have inquired into and determined the following:/ avons enquêté at avons déterminé ce qui suit:

1. Name of deceased / Nom du (de la) défunt(e): Selena Sakanee

2. Date and time of death / Date et heure du décès: November 23, 1997

3. Place of Death / Lieu de décès: Neskantaga First Nations

4. Cause of death / Cause du décès: Asphyxia Due to Hanging

5. By what means / Circonstances entourant le décès: Suicide

The verdict was received on the / Ce verdict a été reçu par moi le 9th day of December, 1999.

Dr. D. A. Legge
Original signed by Coroner

Recommendations (to be numbered sequentially e.g. 1,2,3,4...):

1. We recognize the final report of the Nishnawbe-Aski Nation Youth Forum on suicide and endorse its recommendations.
2. Each community should be involved in workshops or training sessions about the issues and effects of suicide, sexual assault, substance abuse and parenting.
3. Suicide prevention Programs should be implemented in every community. Every member should be involved including professionals, Chief and Council, Elders, parents, children and youth.
4. Mandatory life skills should be taught in the schools for suicide prevention.
5. Parenting skills should be promoted in the community and this should include proper child care, healthy eating and family activites.(activities)
6. Communities with low suicide rates should be consulted as to the reasons for their apparent success
7. Traditional activities should be revived, perserved (preserved) and taught to youth.
8. The recreational needs of each community should be reviewed to ensure that their are sufficient and appropriate facilities and programs for all members of the community, youth, teens and adults.
9. A suicide plan should be developed by each community to respond to a traumatic event. Such plans should include consideration of: Crisis Teams which are created as soon as possible and take into account the following principles: screening of membership to exclude youth and other vulnerable members; briefing prior to and debriefing the following attendance at any crisis intervention situation; continuity of membership.
   Advance response to suicide including what the community will do to avoid glorification of the act and cluster suicide attempts by others. Development of the plan by Band Council, elders, youth, health workers and clergy.
10. locally co-ordinated (coordinated) community service committees should be established in each community and these committees should be comprised of all local service workers including doctors, nurses, police, teachers, Spiritual advisers, NNADAP workers, band family service workers, family counsellors (counselors), community legal workers and probation officers. The responsibility for establishing these committees and their regular meetings should be placed upon the social services or resource co-ordinator (coordinator).
11. The community service providers should develop policies and procedures that govern all aspects of service delivery, including a confidentiality protocol for the sharing of information about their clients.
12. Healing circles and where possible, justice circles should be utilized as a means of resolving community and family problems
13. Each community should actively engage in the orientation of service provides new to their community. Service providers such as doctors, nurses, police, social workers and teachers.
14. Communities should ensure that local service providers such as band family service workers, mental health workers, NNADAP and police officials are qualified, supervised and meet minimum standards where such standards are established.
15. Police agencies that provide services to First Nations Communities must have sufficient staff who are adequately trained to deal with the investigation of sexual assault complaints including culturally appropriate and sensitive follow-up interviews with victims. The services of a trained and qualified female police officer should be offered and made available to female complainants.
16. Police officers dealing with First Nations communities should receive cross-cultural training.

17. Service providers such as doctors, nurses, teachers and social workers should receive cross-cultural training.
18. All cross-cultural training should include a cultural orientation (orientation) to specific communities as well as training on the appropriate use of translators.
19. Each agency should ensure the orientation (orientation) of new service providers to a community including a personal review of client files to ensure continuity of service from one worker to another.
20. Each agency working in First Nations communities should co-operate and ensure that there is adequate and proper communication among all agencies providing services to the individual First Nation communities. The role of each agency should be defined to ensure that there is an understanding of the role of each agency by all other agencies working within a community.
21. The present interagency protocol entitled Sioux Lookout Sexual Assault Response Protocol should be adapted to include persons under the age of sixteen, an outline of each agency's services and a description of how they interact.
22. A protocol similar in nature to the revised Sioux Lookout Sexual Assault Response Protocol, should be developed for use in First Nations Communities.
23. Service providers such as doctors, nurses, mental health workers, social workers and family counsellors (counselors) should develop a protocol on how to deal with a "no-show" patient who needs follow-up.
24. Tikinagan Child and Family Services should establish an internal communications strategy which will provide fail safe communications. This should be completed within 12 months.
25. The Governments of Canada, Ontario and Nishnawbe-Aski Nation should develop, adopt and implement a comprehensive Aboriginal mental health policy.
26. The Governments of Canada, Ontario and Nishnawbe-Aski Nation should develop, adopt and implement a comprehensive Aboriginal child welfare policy that includes a child welfare model that respects the unique needs of Aboriginal children of Northern Ontario.
27. The Ontario Child Welfare Risk Assessment should be modified to recognize suicide and substance abuse as risk factors in child protection.
28. The Ministry of Community and Social Services should establish minimum standards, training and/or qualification for band family service workers.
29. The Ministry of Community and Social Services, together with Tikinagan, should review and revise the child welfare training system in order to include extensive training for all child protection workers in areas of youth suicide, suicide risk assessment and response strategies.
30. The Ministry of Community and Social Services should ensure that there is an adequate level of funding to Tikinagan Child and Family Services to enable Tikinagan to provide child protection services at the level of Ontario standards recognizing travel time, social conditions and other extreme difficulties that Tikinagan workers face in carrying out their child protection duties.
31. The Ministry of the Attorney General (Ontario) should expand the Victim/Witness Assistance program to ensure adequate staffing to service victim/witness needs in all cases of alleged sexual assault and child abuse in remote First Nation communities.
32. The Governments of Canada and Ontario should establish more treatment facilities/programs to deal with the issues of drug, alcohol and substance abuse, sexual abuse and suicide in remote First Nation Communities.
33. The Government of Canada should provide adequate funding for recreational facilities and programming in remote First Nation communities.

34. Health Canada should provide enhanced professional mental health services and referrals both at and from Sioux Lookout Zone Hospital. Those services should include psychiatrists and paediatric psychiatrists.
35. The Governments of Canada and Ontario should encourage and provide financial support for NAN suicide prevention conferences such as one being held in Thunder Bay, Ontario from January 25-27, 2000.
36. The Governments of Canada and Ontario should fund the expansion of educational opportunities for First Nation students to participate in social work and health care programs through post-secondary institutions such as Confederation College and Lakehead University.
37. The Governments of Canada and Ontario should fund the establishment of a Centre of Excellence for the study of all aspects of suicide in Aboriginal communities.
38. The Government of Canada and Ontario should address the poverty issues that exist within First Nation communities such as inadequate housing and unemployment.
39. The government of Canada and Ontario should consult with First Nations Communities and their Service Providers to assess their needs, before adopting new Policies/programs or making changes to existing Policies and programs.
40. Community Members should take steps to provide its members with a copy of these recommendations. This would provide everyone with an opportunity to consider and help in the implementation of these recommendations.
41. The governments of Canada and Ontario should recognize that the Nishnawbe-Aski Nation 9Nan0 suicide epidemic a social crisis of immense proportions. This sad and tragic phenomenon has affected every family and community in NAN and should be addressed.

Ontario

Ministry of the Solicitor General and Correctional Services | Ministère du Solliciteur général et des Services correctionnels | Box 4500, 4th Floor / C.P. 4500, 4e étage 189 Red River Road Thunder Bay, Ontario, P7B 6G9

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December 10, 1999

Dr. Bonita Porter
Deputy Chief Coroner for Inquests
Office of the Chief Coroner
26 Grenville St
Toronto, ON
M7A 2G9

Verdict Explanation: Selena Sakanee Inquest

Ontario Government Building
189 Red River Rd
Thunder Bay, ON
November 29 to December 9, 1999

Dear Dr. Porter:

I intend to give a brief synopsis of the issues presented and explain in some detail the reasons for the jury's recommendations. This explanation will be my interpretation of the evidence and the jury's reasons. The sole purpose of the explanation is to assist the potential reader to understand more fully the verdict and the recommendations. The reader should not consider the contents of this explanation as the actual evidence presented at the inquest, nor do I intend to replace the jury's verdict.

Present:

Coroner's Counsel	Mr. Dan Mitchell, Sr. Crown Attorney, Thunder Bay
Investigating Officer	D/C Brian Peltonen, Thunder Bay City Police
Coroner's Constable	Sgt. Lionel Haigh, Thunder Bay City Police
Court Reporter	Mrs. Leslie James, 807-683-6526

Persons with Standing:

Mr. Peter Mrowiec	counsel for Family
Ms. Catherine Beamish	counsel for Tikanagan Child and Family Services
Mr. Keith Jobbit	counsel for Neskantaga First Nation

The Verdict:

The jury heard testimony for 8 days from 17 witnesses and were shown 25 exhibits. Deliberation required one full day.
They determined:

1) Name of deceased: Selena Sakanee
2) Date and time of death: November 23, 1997, time undetermined
3) Place of death: Neskantaga FN
4) Cause of death: Asphyxia due to hanging
5) By what means: Suicide

Summary of Circumstances

Selena Wendy Sakanee was born May 13, 1982. The family history was notable for many deaths related to trauma, violence and suicide. Her natural father died when she was 6 months old in a house fire.

She began sniffing gas at age 10 and the family's dealings with the native CAS for this area (Tikanagan Child and Family Services) began in 1992 when a Temporary Care Agreement was made when family problems came to their attention.

By February 1994, Selena was experiencing nightmares at her aunt's residence, where she was placed after a non-fatal shooting incident involving the family. By November 1995, Selena was drinking, abusing solvents, and talking of suicide. Preparations were made by Tikanagan for placement at a treatment centre in Winnipeg, but this never took place.

On March 24, 1997, Selena was allegedly raped at a local residence. No charges were ever laid by Nishnawbe-Aski Police Service (NAPS) who did the community (Neskantaga) policing , or O.P.P. who were overseers. Selena had refused to be interviewed by same for a variety of reasons explored at the inquest. The alleged perpetrator remained free in the small community and no doubt had interactions with Selena. She did consent to fly to Sioux Lookout, where she was medically examined, on March 26, 1997. Further attempts by the physician, the O.P.P. sexual assault team leader, nurses and Tikanagan failed to get her to disclose. The sexual assault examination was negative despite physical evidence of a sexual assault.

Selena's personal file with Tikanagan was closed April 8, 1997.

A May 8, 1997 meeting at Neskanataga was convened as Selena was in crisis with drinking and suicidal thinking. Her mother said she was out of control. The Band Family Social Worker claimed he faxed an urgent referral to Tikanagan, but this was lost to follow-up.

In early November, Selena accompanied a volunteer "crisis team" to the neighbouring Webique FN to support the family of a popular 15 year old girl who had committed suicide.

It was only days after returning from that trip that her drinking accelerated and she was found hanging in her bedroom at 0400 hr November 23rd. An empty hairspray bottle was found at the site. There were numerous writings (by herself) on the back of her door in magic marker dating back a few weeks likely. The messages were stark indications of her severe distress, anger and frustration with life.

Subsequent post-mortem confirmed asphyxiation by hanging. Serum/ urine alcohol was 153 mg%/ 217 mg%.

This tragedy was felt to be a very good example of the many problems facing FN youth, the difficulties in service provision by multiple agencies in the north for these issues, and in the big picture the systemic ills of all First Nation society. In particular, the ongoing suicide epidemic in FN youth had not yet been specifically addressed in a coroner's inquest. Sections 20 (b) and (c) were invoked and supported even earlier by a Band Council Resolution to request an inquest by the Chief and Band Council of Neskantaga FN.

Please refer to commentary on the Recommendations to review the main issues explored. They were many.

Explanation of Recommendations:

GENERAL (to all parties and government ministries)

1) We recognize the final report of the Nishnawbe-Aski Nation (NAN) Youth Forum on Suicide and endorse its recommendations.

Coroner's Comments:
This 381 page document, entitled Horizons of Hope: An Empowering Journey, is a distillation of the wisdom of 12 Youth and 5 Adult Commissioners who travelled to selected FN communities in 1994 to get a handle on the youth suicide epidemic. The initiatives and recommendations have been well received in the entire NAN. The jury wish to endorse it as a centerpiece program throughout the area. It symbolizes the importance of FN Youth taking responsibilty for Youth Suicide counselling.

Recommendations for Communities

2) Each community should be involved in Workshops or training sessions about the issues and effects of suicide, sexual assault, substance abuse and parenting.

The jury heard that all of these issues contributed to Selena's death and that training was unavailable at the community level. Support workers had received (minimal) workshop training off the reserve, with no follow-up sessions.

3) Suicide prevention programs should be implemented in every community. Every member should be involved including: professionals, Chief and Council, Elders, parents, children and Youth.

Self-explanatory. Evidence confirmed that despite the suicide epidemic existing for decades, there was no formal prevention programme in Neskantaga, or any other NAN territory reserve. The jury wished to ensure that all segments of the community be involved along with the professionals.

4) Mandatory life skills should be taught in the schools for suicide prevention.

Self-explanatory. Many witnesses, including two expert physicians in FN health care, stressed the need for introducing the topic early on at school.

5) Parenting skills should be promoted in the community and this should include proper child care, healthy eating and family activities.

Self explanatory. There was copious evidence from community workers and others of a general lack of all of the above.

6) Communities with low suicide rates should be consulted as to the reasons for their apparent success.

Neskantaga has a lengthy history of high incident suicide rates, trauma and violence due to a host of factors. It was pointed out that there are some communities, with similar demographics, isolation, and poverty, that have been considerably more successful in guiding their Youth into adulthood with higher hopes, morale and less suicidality. However, to date, the latter have not been asked to help with their more troubled sister communities. This could be done at minimal expense.

7) Traditional activities should be revived, preserved and taught to youth.

Self-explanatory. A Neskantaga elder testified how he took it upon himself to take ten boys on a canoe trip for two weeks. The experience effected a remarkable positive change in the boy's outlook toward life, albeit short-lived. Apparently at the beginning they displayed minimal skills, even for example not knowing how to carry a canoe. The problem is that such opportunities appear to be rare at Neskantaga.

8) The recreational needs of each community should be reviewed to ensure that there are sufficient and appropriate facilities and programs for all members of the community, youth, teens and adults.

Self-explanatory. See (7). Boredom is a major factor in the remote communities. Most communities have for example a hockey rink, but there is no money for decent equipment, and there are few if any older youth or adults to ""coach" or organize teams, tournaments etc.

9) A suicide plan should be developed by each community to respond to a traumatic event. Such plans should include consideration of: Crisis teams which are created as soon as possible and take into account the following principles: screening of membership to exclude youth and other vulnerable members; briefing prior to and debriefing following attendance at any crisis intervention situation; continuity of membership.
Advance response to suicide including what the community will do to avoid glorification of the act and cluster suicide attempts by others.
Development of the plan by Band Council, elders, youth, health workers and clergy.

Evidence was heard that Selena accompanied a group of youth to Webique, a neighbouring community to support family and community after the death of a 15 year old girl by hanging. She apparently had no briefing or debriefing, and expert witnesses felt strongly this was an ill advised maneuvre contributing to Selena's own hanging less than a week later. It seemed that much work was required to develop these crisis response teams, and to have input from mature adults. There was testimony regarding cluster or copy cat hangings, which are not unusual in this area. Research is required here and most witnesses with experience supported the concept that suicides should be considered as socially wrong and unacceptable.

10) Locally co-ordinated community service committees should be established in each community and these committees should be comprised of all local service workers including doctors, nurses, police, teachers, spiritual advisers, NNADAP (alcohol abuse) workers, band family service workers, family counsellors, community legal workers, and probation officers. The responsibility for establishing these committees and their regular meetings should be placed upon the social services or resource co-ordinator.

Self-explanatory. At present evidence suggested there is minimal co-ordination of any of these groups.

11) The community service providers should develop policies and procedures that govern all aspects of service delivery, including a confidentiality protocol for the sharing of information about their clients.

This case raised the difficult issue of preserving confidentiality in a small community where personal events cannot by human nature be kept secret for long. Selena apparently found it unacceptable to confide in any authorized service provider after the alleged sexual assault.

12) Healing circles and, where possible, justice circles should be utilized as a means of resolving community and family problems.

These well known FN concepts were mentioned generally at this inquest by witnesses without full discussion of applicability to this particular case, although it was inferred that because the alleged perpetrator remained at large within the community and in possible contact at times with Selena, there was a feeling of failed justice.

13) Each community should actively engage in the orientation of service providers new to their community. (Service providers such as doctors, nurses, police, social workers and teachers)

The jury heard the common theme of frequent turn-over of virtually all of the mentioned providers, often related to burn-out. At present there is little if any attempt to introduce new people coming in, so that communication and continuity are diminished. One physician arrived by plane, meeting another whom he expected to be working with, only to be told, sorry, I'm leaving.

14) Communities should ensure that local service providers such as band family service workers (BFSWs), mental health workers, NNADAP and police officials are qualified, supervised and meet minimum standards where such standards are established.

Evidence revealed a lack of standardization of training for the above providers with perhaps the exception of the NAPS police who do receive training along with OPP recruits. However, the Band "constable" employed by the Band at Neskantaga had no minimum standard of training.

Recommendations for Agencies

15) Police agencies that provide services to FN communities must have sufficient staff who are adequately trained to deal with the investigation of sexual assault complaints including culturally appropriate and sensitive follow-up interviews with victims. The services of a trained and qualified female police officer should be offered and made available to female complainants.

OPP witnesses indicated the caseload for SA (Sexual Assault) investigations is probably beyond their capacity to respond to follow-ups at a desirable level. Such may have been the case with Selena. Of course there were delays in this investigation because of her reluctance to disclose information. The initial response was to lay off and ask again in a month. The local NAPS officer, though well intentioned, was inhibited by local factors, including concerns for confidentiality. There was conflicting opinion evidence on the advisability of having male vs female police officers investigating SA cases. The expert physicians and professional counsellors felt that female officers were preferable, and the jury agreed.

16) Police officers dealing with FN communities should receive cross-cultural training.

Self-explanatory. OPP officers overseeing NAP are generally non-aboriginal.

17) Service providers such as doctors, nurses, teachers and social workers should receive cross-cultural training.

Self-explanatory

18) All cross-cultural training should include a cultural orientation to specific communities as well as training on the appropriate use of translators.

Self-explanatory. One medical expert (a psychiatrist who deals with FN populations), emphasized the usefulness of developing a "dedicated" translator in any given community to whom the provider can relate to the client in a cross-culturally sensitive way.

19) Each agency should ensure the orientation of new service providers to a community including a personal review of client files to ensure continuity of service from one worker to another.

Self-explanatory. There was evidence for example of discontinuity in the Tikanagan file for the Sakanee family both in the community and back at the CAS office in Sioux Lookout when providers were turning over positions.

20) Each agency working in FN communities should co-operate and ensure that there is adequate and proper communication among all agencies providing services to the individual FN communities. The role of each agency should be defined to ensure that there is an understanding of the role of each agency by all other agencies working within a community.

Self-explanatory. There was heresay evidence that many providers were not necessarily aware of what others were doing for a specific client. For example nurses and visiting MDs wouldn't be aware of the activities of the BFSW.

21) The present interagency protocol entitled Sioux Lookout Sexual Assault Protocol should be adapted to include persons under the age of sixteen, an outline of each agency's services and a description of how they interact.

This protocol was submitted by a physician witness from the Zone Hospital in Sioux Lookout. It lists all the interested agencies interested in the management of SA victims over the age of 16 years. This could be adapted for under age 16 clients. Also, to become a true protocol, it needs in addition to a statement of each agency's resources , some form of algorithm on how to interact or proceed with a given client presentation. This apparently is a work in evolution.

22) A protocol similar in nature to the revised Sioux Lookout Sexual Assault Protocol, should be developed for use in FN communities.

Self-explanatory.

23) Service providers such as doctors, nurses, mental health workers, social workers and family counsellors should develop a protocol on how to deal with a "no-show" patient who needs follow-up.

The jury heard of Selena's "no-show" appointments at the nursing station after her sexual assault. These were vital to maintain contact for both medical and mental health follow-ups. The lack of pursuit by health care providers may be attributable in part in such cases to a rationalization that the provider is hereby absolved of responsibility—i.e. it's his/her problem, not mine. This view was presented by a medical expert in FN health and demonstrates some of the lack of full understanding of the underlying causes for no-shows particularly in cross-cultural relationships. The recommendation is addressing this in asking for a protocol to ensure follow-ups in critical cases are not missed.

24) Tikanagan Child and Family Services should establish an internal communications strategy which will provide fail safe communications. This should be completed within 12 months.

There was evidence of a breakdown in communications mainly through "Intake" in dealing with the events following the alleged sexual assault. A critical referral from the community BFSW on May 8th, 1997 was never picked up, at a time when Selena was in crisis.

Recommendations for Governments

25) The governments of Canada, Ontario and Nishnawbe-Aski Nation should develop, adopt and implement a comprehensive Aboriginal mental health policy.

The Deputy Grand Chief for NAN testified how he had developed a major proposal on FN suicide prevention, and went to Ottawa with it. He was told the federal government did not have a mental health policy because that was under provincial jurisdiction. He then went to Toronto and was told that Ontario did have a mental health policy that consists of many elements, except for status Indians living on reserve who are exclusively under the jurisdiction of the federal government. Though the latter has contributed significant monies to some new programs, there still remains the lack of a government mental health policy specifically for reserves.. Apparently NAN is going ahead with their own mental health policy.

26) The Governments of Canada, Ontario and NAN should develop, adopt and implement a comprehensive Aboriginal child welfare policy that includes a child welfare model that respects the unique needs of Aboriginal children of Northern Ontario.

There was a strong message given by several witnesses suggesting that elements of the new and revised standards in Bill 6, particularly relating to Risk Assessment of Children, are innappropriate for FN communities. Indeed there is a tension now existing between aboriginal child protection agencies and the mainstream CAS elsewhere in Ontario on this issue. Suicidality apparently is not mentioned at all in the lengthy Risk Assessment questionnaire.
The jury is asking for a modified child welfare policy to account for a variety of cultural differences such as the above mentioned.

27) The Ontario Child Welfare Risk Assessment should be modified to recognize suicide and substance abuse as risk factors in child protection.

See (26) above.

28) The Ministry of Community and Social Services should establish minimum standards, training, and/or qualifications for family service workers.

Evidence from different family service workers dealing with FN communities suggested a considerable spectrum of skills. Most learned on the job without any formal training other than occasional workshops.

29) The Ministry of Community and Social Services, together with Tikanagan, should review and revise the child welfare training system in order to include extensive training for all child protection workers in areas of suicide, suicide risk assessment and response strategies.

This recommendation is an extension of (28). It appears large in scope, but much of the evidence pointed to a dire need for extensive training in this area.

30) The Ministry of Community and Social Services should ensure that there is an adequate level of funding to Tikanagan C and FS to enable Tikanagan to provide child protection services at the level of Ontario standards, recognizing travel time, social conditions and other extreme difficulties that Tikanagan workers face in carrying out their child protection duties.

Tikanagan witnesses testified to approximately 200 cases per year of active child abuse investigations. They have by far the largest catchment area in Ontario. Travel time constitutes 60 to 80 percent of their time alone, before even seeing their clients. Vacancies for personnel are constant, recruits are usually from outside the area. Burn-out is the norm. Witnesses testified that Tikanagan is significantly underfunded.

31) The Ministry of the Attorney General (Ont) should expand its Victim/Witness Assistance Program to ensure adequate staffing to service victim/witness needs in all cases of alleged sexual assault and child abuse in remote FN communities.

Self explanatory. However there was only indirect evidence/discussion on this area.

32) The Governments of Canada and Ontario should establish more treatment facilities/programs to deal with the issues of drug, alcohol and substance abuse, sexual abuse and suicide in remote FN communities.

Self-explanatory

33) The Government of Canada should provide adequate funding for recreational facilities and programming in remote FN communities.

Self explanatory and discussed under (7) and (8).

34) Health Canada should provide enhanced professional mental health services and referrals both at and from Sioux Lookout Zone Hospital. These services should include psychiatrists and paediatric psychiatrists.

Evidence revealed that psychiatrists have come in as consultants over the years, especially under the tripartite program involving Medical Services Branch of HC, Hospital for Sick Children and the University of Toronto. However the current need is greater than ever. There are only a few psychiatrists in all of the area who will take outside referrals. The need is desperate.

35) The Governments of Canada and Ontario should encourage and provide financial support for NAN suicide prevention conferences such as one being held in Thunder Bay, Ont from January 25-27, 2000.

Evidence was clear that people are hungry for major educational opportunities.

36) The Governments of Canada and Ontario should fund the expansion of educational opportunities for FN students to participate in social work and health care programs through post-secondary institutions such as Confederation College and Lakehead University.

There have been only a very few workers in the area with post-secondary degrees or diplomas in social work. More are obviously recommended. The above schools have good programs that should be expanded—is the thinking of the jury.

37) The Governments of Canada and Ontario should fund the establishment of a Centre of Excellence for the study of all aspects of suicide in Aboriginal Communities.

This concept was advanced by several witnesses, including medical expert witnesses as a unique response to this unique inquest.

38) The Governments of Canada and Ontario should address the poverty issues that exist within FN communities such as inadequate housing and unemployment

Self-explanatory underlying causes of the suicide problem.

39) The Governments of Canada and Ontario should consult with the FN communities and their service providers to assess their needs before adopting new Policies/Programs or making changes to existing Policies or Programs.

The jury I believe is trying to remind government to ensure that FN are part of the consultative and decision making process.

Miscellaneous Recommendations

40) Community Members should take steps to provide its members with a copy of these recommendations. This would provide everyone with an opportunity to consider and help in the implementation of these recommendations.

Several witnesses expressed concern that the Recommendations would not be disseminated to the communities themselves. The coroner reassured them that access was possible and explained how.

41) The Governments of Canada and Ontario should recognize the Nishnawbe-Aski Nation suicide epidemic a social crisis of immense proportions. This sad and tragic phenomenon has affected every family and community in NAN and should be addressed.

There was plenty of evidence throughout the inquest to support the above. The jury wished to emphasize this as their final recommendation.

In closing, I would like to stress once again that I prepared this document solely to assist interested parties to understand the jury's verdict. It is not the verdict. Likewise, my comments about the evidence are my personal recollections and are not put forth as the actual evidence. If anyone feels that I have made a gross error in my recollection or in a conclusion drawn by the jury I would appreciate it greatly if my error could be brought to my attention and I will correct it.

D. A. Legge MD CCFP FCFP BSc(Med)
Regional Coroner, Northwestern

Note re: Recommendation 40:

The contact organization for dissemination of the verdict would be:

Nishnawbe-Aski Legal Services Corporation
The Fort William Indian Reserve
R.R. 4 Mission Rd
Thunder Bay, ON
P7C 4Z2

Attn: Ms.Sandra Bair-legal counsel