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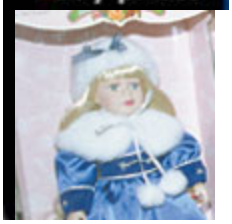

Grey report released

More stringent group home rules urged

By Doug Brown

Herald-Tribune staff

More stringent enforcement of group home rules and a policy of immediately reporting runaways to police may have kept a 16-year-old in government care from freezing to death in a drunken stupor, said a provincial court judge.

Judge Allen Lefever's final report from the inquiry into the death of Aaron Albert Grey, including four recommended changes to Alberta Children's Services policy, was released today.

In it, Lefever said Mounties should have been told immediately when Grey failed to return to his group home at 4 p.m. after leaving that morning to go job hunting.

Instead, the group home supervisor was told about Grey's absence at 9 p.m., and police weren't called until just after 10 p.m. It wasn't until after midnight that staff faxed a physical description of Grey to the RCMP.

"While we will never know with any certainty, had the home alerted police at (4 p.m.) when Aaron was AWOL of his absence, it is possible he may have been found by the police before he went to the party," wrote Lefever.

"Some earlier process to deal with the AWOL should have been instituted by home staff."

Grey's body was found Dec. 21, 2001, in a snowbank in the back yard of an eastside residence, only three blocks from the group home.

He had frozen to death after a night of partying with friends in the house Dec. 19 and was found two days later by a boy who lived there.

Grey wasn't wearing his shoes or his parka and his body was frozen to the ground.

His blood alcohol level was more than three times the legal limit.

Allowing Grey to leave the home at all on Dec. 19 may have been a mistake as well, wrote Lefever.

Grey frequently left the group home without permission, often returning within a day or two, but sometimes disappearing for up to two months at a time.

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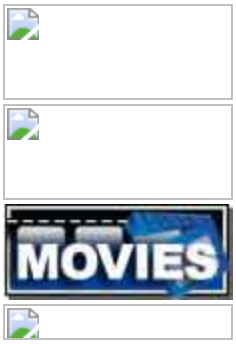

Between October and December of 2001, Grey had been AWOL from the home at least 19 times.

And he had been AWOL from the home just the day before his disappearance. When he returned he smelled of gasoline, which staff feared he was sniffing.

In his report, Lefever said allowing the teen unescorted absences from the home was crucial for him to develop the life skills he'd need when he turned 18, but the numerous AWOLs shouldn't have been ignored.

"In the normal course in that situation, consideration should have been given to grounding Aaron and refusing any unescorted absences from the home."

Lorelei Fiset-Cassidy, spokeswoman for Alberta Children's Services, said the ministry would be taking a close look at the report's recommendations.

"We will take a serious look at them," she said, but added ministry policy already calls for immediate notification of the group-home supervisor in the case of a runaway.

"That is what our policy says," she said.

Recommendations from a fatality inquiry are not binding on the ministry.

Witnesses called during the inquiry said everyone at the house had been drinking heavily the night of the party and no one remembered seeing Grey leave.

Moaning noises heard around the time the house's owner, Gary Rigler, returned home from work later that night were dismissed as a cat.

In the report, Lefever said given the -25C temperature that night, Grey likely died of hypothermia within 1-1.5 hours after staggering outside and passing out in the snow.

Lefever pinned much of the blame for Grey's death squarely on the other people at the house who failed to note the teen's absence, or investigate the noises outside.

"Had any person hearing this noise considered him or herself to be 'his brother's keeper', perhaps Aaron would be alive today," he wrote.

In the span of his 16-year life, Grey went through 14 different foster homes, four group homes and a wilderness camp placement. He was taken into government custody numerous times starting in 1985 until becoming a permanent ward of the government in 1996.

DIDN'T FIND FAULT

Lefever didn't find fault with the general care provided by Grey's case worker Gregory Besant or the group home staff.

But he did make recommendations that Alberta Children's Services should make continuing education on fetal alcohol syndrome available for child-care workers and the programs and resources for FAS should be assessed annually.

Neurological tests completed after Grey's death show he likely had FAS and would have required intensive care for the disorder.

Fiset-Cassidy said provincial spending on FAS programs and training has increased from $1 million in 1998-1999 to a current level of $4.7 million, and more than 40 FAS programs are operating in Alberta.

"Those things we feel we're well on the way with."

What the recommendations say:

1. Alberta Children's Services should ensure that all group homes have in place policies, procedures and practices that require group home staff to restrict unescorted absences from the group home where a child in care exhibits behaviour which is inconsistent with the level of responsibility required for unescorted absences.

2. Alberta Children's Services should ensure that all group homes have in place policies, procedures and practices that require group home staff to alert the group home supervisor immediately that a resident is AWOL so that procedures which govern an AWOL resident are triggered. Any decision on a grace period should be made by a supervisor after fully considering the context of the absent child and the immediate AWOL situation.

3. Alberta Children's Services should establish a regular program of continuing education and training related to fetal alcohol syndrome for all child care workers, with special emphasis being given to those child care workers who work with populations most at risk.

4. Alberta Children's Services should have an annual assessment of programs and resources allocated to fetal alcohol syndrome to determine the efficacy of programs and resources to deal with children within the care of Alberta Children's Services.

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