A Report on

The Independent Review of Cathedral Valley Group Home

submitted to

The Honourable Gordon Mackintosh
Minister of Family Services and Consumer Affairs
Province of Manitoba

Barry Tuckett
January 5, 2010

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The Honourable Gordon Mackintosh
Manitoba Family Services and Consumer Affairs

Dear Minister Mackintosh,

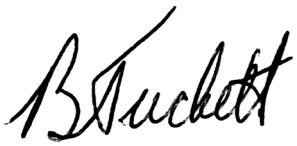
Re: Cathedral Valley Group Home Review

In accordance with your request that I undertake an Independent Review into the now-defunct Cathedral Valley Group Home, I am pleased to inform you that my review is now complete. For your information I now submit my ***Report On The Independent Review of Cathedral Valley Group Home.***

I would like to acknowledge Mr. Robert Tramley, Investigator (retired RCMP Superintendant) and Margarette de Groot, Administrative Assistant, who provided valuable assistance in this review.

Additionally, I would like to express my appreciation for the assistance and cooperation received from your Department and Manitoba Archives in the course of this review, as well as all those who participated and provided us with information regarding their concerns, perceptions and views on these matters.

Yours truly,



Barry Tuckett

CATHEDRAL VALLEY GROUP HOME REVIEW - January 2010

INTRODUCTION

In early 2006, three former residents of the Cathedral Valley Group Home (CVGH), Sam McGillivary, Dean Powderhorn and Brian Richards came forward with concerns about the treatment they received at the home which operated from early 1971 to August 1983 near Grandview, Manitoba.

Their concerns received considerable media coverage. A picture was presented of residents whisked from their families in towns, villages and aboriginal communities (reserves) across the province and placed in the CVGH where they were forced to sometimes work 12 to 17 hours a day, clearing land and working in the farm fields. It was suggested that, at times, there were as many as 17 residents under the age of 14 residing at the CVGH; some resided there for more than 10 years and some were as young as eight or nine. Concerns were raised by the former residents about beatings, sexual abuse, a loss of culture and language as a result of forced stays which lasted for more than a decade, a lack of belonging to their community, a lack of explanation by any authorities for their situation and no communication with their families.

On June 26, 2008, the Honourable Gordon Mackintosh, Minister of Family Services and Consumer Affairs, issued a news release saying the Province would commission an independent review of the Cathedral Valley Group Home.

The purpose of the review, as noted in the release, was to examine and assess the quality of services provided to adolescent youths who resided at the CVGH, and determine whether services provided were consistent with legislation, licensing standards, safeguards and service delivery practices in place at the time.

The scope of the review was to include but not be limited to:

- identifying findings regarding the governance and administration of the Cathedral Valley Group Home, including staff resources;

- examining the supervision, management practice, communication and lines of accountability of the Cathedral Valley Group Home;

- providing profiles of the youth placed at the Cathedral Valley Group Home;

- examining the reasons for the youths' placement status or discharge;

- analyzing how treatment of the male adolescent youth at the Cathedral Valley Group Home compares with current practices and standards; and

- providing recommendations regarding whether supports should be provided to former residents of the Cathedral Valley Group Home, including resources for healing and treatment as well as ways to address current systemic issues.

The Minister made a commitment to Mr. Sam McGillivary that a copy of the report would be made available to him.

Following a meeting with the Minister and a meeting with Mr. Sam McGillivary, it was agreed that I would conduct this review. The Minister advised that resources would be available to acquire investigative and administrative assistance. Activities began to establish an operational workplace and to secure the necessary investigative and support staff. Preliminary contact was made with the appropriate officials in government departments who had worked or currently work in areas such as child welfare, corrections and education who might have knowledge, information or files related to CVGH.

As a result of this preliminary work, steps were taken to broadly identify, locate and interview former residents of the group home, former staff of the group home, and the government employees who were involved with the group home. Information was also sought from people in the community who may have had some knowledge or experience with the group home, the residents or the group home operators. Records that were available were obtained from government relating to the residents, the legislation and policy at the time of the group home's operation, as well as any previous reviews and reports or briefings relating to the group home.

In addition, a copy of Senior Judge E. C. Kimelman's *Group Home Review* report, dated October 1983, was obtained. In 1982, Judge Kimelman, while examining the issue of adoption and foster placements of children of aboriginal descent, was asked by the Minis-

ter of Community Services and Corrections to expand his mandate to include a review of group homes. Judge Kimelman's report on the review provided a foundation upon which the review could formulate a preliminary understanding of the group home environment that existed in Manitoba at that that time.

The review of the CVGH began with the objective to obtain as much information as was reasonably possible relating to the operation of the group home. This included:

- the reasons for placement of individual residents;
- matters surrounding their discharge from the home;
- the expectations relating to the care of residents in the group home;
- the government's monitoring and accountability processes in place at the time; and
- the activities of the residents while it was in operation.

Once the review began, it became clear that the passage of time would have an impact on the ability to obtain substantive information and evidence to verify actual situations and occurrences. Some individuals who could have provided information beneficial to this review had died. Some did not want to participate. Many could not be located. Much of the information gleaned from interviews was based on memories of life matters and instances that occurred over 30 years ago and at times, as one might expect, the recollections of those situations and events differed between individuals or were not consistent with written records and file documentation.

By gleaning information from various sources we identified 40 individuals who may have resided at CVGH and we attempted to locate them. We found that some of these individuals were actually not former residents of CVGH. We had access to and reviewed file records on 21 former residents who had resided at the home. We were able to interview only nine of these former residents.

We contacted 26 members of the community that we felt may have had information relevant to this review. We interviewed 18 of these individuals, which included former neighbours, teachers and people from the community. The others either chose not to participate or we ascertained that a formal interview was not necessary.

We compiled a contact list which included former workers at CVGH, former probation officers and child welfare workers that had involvement with the CVGH and others who we felt could provide us with information relevant to the review. From the list we were able to

contact 28 individuals and we interviewed 24. Requests with Manitoba Family Services for file records on the former residents began in the spring and efforts were made by the department to locate and provide records to our office for review. We also contacted Manitoba Archives and Manitoba Justice and provided identifying information to assist in locating any probation or Child & Family Services files relating to the former residents.

We received some files and some copies of file records on some of the former residents. We were advised that although some files should exist, the departments were having difficulty in locating some of them. We were advised that over the years departments changed or divisions moved from one department to another and the records may not have followed or may have been subject to different policies regarding retention and disposal. We were advised that records relating to licensing, inspections, monitoring and financial transactions relating to the home may have been destroyed in accordance with record disposal policies and practices at the time.

We were advised that it could take some time to locate and retrieve the records that we were looking for if they existed. We received some records as early as April, some in June, July, August, and some as late as October. At the time of writing this report, although a substantial number of records have been made available to us, we have not received files on all of the former residents.

Despite not receiving all the files requested, we were able to garner sufficient information from the files, combined with information received through a variety of collateral sources, to provide insight into the operations of the Cathedral Valley Group Home, the residents of the home, their activities, and the child care system in place at the time the home was in existence.

BACKGROUND ON CATHEDRAL VALLEY GROUP HOME (CVGH or the Blake Home)

Establishment of CVGH

In the late 1960s Mr. Henry (Red) Blake, a retired veteran, was a Scout Master of a troop operating from St. Peter's Church (Elm and Grant) in Winnipeg. While in Deer Lodge Hospital he befriended a World War I veteran who lived in the Grandview area. While helping the old gentleman on his farm, Mr. Blake purchased a piece of property in the Rural Municipality of Grandview situated at NE28-23-25W in the late 1960s. It was about a 20-minute drive from the town of Grandview and was close to the boundary of Riding Mountain National Park. Over a period of time the land was cleared and a house was built with the assistance of his Scout troop.

In 1970, Mr. Blake approached Parkland Child and Family Services with the concept of establishing a group foster home where boys could learn to raise and care for various animals, which would eventually be sold and the boys allowed to retain proceeds from the sales. The home was intended to provide a structured, disciplined lifestyle around activities such as school, recreation and chores. At that time, there were no group foster homes for boys in northern Manitoba. The nearest was far south in the Dauphin/Parkland Region District. The Blake Home arose out of the need to establish a facility as an alternative to an institutional or correctional setting.

The Blake Home would have been subject to a home study which was required to determine whether the applicant for foster parenting was acceptable. The CVGH would have been visited prior to the approval of the regional director. These records were not located by government during the review.

The home was to be solely operated by Mr. Blake and his wife Phyllis, a physiotherapist. The agency agreed with the Blakes' plan, and in January 1971 the home was officially

designated and approved by the regional director as a foster home. The Blake Foster Home would soon evolve into a group foster home with an increase in residents.

Placement of Residents

Residents were placed in the home under the authority of a Probationary Order, an Order of Apprehension [either temporary (TOA) or permanent (POA)], an Order of Guardianship [either temporary (TOG) or permanent (POG)], a Voluntary Placement Agreement (VPA) or a Temporary Contract Placement (TCP) between the Director of (Child) Welfare and the parents, usually for a period of 12 months. The Orders or Agreements could be extended and we found many instances where they were extended at CVGH.

The home agency responsible for each resident's care and placement would make a referral for assessment and placement at CVGH. Such matters as an extension of Orders, maintaining contact with parents and guardians, monitoring the resident's progress and disposition of residents remained the responsibility of the home agency. Meanwhile, Parkland Child and Family Services, in whose agency CVGH was located, was responsible for monitoring the home and the residents.

Before a child was placed at the Blake Home, a screening committee made up of in some cases the senior probation officer and a child welfare supervisor assessed the suitability of the resident's placement. The screening committee for placement at the Blake home primarily considered residents who would benefit from a structured setting with limits on the behaviour of residents, as well as supervision and control. A child welfare supervisor who was involved in the screening of the residents for the Blake Home, in a memo to another social worker stated: "In screening referrals for the Blake Home I have always used the rule that the boy must have some motivation or potential motivation to stay. Also there has to be some indication that placement will work." We were advised by members of the screening committee that other factors coming under consideration were age and behavioural characteristics of the boys.

CVGH Activities

The description of activities at the CVGH was based on what we were told from residents, staff and the community, as well as what we found in file records. Although there were differing views concerning the extent of the activities there was a general consensus about the sorts of work and recreation undertaken by the boys.

The residents did chores around the house, looked after the animals on the farm and they were bussed to school. A description of the work undertaken by the residents included clearing land, rock picking, stacking bales of hay, and helping in the construction and repair of various structures and farm work. It also included some work for local farmers.

In terms of recreation, some of the residents were involved in Boy Scouts. Some went on day trips during the summer to such places as Yorkton, Saskatchewan, and Assessipi Park. There was also an annual summer camping trip to Granite Lake, Saskatchewan, where the residents did some work, camped, swam, canoed and fished for approximately two weeks.

The residents were usually taken to town, weekly, where they went to the local restaurant and pool room. The CVGH was equipped with books, games, television, bikes, fishing equipment and other recreational equipment.

CVGH Staff

From the CVGH's inception as the Blake Home to 1977, Henry (Red) Blake and his wife Phyllis were virtually the sole staff and caregivers at the home. It appears that Mr. Blake would occasionally hire workers on a temporary basis, as required. Phyllis Blake was also employed in Dauphin as a physiotherapist, while helping manage the group home.

After the murder of Mrs. Blake in 1977, there were several changes in terms of staffing, funding, and licensing. A young couple from southern Manitoba with no experience in the field were hired by Mr. Blake to work at the home. They advised that Mr. Blake was looking for Christian people who liked kids and would be willing to read them Bible studies at night. The couple only stayed six months at the home.

Mr. Blake seemed to rely on local farmers and neighbours to work at the home. One couple who lived close to the Blake Home worked there for several years. She worked at night doing laundry and cleaning while her husband worked during the day supervising and helping with the day-to-day activities.

Another individual who we interviewed knew Mr. Blake from when he was a Boy Scout in Winnipeg in the late 1960s. Over the years, he visited the Blake Home several times, staying there and helping out. He was hired for a short period of time after Mr. Blake died in 1982.

Mr. Blake remarried after the death of Phyllis Blake. His new wife, Barb Blake moved to the home from Scotland with her two teenage daughters. After Mr. Blake died, Barb Blake continued with the operation of the CVGH. She hired an individual who had taken child care worker courses at Brandon University. He advised that he supervised and counselled the residents.

The Murder of Mrs. Phyllis Blake

On December 17, 1977, Mr. Blake was in Winnipeg attending a meeting with a government department; Mrs. Blake remained at home with seven residents. A youth whom we have identified in this report as Resident U had been placed at the CVGH in August 1977 on a Probation Order. In a plan to steal a vehicle and leave the home, he shot and killed Mrs. Blake. The youth fled in the vehicle and was subsequently arrested. He was charged with her murder, and dealt with in the court system.

From information received, it appears that Resident U had talked to other residents earlier that day about his plans to run away and he was looking for others to join him. However, the other residents were not interested in doing so.

In the evening, Resident U got access to a gun from a gun rack in the home and went to the bedroom, where Mrs. Blake was sleeping, to get the keys to the CVGH vehicle and shot Mrs. Blake when she awoke.

Due to sound-proofing in the basement roof, the residents did not hear the gun shots. In the morning, one of the residents noticed the kitchen and hall lights on. Feeling something was wrong, he entered the bedroom and discovered the body of Mrs. Blake. The other residents were alerted to the murder and saw the body of Mrs. Blake. Apparently one of the residents called a neighbour and subsequently the RCMP attended at the scene.

We interviewed the former sergeant in charge of the RCMP Grandview Detachment who investigated the murder. He recalls all six boys were in the front entrance of the home when he arrived and they were all talking at once. He said all six continued to talk about something terrible happening to “Mom.” He believed that if Resident U had mentioned shooting Mrs. Blake to the boys, Mr. Blake would have been advised. He said that the boys were not surprised that Resident U was gone but they were shocked at what he did to Mrs. Blake.

The murder occurred during a heavy snow storm; consequently, Mr. Blake could not immediately get home and was forced to stay in Portage la Prairie overnight. A probation officer and a social worker summoned by the police stayed at the CVGH with the boys until Mr. Blake returned the following day.

From the records and interviews, it is difficult to determine what actually happened after Mr. Blake returned home. It appears, however, that some of the residents were either sent home or placed elsewhere within days of the murder, returning early in the new year. Some of the boys remained at the home.

The Closure of CVGH

The CVGH closed in August 1983 and Barb Blake sold the farm and moved to Dauphin in 1984. The Kimelman *Group Home Review* (October 1983) reported the following reason for the closure of the CVGH and a group home at Bellsite (near The Pas):

> *"As Level II facilities, they have had long term difficulties in maintaining their occupancy at an acceptable level. This is partly due to the homes' inability to handle more acting out youngsters and lack of need for that level of care in those particular areas."*

INFORMATION ABOUT THE OPERATOR OF THE CVGH, HENRY (RED) BLAKE

Henry Blake was the main operator of the CVGH from its inception to his death in 1982. Many of the concerns that were raised about the operation of the CVGH related to the style and behaviour of Mr. Blake. Accordingly, we sought to present a portrayal of Mr. Blake from information we could obtain from the records and the many personal interviews we conducted. We also received the comments and opinions of others on Mr. Blake's style of discipline.

Mr. Blake was born in 1920. He had a military background, and was heavily involved in the Scouting movement throughout his life. Based on interviews with the residents, neighbours, community people and government employees, one could describe Mr. Blake as a big man, with a rough and imposing personality. Some described Mr. Blake as a "John Wayne" type of character. Mr. Blake was also described as an overbearing and intimidating man who was a firm believer in strict rules, obedience, discipline and punishment. It was suggested that Mr. Blake believed that structure, hard work and discipline were good for the residents in terms of character building.

The young couple, noted earlier in this report, who were hired in 1978 to help in the running of the home left after six months finding Mr. Blake's hard-nosed style was stressful and not, in their opinion, suitable for some of the residents. They said that Mr. Blake believed in making men out of boys and there was no room in the way he functioned to address troubled boys or the emotional needs of some of the boys. They said Mr. Blake was inconsistent. He changed his mind regularly; his rules, schedules and methods could be different in a short period of time. They felt he was not an easy man to please and that this aspect of his personality gave the home an unstable atmosphere which would have been felt by the boys. They said there was no physical abuse of the boys.

A frequent visitor to the Blake Home who helped out from time to time and who accompanied the residents several times on camping trips referred to Mr. Blake's "circle of ridi-

cule." He said the residents would sit in a circle and a resident who had displayed bad behaviour would be disciplined in front of the others. He felt it was humiliating. He also felt that Mr. Blake thought there was a difference between aboriginal and non-aboriginal boys and that non-aboriginal boys were better. He also said that Mr. Blake was not anti-aboriginal and that there were beads and leather craft in the home and a totem pole that was erected on the property. He said that Mr. Blake favoured boys who were good. He said physical punishment occurred at the home.

Mrs. Barb Blake said that while she never saw Red Blake strap the boys, he had a habit of ridiculing the boys in front of one another. She noted that he ran the home as though he was still in the army. She felt he was pretty hard on the boys and would pick on them if they were not doing well at school.

One individual noted that when the residents went to town, Mr. Blake would blow a whistle when it was time to go and the residents would come running. This suggested to her that the residents feared Mr. Blake. In fact, many of those interviewed thought the residents were afraid of Mr. Blake.

Many of the residents spoke about the frequent use of corporal punishment which was meted out by Mr. Blake when they disobeyed his stringent rules. Most of the residents referred to this punishment as a beating and described it as a strapping on the hands and backside with a strap made from a tractor belt. Some referred to slapping and punching.

Others spoke of the home being run like a military camp. Some felt Mr. Blake had his favourites and did not like aboriginal boys or their culture. Some said Mr. Blake did not like the boys speaking in their native language.

A woman who had been a girlhood friend to some of the residents described Mr. Blake as a good man who tried to make a difference in the lives of the residents. She had ridden the school bus with the residents and was often at the home as her parents worked there. She said Mr. Blake was a big man who you listened to if he yelled at you. She said she believed his gruffness was more of an image that he promoted to ensure everyone was kept in line. She felt he had a good heart.

One of the former residents described Mr. Blake as a great man who ran things strictly. He credits Mr. Blake for changing his life. He said he was a different person after leaving the home. He said he went the straight and narrow route and he named his son after Mr. Blake.

A teacher described Mr. Blake as being a disciplinarian, fairly intense and not soft spoken. We were told that Mr. Blake maintained close contact with the Grandview School principals and teachers and while being supportive of the teachers, he would stand up for residents if he felt they were being treated unfairly.

A man who worked at the CVGH after Mr. Blake died said he was advised there would be no corporal punishment. He did, however, say that his late father who had worked at the Blake Home in the 1970s told him that corporal punishment was used in the home by Mr. Blake but his father did not describe the punishment to him.

Some heard rumours of Mr. Blake using the back bedroom of the home as the room where the residents were disciplined. One individual heard that Mr. Blake strapped the residents on the legs. On one occasion, two of the residents were having a violent fight on the school bus and the bus driver had to kick them off the bus a half a mile from the group home. We were advised that Mr. Blake had authorized the bus driver to use as much force as necessary to stop the residents from fighting, including punching, if necessary.

Interviews with staff, the community and others showed a mix of views relating to whether Mr. Blake used corporal punishment on the residents. Some said he did. Others said they didn't think he did. Most said, however, that he was a very strict disciplinarian.

PROFILES OF THE FORMER RESIDENTS GAINED THROUGH FILE RECORDINGS AND INTERVIEWS

In this review we were able to access and examine provincial government records from Child and Family Services, the Children's Aid Society and Probation Services relating to 21 former residents of CVGH and we personally interviewed nine of these residents.

As previously noted in this report, the residents were placed at CVGH under the authority of a Probation Order, a Temporary Contract Placement (TCP), or a Temporary Order of Apprehension (TOA). Irrespective of the legal process that resulted in the residents being placed at the CVGH, it was apparent from the interviews and files that the residents came from homes where they were not receiving the care they required or were involved in delinquent activities and they needed protection or a supervised environment.

Based upon the information we received, it appears that there was a greater ratio of aboriginal boys to non-aboriginal boys placed at CVGH. The residents placed there came from homes as far away as Churchill and as near as Grandview. They resided at CVGH for various lengths of time, from weeks to years. They ranged in age from 9 to 17.

For each of the 21 boys, we attempted to determine why they were originally placed at the CVGH and the circumstances of their release. We reviewed whatever records were available on their stay at the home. Sometimes we interviewed residents on several occasions. What follows is a summary profile on each of the 21 former residents, gleaned directly from interviews with them and/or through the review of available files on them.

Resident A

This resident was interviewed several times. In addition we were able to review records on this individual and his family.

In interviews with this resident we were advised that he did not recall how long he had spent at the group home or why he was placed there. He said, however, that he thought he was six to eight years old.

He described the group home as a farm where the residents worked excessively, doing chores, clearing land, picking rocks, removing stumps and working off-farm for local farmers and others. He said that during holidays, they still had to get up at 4:30 a.m. to do chores. He said that residents went to school but were taken out from time to time to work. He said that residents were given three meals a day and they received $5 a week.

He described Mr. Blake as a powerful man in the community. He said that when the residents acted up Mr. Blake would throw things at them and strap them with a belt. He said that he was strapped a lot and that Mr. Blake kept pinching his stomach. He believed Mr. Blake had his favourites and he favoured white residents over natives. He said the native residents worked 'like dogs' and when clearing land the white residents would supervise when no farmers were available.

He said that he was sexually abused by one of the residents but he did not want to tell anyone as he thought all the residents would be punished if a problem was reported. He said there were intercom systems in the bedrooms that were on all the time and conversations were monitored so the residents hardly talked.

At one point he advised that he talked to teachers and classmates about the abuse but nothing was done. He said he had no recollection of contact with social workers.

When asked about his worst experiences and/or memories of the home, he referred to the strappings, the sexual abuse and his recollection of the residents being allowed to play with pellet guns and shoot at one another. He said one boy shot him in the foot once.

He considered Mr. Blake someone who did not like aboriginal boys or their culture and he offered the example of a totem pole as support. He informed us that some aboriginal boys had crafted one before his time at the home, but Mr. Blake knocked it down, and that the next-door neighbour's son still has it in his yard.

This resident stated that he felt disconnected from his family, his language and his traditions. He said he wanted an apology, professional counselling and acknowledgement

of what happened to him. He said memories of what happened enraged him. It wasn't right. He felt isolated with no place to turn. He said he lost trust and belief in the system and people.

He recollects that when he left the group home he was given a bus ticket to Winnipeg, his clothes and letters from his parents. He said no one met him at the bus terminal in Winnipeg and he was on the streets for a year and a half.

In reviewing file documentation we learned that this resident was born in September 1963. In 1970, along with two siblings, he was placed in a foster home at Snow Lake, Manitoba.

In October 1974, at the age of eleven years old, he was apprehended from his family under a Temporary Order of Apprehension (TOA) for a period of one year and placed at CVGH. A portion of the file contains the following notation by a social worker, "There are several positive aspects as far as placement at the Blake Home: a) Resident A has previously been fostered out and he created no problem, and b) Resident A wants to leave to go to the home."

File documentation suggests that there was monitoring of Resident A's progress. On October 1974 a social worker noted that monthly contact be maintained with Parklands Social Services with regard to Resident A's progress.

Records after that indicate that Resident A was returning home for visits, that a social worker saw Resident A at school on several occasions and that progress reports were being done.

Records show that Resident A had two visits home in 1975. He spent one week at home in late August 1975. The TOA was extended for one more year in November 1975.

The records show two home visits in 1976. On one visit a social worker informed the Parkland Family Services that Resident A wanted to know when he could return to the Blake Home. In an October 1976 report, the Regional Director CFS Parklands Region reported, "Resident A is making good progress in the Blake Home since his placement…" The report also states "Resident A is relatively happy at the Blake Home. There are times when he misses his parents, but this has been satisfied in periodic visits he has had home."

Records show that there were seven visits in 1977 to his home.

In April 1978 a Dauphin social worker noted that Resident A presented in a fairly happy manner and was looking forward to going home at the end of the current school year.

There are two instances recorded where Resident A complained to a social worker about not hearing from his family or having a response to his letters home. It was noted that follow up was done with a letter sent to Resident A at CVGH informing him of the action taken by the worker.

An archived file shows that Resident A was formally discharged on July 6, 1978 from CVGH to the custody of his parents—who had moved to Winnipeg and were living in the city's north end. Parkland Region arranged for Henry Blake to take him to Dauphin for the bus trip to Winnipeg, and the Winnipeg Services To Other Regions was informed that this resident would be arriving in Winnipeg at 9:45 p.m. There was also a request to the Winnipeg agency to notify the parents to meet him at the bus depot.

A record dated in December 1978 shows that a social worker received a telephone call from Resident A's mother approximately five months after Resident A's return to his family, saying he had not been home since Friday. His mother also said that he had been placed in a home for three years in Grandview, Manitoba and had just recently been released.

There is also a record of a visit by a social worker to Resident A's Winnipeg home in November 1979 wherein it was stated the social worker spoke to Resident A who said he had been returned home about a year and a half ago.

Upon his release, Resident A was a few months shy of 15, and would have spent a total of three years and eight months at CVGH.

Resident B

We interviewed this resident and we also received and reviewed file documentation on him.

Resident B was born in 1962 and was apprehended in a northern Manitoba community in 1971 when he was nine years old due to what was reported as inadequate care and various delinquencies. A Permanent Order of Guardianship was granted in 1972. In all, he spent approximately seven years and seven months at the CVGH.

His recollection was that at eight years old he was stopped by the RCMP and taken to the police station where he met a young native case worker who made him sign a paper, following which he took a three day trip to Dauphin. He says to this day he does not know why he was picked up.

He recalls meeting Mr. Blake at Dauphin and he was taken to the farm where he stayed upstairs for a few days and then was moved to the lower level with the other residents. He said that he was told he couldn't contact his mother and she couldn't contact him.

He thought there were about 12 residents at the home at the time and that they all slept on a cement floor as Mr. Blake was in the process of building the house. He said it was about two years before the residents had bunk beds.

In terms of "lickings", he said Mr. Blake would strap them with a combine belt on the hands, the butt and sometimes just hit them on the back. He said they would be strapped for speaking their own language and talking after they had gone to bed.

He said he was afraid of Mr. Blake. He described Mr. Blake as being mean, arrogant, tough, straight to the point, no beating around the bush, and strict.

Resident B described a number of incidents where he and others were strapped or received physical discipline. He stated that on one occasion he was strapped so hard on the hands and on the butt that it caused bleeding on some parts of his body.

According to Resident B, work consisted of picking roots, pitching bales, and at one time skidding logs for two or three days. He also spoke of working for neighbours, brush cutting, chores, and helping to build a neighbour's home and cabins at Creighton, Saskatchewan. He recalls receiving an allowance of $5 every three weeks to a month and going to Grandview from time to time.

During this interview, Resident B spoke about their activities such as Cubs and Boy Scouts, Air Cadets and camping. He recalled going to many churches.

He said that he recalls speaking to a social worker about the way the residents were being treated and in particular the "lickings" but was told that was part of the learning stage and more or less a standard procedure for a group home. An individual who worked at the home after Mrs. Phyllis Blake died recalled going to work one day and encountering

another worker who was visibly distressed as a result of his witnessing Mr. Blake punching Resident B.

Resident B was living at the home when Mrs. Blake was murdered by one of the residents. He said that Mrs. Blake was kind to him and that when she was murdered he went numb and would cry to himself as he did not want the other residents to see him. He said while some of the boys went home for Christmas after the murder, he and three other boys remained at CVGH. He said there was no one to talk to about the way he felt when she was murdered.

He also referred to the time when Mr. Blake died and he was advised by a former resident that the residents' were not allowed to attend the funeral. He said he had continued to visit the CVGH on weekends after leaving there and working in Brandon. He was upset he was not allowed to say his good-bye when Mr. Blake died.

Resident B said the good memories of the home were going to the lake, getting new clothes rather than hand me downs from the older residents. He said the food was good and they also had bicycles which they earned. He also informed us that in the early years he was involved with Cubs organized by Mrs. Phyllis Blake, and later graduated to Boy Scouts and Air Cadets.

In terms of the system, he said he rebelled because of the system and after turning 18 and returning to his community he committed every crime you can think of. He said he was still mad at the government for picking him up and placing him in the home without reason. He was also concerned about the loss of his Dené language.

Records obtained from the Department were reviewed. The records indicate that Resident B took special education class in Gilbert Plains and that in 1974 Mr. Blake felt this resident should attend regular classes in Grandview. Records show his social worker referred him for a psychological assessment. There appears to be little in terms of records relating to the monitoring of the progress of Resident B while at the home in the early years. In August 1972 there is a memo from a probation officer that he was the youngest boy of the home and he seemed to have adjusted well to the program.

We have no records relating to the activities or progress of this Resident B during the years 1974 to 1977.

In 1977 there was a recording from a social worker referring to a conference with Mr. Blake wherein it was stated, "It is recognized that it was likely an error placing Resident B in a group home at the age of nine since he probably could have been more appropriately placed in a regular foster home. However, because of his dependency and the adjustment that he has made we do not foresee any plan to remove Resident B from the Blake Home in the near future."

Records show that in 1978 and 1979 school progress reports were being sent to the social worker. In 1979 the school advised that this resident had reached the highest academic standing within his capabilities at that school and suggested he was ready for vocational training.

This resident was subsequently placed at the Victor House in Brandon to receive training at Arms Industries in November 1979. Records show that he began acting out and was removed from the program in February 1980. We received and reviewed records relating this resident's progress from that point. It appears this resident was involved in juvenile delinquencies and was remanded to the Manitoba Youth Centre in June 1980.

We were informed by this resident that he had no contact with family during the time spent at CVGH. Records we reviewed show a July 25, 1978 request from a social worker to Parkland Region CFS for authorization of Resident B's brother to pay him a visit at CVGH. The worker also states that the brother attempted to visit Resident B three years previously but was rebuffed by Mr. Blake. Parkland Region approved a visit at the Blake Home. It is not known if the visit occurred.

Resident C

We did not receive any records on this resident nor were we able to interview him as he died in his mid 30's of natural causes. We did locate a cousin who provided us with information about Resident C. We also located and interviewed the probation officer who placed Resident C at the Blake Home. Resident C was born in 1958 and died in 1994 at age 36. It is difficult to determine when he was at CVGH but it appears that he was there for approximately four years in the early 1970s.

He was from northern Manitoba and when he returned home for visits he would stay with his cousin. She recalled he cried when he had to leave to return to the CVGH.

The cousin said that Resident C did not say anything about the CVGH when it was operating but did speak about what happened to him years later. The cousin indicated that Resident C would have bouts of depression. Both the cousin and the probation officer said that Resident C, when he was in his early 30's, told of being raped by older boys while at CVGH but did not want to tell anyone as he felt guilty about what people would think of him. As a result of being assaulted, he had a phobia about being touched by a male, and if this ever did occur, there would be an immediate aggressive reaction. This type of reaction was also witnessed by one of his teachers who related to us that one day in class he accidentally touched Resident C on the shoulder as he walked past him and he literally jumped out of his seat. The resident told his cousin and his former probation officer about punishments received for running away from CVGH, for smoking, for gambling or for talking back to Mr. Blake. According to the former probation officer Resident C advised them of sitting at the breakfast table in the nude, kneeling on rice for hours and cutting the lawn with a table knife. He said he and other boys had rifle shots fired over their heads when being marched home after an escape attempt. In terms of corporal punishment, his cousin recalls Resident C saying that he got slapped for talking back to Mr. Blake.

His former probation officer says that before Resident C died, he suffered from depression and that he drank heavily. He says that Resident C tried to commit suicide several times after consuming a quantity of alcohol. The cousin also spoke of Resident C's suicide attempts and attributes his mental problems to his stay at CVGH.

His former probation officer said he heard good things about the home at the time of placement. It was being supervised by the Dauphin Child and Family Services. It had a good reputation and it was viewed as a good placement.

Resident D

We received records on this resident but we were unable to interview him as he is deceased.

The resident was born in 1962. He was placed in the Blake Home in 1975 under an Order of Guardianship at the age of 13.

File recordings show fairly regular monitoring of his progress at school. There are a number of school reports including a psychological assessment. Resident D did have learning difficulties for which a tutor was hired, but this only lasted about six weeks due to

a lack of progress. Consequently his problems at Grandview School continued, causing a vice-principal to comment on an ongoing difficulty the boy was having with Mr. Blake. In his first year at CVGH, a social worker commented about a problem with Mrs. Blake, which the social worker indicated he would address with the Blakes. Other boys teased him at the home causing outbursts of temper.

In July 1975, three months after his placement at CVGH, a social worker questioned the long term placement of this resident in a group home setting, noting when he is away from the home he is not a discipline problem, and suggested that they look at the possibility of a private foster home. Records show that he was not moved to another home, but there was no reason given for this not occurring.

This boy was also a resident at CVGH when Mrs. Blake was shot by another resident on December 17, 1977, which did have an impact on him as noted by a social worker, "Resident D was actually quite profoundly affected by the tragedy of Mrs. Blake's death."

The file indicates that an appointment was made to have this resident examined by a medical doctor in Grandview on April 21, 1978, purportedly to receive a prescription for Haldol, which he had previously been taking. It appears, however, that the resident did not receive the medication until July 28, 1978 after another worker obtained the prescription.

In early November, 1978 the principal of Grandview School expressed concern to a Parkland Region social worker that he believed that Mr. Blake did not like Resident D which could be a handicap to his continued living at CVGH.

The file shows that Resident D was discharged from CVGH in 1978 to receive vocational training and he stayed with his mother.

Resident D subsequently committed suicide in a provincial facility.

Resident E

We did not receive any records on this resident but we did locate and interview him.

Resident E was born in 1959. At 13 he was getting involved in petty crime. Through a TCP Agreement with his parents he was placed at CVGH where he stayed for about one year.

He recalls that there were eight boys there at the time, although there might have been up

to 10. He attended Grade 8 at Grandview School. He described CVGH as a hobby farm. He said they would get up at 6 a.m. to feed and water the animals which consisted of one cow, chickens and pigs. He said they had to clean the barn and that the boys basically did all the work on the farm. He said they didn't do anything for other farmers.

In terms of recreation, he said the older boys were allowed to go to school dances. They went to town on Saturdays and hung around the pool room for four or five hours. They were allowed to hunt on the property and they watched television. He said Mr. Blake gave them money to go to the pool hall on weekends. He advised that he received mail from his parents and siblings and that he went home at Christmas.

Resident E said he recalls residents receiving "lickings." He remembers one resident getting the strap for stealing Mr. Blake's snowmobile. He also recalled one resident who he considered "a pretty bad little dude" being taken to his room where he was strapped on the butt through his clothing. This resident said he did not feel there was any abuse of the boys and he did not feel there was anything sexual occurring in the home.

He described Mr. Blake as a great man who ran things strictly. He said he was a military man and he ran his life and his home that way. Resident E said it changed him completely and when he left he was a different person. He went the straight and narrow route and named a son after Mr. Blake.

Resident E did not recall any visits from probation officers or social workers either at the home or at school. He did, however, believe there was an inspection done at the home while he was there. He recalled three or four people walking through the home.

Resident F

We received file records on this resident and we made contact with him, but he did not want to participate in this review.

Resident F was born in 1962. He was committed to the temporary care of the Director of Child Welfare in 1972 and was placed at the Blake Home. Records indicate that Guardianship Orders were regularly extended.

In 1973 it was noted by a social worker that this resident had made very good progress at the group foster home and had not been involved in any known delinquency. Records indicate that this resident enjoyed his visits home but preferred remaining at the Blake Home. These records noted that this resident had responsibilities such as feeding chickens and working with some of the livestock.

Although records on this resident were incomplete there are notations of yearly progress reports. There is an entry in March 1978 concerning an appearance in Juvenile Court relating to minor Criminal Code offences. The records show in 1978 that Mr. Blake felt this resident was one of the most responsible boys in the home and that he seemed to have a good insight into his own situation. It was noted that his case would be reviewed later in the spring with regard to future planning and that he might be returned to his father. His file does not indicate when he was released.

Resident G

We received a case file of this resident and we located and interviewed him.

Resident G was born in 1957 in northern Manitoba and as a result of neglect was committed to the care and custody of the Director of Child Welfare in 1963. The file shows that in 1972, while in a foster care home, his social worker requested a review and referral to the Blake Home as his present foster parents were having a great deal of difficulty with him and other arrangements had failed. Records indicate that based on this resident's patterns and behaviours it was felt that he was suitable for placement in the Blake Home and it would be a positive direction. He was placed at the Blake Home in 1972.

Resident G recalls that he was in a fair amount of trouble when living in a foster home and subsequently placed at the Blake Home. He recalls his activities as going to school, feeding the animals on the farm and working on weekends as Mr. Blake would rent them out to work on farms. He said he pitched bales for the neighbour on the weekends. He said he never got paid for this work and he doesn't know if Mr. Blake did.

This resident referred to a number of incidents of sexual abuse among the boys and Mr. Blake. He named some of the residents involved. However, we were not able to substantiate or support this allegation through our interviews or records.

Resident G felt that he was unfairly turfed from the farm when he was 17, saying that he was not ready to leave and he should have been looked after for one more year. He said that it was the worst part of it for him.

The case file on Resident G shows a progress report in 1972, 1974 and 1975. The records suggest that Resident G responded well in the Blake setting; however, records show that Resident G quit school and wanted to work for a living. It was noted that this was agreed to as it was felt they could not force him to go to school. The records indicate that this resident returned to the Blake Home for several months when he was 18 as he

was hoping to get employment in Grandview and Mr. Blake agreed to provide him with a home until he got on his feet.

Resident H

We received some file documentation on Resident H and we contacted and interviewed this resident.

Resident H was born in 1960 and spent about a year at the Blake Home between 1973 and 1974. File records show that Resident H was involved in juvenile delinquency and that a Temporary Contract Placement (or VPA) was entered into with the parents. The files show a social history record pertaining to the family and the resident along with a referral from the probation officer to consider placement at the Blake Home.

Resident H described the home as a Scout camp. He said the residents were taught to tend animals and that he found the environment to be wonderful.

In terms of corporal punishment, Resident H said if the boys did anything wrong they would be called into Mr. Blake's room and they would be strapped, always and only on the hands. He described Mr. Blake like a sergeant in the army. He said he had a voice on him and you knew your limits. He recalled going to local farms where they would pick rocks and pitch bales in spring and fall. He said they did this three or four times and they would get a meal and a dollar added to their allowance. He said it was fun and he considered it work experience even though the work was hard. He did not consider it slave labour and he felt the Blake boys had more leisure time than the local boys.

He recalled Mr. Blake giving him $100 when he left. He also recalled Resident G returning to the Blake Home to visit.

There are no recorded progress reports in any of the records we received but there is a note that Resident H's progress had reached a maximum at the Blake's and he was ready to return home.

Resident I

We received file documentation and we interviewed this resident.

Resident I was born in April 1964 in the Parkland Region. He advised that he was placed in local foster homes at the age of six years old and was in a number of foster homes before being placed at the Blake Home at nine years old.

He remembers getting up at 6 a.m. to feed the pigs, goats, chickens and other chores before going to school. He recalls doing farm labour for Mr. Blake and helping other farmers clear their fields of stones and hauling logs from the brush. He says that they'd work until sundown.

Resident I said the boys would go to town on Saturday where they would go to a restaurant or the pool hall. He said everyone would get $5. At the home they had television, books, and board games. He said that every summer he and other residents spent two weeks at Granite Lake clearing land and fishing. He said they helped build a cabin at the lake.

Resident I said that Mr. Blake gave him the rules and if you were bad you would get a "licking". He said he had never experienced anything like that. He described the discipline as a strapping on the hands or backside with a tractor belt. He said some boys had to drop their pants and lean over the bed and Mr. Blake would jump up in the air and hit them. He said Mr. Blake did not want the boys talking in their native language and would discipline them if they did. This resident said he advised some of his friends when they came to the home about the strappings.

Resident I could not recall the name of the worker who placed him and he said he had no visits.

Resident I said there was sexual activity amongst the residents, usually the older boys against the younger boys. He indicated the boys were afraid to complain.

This resident resided at the Blake Home when Phyllis Blake was murdered. He said he didn't go to school for about a month after the murder. He said he remained in the Blake Home after the murder. He said he didn't see a social worker and he does not recall anyone coming to see the other boys. He advised that he still had nightmares about the murder.

This resident said he walked away from the Blake Home when he was 17 and no one tried to locate him. He advised that he still would like to know why he was kept at the Blake Home.

Records show that Resident I was placed from a foster home to Blake Home in July 1975 under the authority of a Permanent Order of Guardianship. There were a few progress reports. The records show that Resident I got into some delinquencies while at the Blake Home. A file recording in May 1981 noted that Resident I went to Winnipeg to visit his sister and failed to return. This recording also provided an assessment of Resident I's

situation while living with his sister and it was decided to allow him to remain there. There are also records indicating some monitoring of Resident I's situation until he turned 18 and his case file was closed.

Resident J

We received file records on this resident but we are unable to locate and interview him.

Resident J was born January 1961, in northern Manitoba. In 1974, this resident was involved in numerous delinquencies, mainly break and enter, and theft. The records show that an assessment was completed and a report made to the court. The resident was sentenced to 18 months in the Manitoba Home for Boys. In August 1975 this resident was discharged from the Manitoba Home for Boys and placed at the Blake Home as a trial placement. It was noted that the resident was found to be better suited for a group home situation.

The file records show a progress report from the CVGH and from school in March 1976 indicating extreme satisfaction with his performance. It was noted that his parents visited him. In November 1976 there is a report that this resident had made a fair adjustment and significant progress. In 1977 it was reported that this resident had matured; accepts more responsibility and had a better self image and he was ready to leave the CVGH.

Resident J was released to his parents in June 1977.

Resident K

We received no file information on Resident K nor were we able to interview him as he is deceased. A third party (friend) was identified and interviewed.

We were advised that this resident was born in 1958. The friend said he met Resident K in 1976. Resident K lived with the friend's parents in Winnipeg. He said that Resident K described Mr. Blake as an ex-military person who was very strict. According to his friend, Resident K said if he slipped out of line, he would be beaten by Mr. Blake with a belt. The friend said there was no mention of sexual abuse at the Blake Home. The friend said Resident K spoke of working on neighbouring farms picking potatoes.

The friend said Resident K spoke of stealing money from Mr. Blake and when he was told Mr. Blake knew about it, he stole a car and was chased by the RCMP. The friend said Resident K crashed into a police car, crippling a police officer for life, following which Resident K never returned to the Blake Home.

From enquiries about this matter, we were able to confirm that Resident K did steal a car and ran into a police car on the outskirts of Dauphin but there were no injuries sustained.

The friend advised that Resident K had continued problems with alcohol consumption which resulted in his committing crimes and in 1982 he committed suicide.

Resident L

We received some file records on this resident and we interviewed him.

Resident L was born in 1960 and was placed at the Blake Home in 1975 under a Temporary Contract Placement Agreement with his mother. The records indicate that Resident L went home for visits and that his mother wanted him returned by the end of August but agreed to extend the TCP until January 1976. Records indicate that Resident L was home for the Christmas holidays and wanted to stay. The record further noted that it was felt Resident L should complete his school year but if his mother insisted they would terminate the TCP. We do not know what happened after this as the records are incomplete.

Resident L advised during the interview that he thought he was 11 years old when he was placed at the Blake Home and that he was there for about two years. He thought there were 13 boys there at the time but only recalled eight names. He described the Blake Home as a labour camp, saying that they were always working right after school in the fields. He said they would work for local farmers. Resident L said he received no pay for the work. There was no time for leisure activities, except maybe on Sundays. He said they never went to town on weekends as they would get up and do chores.

He recalled going to the Flin Flon area for about three weeks where they camped and fished.

This resident said that Mr. Blake had a large strap and that if you did anything wrong, he would take you to his room and give you the strap. He said Mr. Blake usually hit them through their trousers on the back of the legs and also on the hands. He said he was not aware of any sexual activity among the boys.

Resident L said that he advised a social worker about his problems with the home and that he wanted to go somewhere else but the social worker didn't do anything about it. He said he saw this social worker at the home as he would visit every one or two months.

Resident L said he ran away from school and made his way home and he said he was never apprehended.

Resident M

We have no file records on him but this resident was interviewed.

Resident M said he was born in 1964. He recalled committing juvenile delinquencies because he wanted to get away from his reserve and he was placed in the Blake Home through the courts when he was 13. He thought he was the only native boy at the home for a while.

He recalls working off the farm, picking rocks and haying. He said farmers would pick the residents up at the home and they would ride in a trailer towed by a farm tractor. He said Mr. Blake would accompany them. They did not get paid and he didn't know if Mr. Blake did. He said he tended his own chickens at the Blake Home. He recalls a couple who helped at the farm who took them to their farm for about a week to work with bees. Resident M recalls going to town and getting about $5 a month.

This resident spoke of stealing a tractor with two other residents and being caught in Dauphin. He said they got strapped on the hands when they got back home. He said Mr. Blake never hit them with his hands, only the strap.

Resident M was residing at the Blake Home when Phyllis Blake was murdered. He said when his time was up at the Blake Home he was 15 and did not want to be returned to the reserve, so he got into more trouble and ended up living with his sister in Dauphin.

He alleged that he was molested on the reserve as the reason he never wanted to return there. During the interview, he indicated that he was currently open to counselling to help him deal with this.

Resident N

We were not able to locate or interview Resident N but we received some file records on this individual.

Resident N was born in 1958. He was placed in the Blake Home in August 1974 under a TCP Agreement with his mother. Records show an assessment of his suitability for the Blake Home and monitoring of his progress.

Records indicate that Resident N had made significant progress and that he benefited from the experience at the Blake Home. In February 1976 the TCP Agreement was terminated and Resident N returned home.

Resident O

While we received some records on Resident O we were unable to locate or interview him.

Resident O was born in 1966 and was from Winnipeg. This resident came into care of the Children's Aid Society via a TCP Agreement in February 1980. This resident was at the Seven Oaks Youth Centre when an assessment was done and it was recommended he be placed at CVGH in March 1980. Records indicate that he had adjusted well and made good progress at the Blake Home. He attended school regularly and had a number of home visits. During 1981 he participated in summer camping along with day trips in Manitoba and Saskatchewan. It was noted however that on a summer camping trip to Granite Lake, he and another boy stole the CVGH van and were apprehended in Saskatoon and returned to CVGH. No charges were laid. He and another resident stole another vehicle in Roblin in October 1980. Records indicate that Resident O wanted to remain at CVGH and that he was relating well to the other boys.

Resident O was returned to his mother in 1981. A closing summary on file suggested that since the car theft in 1980 there had been a number of improvements and that he had progressed substantially in the year and a half he was at CVGH.

Resident P

We received file records on Resident P but we were not able to locate or interview him.

Resident P was born in 1966 in the Parkland Region. He was placed in CVGH in June of 1979 through a TCP Agreement made with his mother.

Records indicate a fairly regular assessment of the progress of Resident P including family assessments to determine if Resident P could be returned to his family. While at the CVGH he was getting into some trouble due to his attitude and behaviour. He had suspensions from school and lost his bus-riding privileges for a period of time. In the fall of 1979, he and another resident tricked an elderly lady living in a personal care home in Grandview out of $25. On October 8, 1980, he and another resident ran away from school and stole a vehicle in Roblin.

Records show he went on day trips to Assissipi Park and camping trips to Granite Lake. He had regular home visits. Records indicate that while Resident P wanted to go home, he seemed to enjoy his placement and he got along well with Mr. Blake and the other boys.

Resident P was discharged from CVGH in July 1982.

Resident Q

We received file recordings on Resident Q and were able to locate and interview him.

Resident Q was born in 1964 in the Parkland Region. This resident had been committed to the Agassiz Centre for Youth for 18 months in November 1977. In a pre-disposition report by his probation officer it was felt that this youth would be a suitable candidate for the CVGH as he would profit by the set rules and regulation of the home and by the strong male influence of Mr. Blake. It was noted however that there were no openings at the time. He was eventually placed at CVGH in March 1979 and remained there until February 1980. Records show that a TCP Agreement was agreed to by his mother and that a treatment panel recommended his placement at the Blake Home.

In the telephone interview with Resident Q he advised that there were nine boys at the home and it was a mix of aboriginal and non-aboriginal boys. He said they had chickens, pigs, sheep and cows. He said the boys got up between 5 a.m. and 6 a.m. and did chores, went to school and did chores after school. He said they did some work on other farms but not as hard as on the Blake farm. He said they worked steady on the farm, shearing sheep, clearing brush and other chores.

In terms of activities, Resident Q referred to snowmobiling, camping, fishing and going to town.

Resident Q thought Mr. Blake was terrible. He said he ran the home like a military camp. He said he would strap the boys with a tractor belt on their hands if they did not follow his directions and that often he would mix up his directions on purpose to pit the boys against each other. He said Mr. Blake sometimes would smack the boys behind the head.

Resident Q spoke about an injury he received while Mr. Blake was moving a big rock with a tractor. The rock rolled over onto his foot, also hurting his back and elbow. He said he did not go to the doctor and he still has back problems today.

Resident Q also spoke of being assaulted by an RCMP officer and telling his probation officer about it, but nothing was done about it.

During the interview Resident Q said that he feels angry and isolated from his community. He said he didn't talk about his problems to anyone because he lost trust and his spirit was broken, referring to his family, the youth centres and Mr. Blake's military camp. He said he would like to receive some counselling to deal with his feelings and his anger.

In the records we received there are reports on Resident Q's progress. These records show this resident was involved in delinquencies and had problems at school while at the CVGH.

On December 18, 1979, Mr. Henry Blake informed Parkland Region that he could not handle Resident Q any longer. Mr. Blake noted that this resident can be very difficult with staff, and involves other residents with his disruptive actions. Resident Q was discharged from CVGH on February 17, 1980 and returned to the Manitoba Youth Centre.

A probation officer wrote that in March 1980 Resident Q stated he disliked CVGH from the beginning and did not want to return there. He said the reason he committed criminal offences was to get out of the home.

In a forensic assessment submitted by a medical doctor on April 22, 1980, there is no mention by Resident Q of being the recipient of any inappropriate physical treatment or abuse while at CVGH.

Resident R

We received some file recordings on Resident R but we could not locate or interview him.

This resident was born in 1964 and was placed at the CVGH in March of 1978. The records show he was committed to the Director of Child Welfare under the provisions of the *Juvenile Delinquents Act* in February 1978. An assessment of his suitability for the Blake Home was done. Records indicate there were regular contacts with the school, Mr. Blake and the parents. It was noted that this resident had made good progress and after six months he was returned to his family.

Resident S

We received some file records on Resident S but we were not able to locate or interview him.

Resident S was born in 1963. He was placed in the Blake Home under a TCP Agreement due to unmanageable behaviour. It was noted that he had been functioning fairly well at the home in February 1976 and he was returned to his parents in August 1976.

Records show that problems within the family continued and in October 1979 he committed a criminal offence, ran away, and was apprehended in Chicago. He was returned to Winnipeg and held at the Manitoba Youth Centre. He was subsequently placed at the CVGH under a TCP Agreement in October 1979.

The file records show some progress reports and assessments. This resident was visiting with family and seeing a dentist for dental work. There was also a request to purchase a bicycle for a field trip.

The records show the TCP Agreement was terminated by the parents and this resident returned to his family In January 1981.

Resident T

We received some file recordings on Resident T but we could not locate or interview him.

Records show Resident T was born in 1962. There were records indicating that Resident T was a non-ward of the Director of Child Welfare and the mother had signed an Agreement to place Resident T at the Blake Home. This TCP was cancelled in August 31, 1975 and it appears that Resident T returned home.

Prior to this Resident T was apprehended in 1970 as a result of a break down in the parental home and a request by the mother to re-establish in Winnipeg. Resident T was returned to the parents but due to behavioural problems he was referred to the Children's Home of Winnipeg.

A file record of May 1974 notes that Resident T showed a lot of functioning at school and at the Children's Home and that he was ready to return home. Further records indicate that he was unmanageable at home.

In December 1974, a doctor from the guidance clinic indicated that Resident T was a head banger and had a callous formation on his forehead as he banged his head before he went to sleep at night and when he woke up in the morning. It was noted that he had a history of epilepsy but had not had seizures for some time. He was on medication to help him sleep better and stop banging his head.

In a report in January 1975 the doctor wrote: "It does appear that Resident T can not be managed at home as there is no strong male figure there and he does not have the super ego to control himself. There will be a discussion probably today about going into the Blake Home. Certainly if there is not a foster home available, an institutional treatment centre will have to be considered as this boy needs 24 hour a day care, not to be seen on a once a month basis".

In a social history report completed by a social worker in 1974 it was suggested that Resident T receive a full assessment of his functioning before a treatment plan is implemented and that it was anticipated alternatives such as a foster home, group home, or institutional placement be pursued.

A file recording in June 1976 notes that Resident T was placed in the Blake Group Home in January 1975 and was returned to his parents in August 1975.

Resident U

We received some file recordings on Resident U but we did not interview him.

This resident was born in 1963. As a result of the inability of his parents to control his behaviour and delinquencies Resident U was placed at the CVGH. We have been unable to obtain records showing how and when he was placed at CVGH but it is apparent that Resident U went before the courts for a disposition and it is likely his placement was court ordered.

File records on Resident U show a disposition report prepared in July 1977 by his probation officer relating to offences committed under the *Juvenile Delinquents Act*. The report identified behavioural problems, control problems, delinquencies and need for stricter controls.

The probation officer recommended a psychiatric assessment to help in planning for Resident U.

The records show a forensic report was ordered by the court and it was completed in July 1977 by a consultant in Psychiatric, Children's Forensic Services. The report contained a recommendation that Resident U be placed in a group home and that "the most appropriate placement would be at Mr. Blake's."

Resident U murdered Phyllis Blake on December 17, 1977. He subsequently pleaded guilty to second degree murder and was sentenced to life imprisonment, with no eligibility for parole for a term of 10 years.

A supplementary report to the court dated January 9, 1978 was prepared by his probation officer after the murder. The probation officer interviewed Resident U at the Manitoba Youth Centre. It is reported that Resident U discussed his stay at the Blake Home, noting that he felt picked on by the older boys who had been there longer and he felt he was intruding. He felt picked on by Mr. Blake and he was accused of things for which he was not responsible.

The report further notes that recordings in Resident U's file show contacts had been made with Mr. Blake and the youth during the time Resident U was at CVGH by a supervising probation officer from Dauphin. These meetings mostly took place in the school at Grandview. The officer's file recordings point out that Resident U was entirely happy in the group home and adjusted quite well. He liked Mr. and Mrs. Blake and had no complaints.

According to the report, Mr. Blake had expressed a great deal of concern about Resident U, describing him as being a boy with many problems and a ring leader. He felt psychiatric counselling should be explored.

In a report to the court by a psychiatrist in May 1978 it was noted that during an interview with Resident U he said he viewed the Blake Home as restrictive, limiting and depriving. Rules and responsibilities were imposed on him and he was subject to some corporal punishment in the form of strapping if the rules weren't followed.

In a report to the court prepared by a Children's Forensic Services consultant in psychiatry in February 1978 it was noted that Resident U had said that the boys and Mr. Blake ganged up on him and he got the most severe punishments, 11 lashes on the palms of his hand.

The same consultant in a report to the courts in May 1978 stated, “Last year’s decision to place Resident U at Blakes’ was some attempt to supply this youngster with some of the ’goodies‘ which he missed. However, the difficulty that we faced was that Resident U suppressed his real feelings and the input was not of the nature that would ferret out this defensive nature. So that was a first attempt. In other words, there were definite flaws in the Blake placement, which unfortunately came to light by the act of violence.”

INFORMATION FROM FORMER CVGH STAFF

Staff comments on Mr. Blake have been previously noted in this report.

In general terms, staff described the resident's work as picking rocks, clearing land, some hay baling, looking after the animals on the farm and working in the garden. The residents also helped in the construction and repair of various buildings. We were advised that some of the boys learned how to drive a tractor.

One staff person described the work as chores and a little farm work. He said that some of the residents worked at the Boggey Creek Festival, preparing the grounds, weed whacking, filling potholes and picking up garbage. He said that at the closing of the festival the boys collected the beer bottles and the money went to the boys. He said the boys did some work off-farm doing baling. He recalled doing daily logs and monthly reports on all the boys and sitting down once a month with a worker to discuss the boys' progress.

A person who spent time visiting and working at the farm over the years said that the boys came with money from the government and that they had bikes, sleeping bags, jean jackets, school clothes, work clothes and clothes to wear for dentist appointments. He said the boys had sufficient food and clothing. He said the boys went to town, went home for visits, went camping and fishing, and had free time in the evenings after the chores were done. He also recalled that there was a totem pole on the farm that had been made by the Boy Scouts in Winnipeg and brought to the farm by Mr. Blake. The wife of a former worker at the CVGH advised that after Mr. Blake died, her husband was given the totem pole and she still had it on her property.

The young couple hired after the death of Phyllis Blake considered the farm like a petting zoo. They said the boys did chores but the boys didn't have a lot of work to do and they had ample free time. They recall the boys talking about stacking bales but it was not the practice for the residents to work on other farms during the time the couple were em-

ployed at CVGH. They recalled a probation officer visiting once and they felt there could have been more oversight by government. They felt the underlying problems of the boys were not being addressed. They commented that some of the boys had anger management issues. They felt that Resident D was not a good candidate for a group home as they thought he was mentally and emotionally delayed and was the brunt of jokes and ridicule. They said the boys did not know much about their cultural spiritual beliefs.

Unfortunately most of the staff recollections come from staff who worked at the CVGH after Phyllis Blake's death. There is a minimum of information we received from staff about the operation of the CVGH between 1971 and 1977. The Blakes were pretty much the only staff working at the CVGH during that period and both are deceased.

INFORMATION FROM THE GRANDVIEW COMMUNITY

We travelled to Grandview and the community to view the former CVGH and to interview teachers, neighbours and community. Of the 21 individuals we were able to identify as having some knowledge of the CVGH and/or the residents, we were able to interview 15. These included school principals, neighbours and community members.

Some of the information received from the community was based on vague recollections, rumour and hearsay. However, there was some consistency in the recollections individuals had of the operator, the residents and the activities of the CVGH.

The community's comments on Mr. Blake have been previously noted in this report. In terms of other activities, we were advised that the residents came to town and had money to spend. Some recall, and some participated in camping and fishing activities with the residents.

One friend of the Blakes and the residents recalls the residents going to a Christmas concert, sporting events, skating and movies.

Neighbours recalled the residents working on the farm, doing chores and picking rocks. No one could remember any off-farm work by the residents. One individual remembered that the residents did some logging on the CVGH property one winter with the intention of selling logs and using the money for the home. This individual also recalled going to the home for a wiener roast and remarking that there was an abundance of food and snacks available to the residents.

INFORMATION FROM FORMER PROBATION OFFICERS AND FORMER CHILD WELFARE WORKERS

We spoke to probation officers and child welfare workers who were responsible for referrals to the Blake Home, for screening residents for their suitability and for monitoring the resident's progress. While most had difficulty recalling specific situations and circumstances and the identities of the residents who were placed at the Blake Home, there was some consistency in their recollections of the placement process and the monitoring and supervision that took place at that time.

All recalled that the boys were apprehended under provisions of the *Child Welfare Act* or the *Juvenile Delinquents Act* and that an assessment was made regarding their disposition. Some recalled making a referral to a screening committee for placement at the Blake Home. It was understood that the Blake Home was suited for boys who needed a structured and controlled environment.

One social worker commented that it was a simple process to obtain a Temporary Placement Order as things were done informally with few checks and balances. A senior probation officer said that the decision to place a probationary boy would never be made without a forensic assessment being done on the boy.

In terms of the work at the Blake Home most understood that the boys did chores, clearing land, picking rocks, and gardening. While some said they were not aware of any off-farm work, they also said they thought there may have been some opportunities for the boys to work for local farmers and earn some money, but this would be infrequent. We were told that the boys were expected to work but not in day after day labouring in fields.

Most recalled the boys having leisure time which included going to town and camping. We were told the boys had spending money which likely came from the family allowance which was collected by the Department. We were advised that the regional office was responsible for administering funds for the boys.

A former senior social worker in Dauphin said the Blake Home would have been visited and there were standards for space footage, windows, beds, recreation, spending money, diet and clothing. He said he routinely visited the boys in care and that it was a responsibility to visit foster homes regularly.

We were advised that the home was monitored through occasional visits by social workers and probation officers. We were advised by one probation officer that she would try to see the residents once a month, that probation officers were required to keep running records and they had to do periodic progress reports. Another social worker said he would see the boys in school and that sometimes Mr. Blake would bring them to Dauphin where he would see them. One social worker referred to flexible monitoring suggesting that there was no fixed schedule for visits or speaking to the boys.

A former senior probation officer said he once spent a weekend at the home looking after the boys. He also advised that quarterly reports were done on probation cases based on information gathered from Mr. Blake, school and the boys. These were done either at school or at the home.

Some social workers and probation officers advised that they would find it more convenient and private to meet residents while they were attending school at Grandview.

No government worker recalled ever receiving a serious complaint from any of the residents of CVGH. There were no recollections of residents raising concerns about corporal punishment in the form of strapping or of sexual abuse. While most said this would not be condoned, they had no evidence of this occurring. Some did say they heard rumours and that it could have taken place.

LEGISLATION AND REGULATIONS

Legislation in 1971 allowed for approval of a foster home by the Regional Director, limiting the number of residents to four. However, as early as 1972, a Dauphin social worker noted CVGH was housing nine boys, and later in 1974 the same social worker noted there were 10 boys at the home ranging in ages from 11 to 15. It seems that the home quickly evolved into a foster group home authorized by the department.

Manitoba Regulation 321/74 provided for the licensing of foster homes and group foster homes. The noted regulations stipulated that foster homes were only allowed to have more than four residents with special permission of the Director of Child Welfare. Thus the decision on resident numbers was determined by Parkland CFS in this instance. In the case of foster group homes, the regulation stipulated that the licensing authority may require and shall designate the maximum number of children and specify the age range and sex of the group or groups of children who may be accommodated therein.

The regulation also had stipulations concerning the premises and the foster parents respecting foster homes. For foster group homes, the regulation included a number of stipulations relating to the premises, record keeping, and care of the residents.

It appears that the CVGH was not licensed as a group foster home at that time and it continued to operate under the authority with the approval of the Department.

In 1977, the *Social Services Administration Act* was amended requiring a foster home or a group foster home to be licensed and it appears that the CVGH was licensed in 1978 as a Level II facility.

The Kimelman report referred to the CVGH as a Level II facility in his review of group homes. He described the Level I and Level II designations as follows:

> ***Level I***
> *Client Characteristics - Situational Problems –*
> *"Refers to those children requiring placement largely because of factors beyond their control and not of their own making, i.e. neglect, abandonment,*

parent's inability to function. This type of child would show limited behavioural or emotional difficulties other than responses related to the stress of the circumstances which led to their need for placement."

Program Orientation

"Program" per se at this level would be non-existent. Children in placement would be expected to accommodate to the routines of life in the family in which they were placed. Community activity is based on individual choice to be involved with little or no support from houseparents."

Level II

Client Characteristics - Situational problems, minor behavioural, emotional or interpersonal problems.

"Children whose backgrounds are comparable to those described in Level I and in this sense suffer "situational difficulties" but who also show behavioural emotional and interpersonal problems requiring placement away from home. Examples would include poor school attendance, delinquent activity (property offenses), resistance to parental attempts at control, etc. Children who are mildly retarded requiring placement would also be included in Level II."

Program Orientation *– Family Routine directed toward living in a family.*

"As part of family living, houseparents plus support child care staff would consciously involve all children placed in activities geared to enhance learning, socialization and work or activity skills, i.e. recreational involvement with ongoing support from houseparents or child care staff. Houseparents or child care staff will need to provide support and facilitate resident's participation and attendance in appropriate recreation."

In 1981, *Manitoba Regulation 41/81* came into effect governing the licensing of foster homes wherein stipulations were quite broad in terms of staffing, records, safety, and personal services.

MANITOBA'S CHILD WELFARE SYSTEM AND GROUP HOME ENVIRONMENT WHEN CVGH OPERATED, THE KIMELMAN REPORT

The child welfare system in the 1970s as it related to group foster homes can be better understood after reviewing the Kimelman report which was based on a review he had undertaken in 1982/83 on group homes. I believe references to Judge Kimelman's report are beneficial to this review.

In commenting on the development of group homes in Manitoba, Judge Kimelman's report states:

> *"The emergence of group homes as an alternative to institutions and to foster care began in the late 1940s in North America. In Manitoba there was a major increase in the number and use of group homes during the early 1970s. This development was largely unplanned and uncoordinated. There were no policies or standards in relation to licensing and funding of these homes. Primarily responsibility for approving and funding group homes rested with a variety of program directorates and private agencies."*

The report noted what Judge Kimelman felt were a number of reasons for an unplanned proliferation of group homes mainly concentrated in Winnipeg, concluding that this seemed to occur as a result of an attitude that group homes were almost a panacea in placing older children, particularly those with moderate emotional and/or behavioural problems and that there was an increasing difficulty in recruiting and retaining foster parents in the urban community. The report noted that in the late 1960s and the early 1970s group homes for children were developed as a less costly and community based alternative to institutional care and as a substitute for foster care.

Reference was made in Judge Kimelman's report that a committee was established in 1977 by the Deputy Minister of the Department of Health and Social Development to review the

entire provincial spectrum for residential services for children, including children who fell under the responsibility of Child and Family Services, Juvenile Corrections/Probation Services and Mental Retardation Services. It was noted that at that time there were 92 homes classified as group homes either private or non-profit, and a number of unspecified agency-operated group homes.

Judge Kimelman's report noted that the committee identified the following problems in the system:

"a) A preponderance of group homes located in Winnipeg.
b) A lack of services to support families to prevent children from coming into care.
c) A lack of resources for highly specialized care including
- community settings for the moderately retarded.
- community settings for aggressive children.
- secure long-term inpatient psychiatric care.
- culturally relevant programs for native youth.
d) Poor integration and co-ordination of resource development and utilization with no connection between the various types and levels of care.
e) No standards or accountability in relation to admission or discharge criteria or procedures.
f) No systematic provincial review of group homes or institutions.
g) No rationale or control regarding per diem rates or service expectations of group homes."

It was further noted that as a result of this committee, the Office of Residential Care was established to license, fund and review group homes and a level of care system was developed. The report talks about the further establishment of an interdepartmental committee in 1977 eventually referred to as the Residential Care Coordinating Committee that worked on the development and/or refinement of recommended standards, policies and procedures, reviews of group homes and investigations of incident reports and/or complaints.

Judge Kimelman's report refers to the passing of *Manitoba Regulation 41/81* which gave the licensing authority both the authority and the responsibility to licence residential care facilities in accordance with legislation, regulations and standards governing fire safety, public health protection, residential care and other standards and conditions as may be required. The report noted that a significant change resulting from this regulation was

that group homes for children would require licensing in accordance with residential care and other standards as well as fire safety and health protection.

Judge Kimelman's report clearly identifies many of the problems with the system at that time as it related to group homes and answers some of the concerns that arose in conducting this specific review of the Cathedral Valley Group Home which operated from 1971 to 1983. I believe Judge Kimelman's comments are more beneficial to the understanding of the system at that time than any comments I might make some 25 years later.

In this report I am drawing attention to the following comments in Judge Kimelman's report that are particularly relevant to this review. Under the headings:

Adequacy of Facilities

"It must be said firmly and strongly that group homes are a necessary and valuable component of the child care system. There will always be children who have been so damaged in their relationships to parents or parent surrogates that no in-home service or foster home can provide them with the security they need."

"It must be recognized that for a child care worker who feels overburdened, overworked and jumping from one crisis to another, placement of a child in a group home bed must seem to be the ultimate answer. Safety and security are assured. The worker can move on to the next crisis."

"There is no system in place to ensure that group homes are used for those who can benefit from them. Agencies can place children directly into Level I, II, or III homes if there is a vacancy and if the home agrees to accept that particular child."

Program Standards

"It is obvious that a brief visit to a group home does not, and cannot, constitute an evaluation of the effectiveness of the program offered. Again we must rely on the impressions and on what we were told by group home staff."

"It is highly possible that in many group homes children are not being helped but simply housed. It is also possible that children are actually being

psychologically harmed in some group homes and, if this is the case, such group homes should be closed."

"Child caring agencies and Probation Services must build into their systems a way of monitoring worker visits to ensure that contact with the child is maintained on a regular basis. If placing workers do not visit the children in group homes, one can have little confidence that time is being spent with the child's family to prepare for the child's return."

"It is of concern that there is no regular training course available for group home staff to enable them to improve their skills."

"A child should not be placed in a group home (or any other setting) unless there is a clear understanding by the family, the child, the placing agency and the group home of what is expected to happen in what time frame. We are simply not confident that a treatment plan is consistently available prior to placement."

"In common with any group living situation, certain problems are inherent in group homes. A child previously involved in minor delinquency acts may be subject to the negative influences of more sophisticated delinquents. All a group home can do is take reasonable precautions to protect the younger or more innocent children."

"It is also possible that incidents of physical or sexual abuse between children go unreported due to a child's fear of further intimidation. Such dangers must always be considered and measured against the actual situation in a child's home."

Judge Kimelman's report raises issues that are reflective of many of the shortfalls in the placement of residents, their supervision and monitoring, along with the care and treatment they received at CVGH in the 1970s and 1980s when the home operated.

Legislation and policies have evolved over the years in ways which appear to address many of the concerns and deficiencies noted in the Kimelman Report. Relevant to this review are what I would suggest are positive advancements in the legislating from what existed in the 1970s.

In particular, *Foster Homes Licensing Regulation 18/99* under *The Child and Family Services Act* stipulates far more requirements for operating a foster home than existed when CVGH operated.

An applicant for a license to operate a foster home must now have a criminal record check, a child abuse registry check and references from four persons or a recommendation from the local Child Care Committee. The regulation also requires that a personal assessment of the applicant for a licence to operate a foster home is conducted as to his /her ability:

- to protect nurture and care for the number of children placed in the foster home;
- to provide a culturally appropriate environment for these children placed in the home; and
- to meet the children's needs.

Furthermore, this regulation clearly speaks to the issue of discipline wherein Section 20, states:

Unacceptable disciplinary practices

20 *A licensee shall not*

(a) permit, practise or inflict any form of physical punishment, verbal degradation or emotional deprivation upon, or denial of any basic necessities to, a foster child;

(b) physically restrain a foster child other than physical restraint for the purpose of protecting the person and property of a foster child or others, and only to the degree and duration necessary for such protection;

(c) encourage or condone punishment of a foster child by other children;

(d) force a foster child to take an uncomfortable or degrading position as a form of punishment;

(e) establish a room for the purpose of isolating a foster child;

(f) exclude a foster child from entry to the foster home;

(g) use excessive or prolonged confinement;

(h) permit or refuse home visits as a form of reward or punishment; or

(i) practice any other disciplinary measure expressly prohibited by the licensing agency or the mandating authority.

There is also a grievance policy for complaints established under this regulation.

There are many more advancements in legislation and policy in the child welfare system since the 1970s, however this review did not undertake, nor was it established to undertake a comprehensive review of the current legislation.

CONCLUSIONS

The conclusions arrived at from this review were drawn from individual recollections from about 30 years ago and records that, while helpful, were incomplete. Nevertheless, I am satisfied that there is sufficient information available to support the following conclusions.

CVGH WAS ESTABLISHED TO MEET LEGITIMATE NEEDS AND WAS APPROVED CONSISTENT WITH THE STANDARDS OF THE DAY

There was a need for safe, structured, controlled environments as an alternative to an institutional or a correctional setting and the CVGH was approved in accordance with the legislation at the time. As the Kimelman report noted in 1983, group homes were a necessary and valuable component of the child care system.

THE REVIEW COULD NOT SUPPORT A SLAVE OR BOOT CAMP SCENARIO

The residents went to school, did chores around the home, worked outside the home, participated in recreational activities, and had spending money, food and clothing.

At times, the residents worked hard doing farm work. To some, the work was perceived as excessive. Considering the environment some were coming from I can understand their perception. The work, however, did not appear to be disproportionate to the other activities.

SOME RESIDENTS WERE EMOTIONALLY HARMED BY THE STYLE AND BEHAVIOUR OF THE OPERATOR

While the operator provided structure, control and discipline, it was one dimensional. He ran the home like a military environment and employed fear and corporal punishment as a means of discipline and control, which I believe, based on the many interviews conducted, was at times excessive.

I would categorize the operator's style as a one size fits all. There was no room to accommodate special emotional needs of some of the residents.

While we discovered no reasons to suggest that the operator's intentions were not good or that systematic abuse or exploitation existed, some were emotional harmed by this

strict militaristic and disciplined environment that used corporal punishment as a means to instil fear and control over the residents.

SOME PLACEMENTS AT THE CVGH WERE QUESTIONABLE

Resident B was placed at the CVGH when he was nine years old and remained there until he was almost 18. It was acknowledged in a file recording by a social worker that it was likely an error placing him at the group home at nine years old as a regular foster home could have been more appropriate.

Resident D and Resident T had special emotional needs that, in my opinion, made placement at CVGH unsuitable in view of the operator's style.

However, in reviewing the basis for placement of the residents at the CVGH, one could see the rationale and support for assessing the CVGH as an appropriate placement for most of the residents, taking into consideration the system at the time.

There were no foster group homes for boys in the region through to Churchill. In some ways, Mr. Blake's well-documented reputation for running a strict, regimented foster-care setting may have been seen at the time as a highly desirable resource by those working within the systems that were challenged to find placements for some of the boys. There were few places in the province for children that might be deemed difficult to place in other foster family settings.

While there were inconsistencies in placements and the CVGH may have been the wrong environment for some of the boys, I believe the workers involved in the placement process were acting in what they felt were the best interests of the boys they were placing.

MONITORING AND OVERSIGHT WAS NOT SUFFICIENT TO IDENTIFY SPECIFIC PROBLEMS OR ISSUES OF THE RESIDENTS

The Kimelman report noted there were certain problems inherent in group homes where some boys involved in minor delinquencies may have been subject to the negative influences of more sophisticated delinquents. The report also noted that it was not uncommon for incidences of physical or sexual abuses which occur in group home settings to go unreported for fear of reprisal or embarrassment.

Some of the boys related incidences of physical or sexual abuse noting that they didn't feel they could tell anyone for the above reasons. Some workers acknowledged the

problems the boys might have in speaking out, but it appears no process was put in place to counter these problems.

Resources, caseloads, and a lack of program standards were factors in the extent to which monitoring and oversight took place. There are other reasons for the deficiencies in the system which are noted in the Kimelman report, all of which suggests to me that the shortfall in monitoring and oversight of the CVGH was related more to the system than individual responsibility.

SYSTEM LACKED SENSITIVITY TO THE EMOTIONAL NEEDS OF SOME OF THE RESIDENTS

While intentions may have been good, I found that there was a lack of sensitivity to problems some of the residents experienced both emotionally and physically during their stay at the CVGH.

Whether one is coming from a major urban centre or a small northern community and they are faced with unfamiliar farm life or a military style environment, it is a major adjustment. No doubt some felt isolated, abandoned, lonely, afraid and confused.

In addition, the environment consisted of a mix of younger and older boys. Some had not received the proper care and needed protection. Others had committed delinquencies and all had been deemed as needing control and supervision. Behaviours were different. Some residents adjusted to the environment and others did not or got into trouble. With a mix of residents like this in a group home setting, one might expect that there may be issues of inappropriate physical or sexual behaviour amongst residents. However, this review could not identify any specific processes at that time to address these concerns.

Mrs. Blake's murder was a particularly traumatic event for the boys who were there when it occurred. There was no counselling then and there has been no counselling to date for some of these former residents who still suffer from the memories of that event.

SOME RESIDENTS STILL CARRY EMOTIONAL DAMAGE OR SCARS FROM MEMORIES AND FEELING OF THEIR STAY AT CVGH

Some of the former residents feel they were subject to emotional, sexual or physical abuse while residing at the CVGH. I believe many still carry emotional damage or scars from their memories and feelings of their stay at CVGH. Some of the former residents said they felt they needed and wanted help to address their feelings and behaviours that have followed them since leaving the CVGH. Unfortunately in many cases the former

residents simply dropped off the radar after they turned 18 and their files were closed. They left CVGH with little emotional preparation or skills to adjust to living outside their group home environment.

THERE NEEDS TO BE A RECOGNITION OF THE EMOTIONAL DAMAGE AND A PROCESS FOR HEALING

During this review we received telephone calls from others who wanted someone to hear their stories of what they alleged were abuses and ill treatment while in foster or group home environments. They were seeking somewhere to go where their concerns would be heard and their feelings validated. While we could provide no direct assistance to these individuals other than listening, their desire to tell their stories and have their feelings validated were not unlike what we heard from some former residents of CVGH.

This review has led me to the conclusion that there remains a need for recognition of the emotional damages suffered by some of the boys. Their removal from their families and communities and the resultant feelings they inevitably felt of fear, isolation, abandonment, loneliness and confusion were exasperated by their experiences at CVGH, which for some may have included physical and sexual abuse. There needs to be healing, a process for healing, and a plan to provide it.

What may be required to bring healing may be different from one individual to another. Therefore there needs to be a process to identify and develop individual plans to bring healing to those former residents who suffer emotional damage and who choose to participate. I have not directly addressed matters such as compensation or an apology as these are matters that may or may not be considered as part of that healing process.

RECOMMENDATIONS

I recommend that:

- the Department commit to developing a plan to identify a means to provide a healing process for those who suffered emotional damage while they were residents at the CVGH;
- the Department commit to the provision of resources necessary for the development and implementation of this plan;
- the Department consult with former residents to give them the opportunity to participate in the development of individual plans to support their healing;
- consideration be given to appointing an independent third party service organization which could include professional expertise and peer support to develop and implement the plan; and
- resources be available for former residents to access both the consultative and the healing process.