

FEDERAL COURT

B E T W E E N:

ATTORNEY GENERAL OF CANADA

APPLICANT/MOVING PARTY

- and -

**FIRST NATIONS CHILD AND FAMILY CARING SOCIETY OF CANADA,
ASSEMBLY OF FIRST NATIONS, CANADIAN HUMAN RIGHTS
COMMISSION, CHIEFS OF ONTARIO, AMNESTY INTERNATIONAL
and NISHNAWBE ASKI NATION**

RESPONDENTS/RESPONDING PARTIES

MOTION RECORD OF THE RESPONDENT/RESPONDING PARTY

ASSEMBLY OF FIRST NATIONS

Volume 2 of 3

NAHWEGAHBOW, CORBIERE

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TAB 2

FEDERAL COURT

B E T W E E N:

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APPLICANT

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**FIRST NATIONS CHILD AND FAMILY CARING SOCIETY OF CANADA,
ASSEMBLY OF FIRST NATIONS, CANADIAN HUMAN RIGHTS COMMISSION,
CHIEFS OF ONTARIO, AMNESTY INTERNATIONAL
and NISHNAWBE ASKI NATION**

RESPONDENTS

AFFIDAVIT OF DR. MARY ELLEN TURPEL-LAFOND

(Affirmed November 7, 2019)

Volume 2

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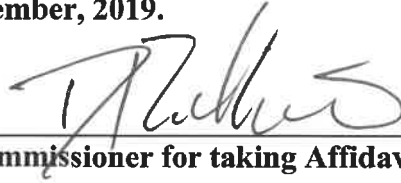
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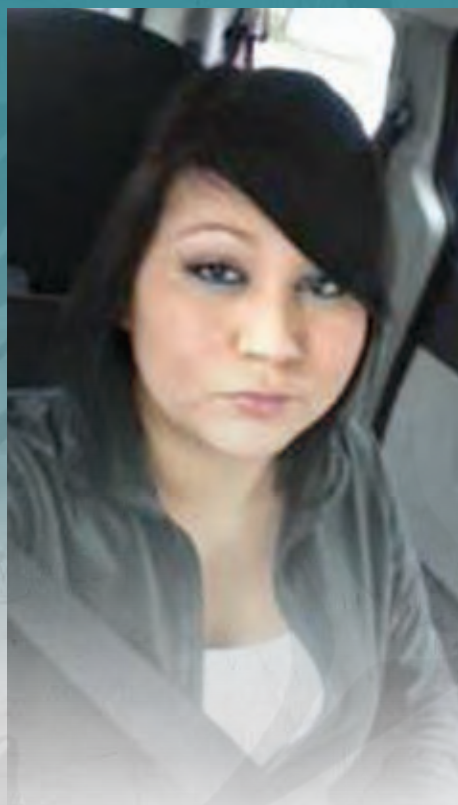
**This is Exhibit "H" referred to in the
Affidavit of Mary Ellen Turpel-Lafond,
sworn before me, on this 7th day of
November, 2019.**

A handwritten signature in dark ink, appearing to read "T. R. L.", is written over a horizontal line.

A commissioner for taking Affidavits

Paige's Story

ABUSE, INDIFFERENCE
AND A YOUNG LIFE DISCARDED



REPRESENTATIVE FOR
CHILDREN AND YOUTH

May 2015

May 14, 2015

The Honourable Linda Reid
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Ms. Speaker,

I hereby submit the report *Paige's Story: Abuse, Indifference and a Young Life Discarded* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of critical injuries and deaths of children receiving reviewable services.

Sincerely,

A handwritten signature in black ink, reading "meturpellafond", written in a cursive style.

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Craig James
Clerk of the Legislative Assembly

Jane Thornthwaite
Chair, Select Standing Committee on Children and Youth

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Preface

There is no greater tragedy than the death of a child or youth, especially when it could have been prevented. It is an occurrence that produces an immense and unrelenting sense of loss and grief for the immediate and extended family and also a tremendous loss of potential for society as a whole.

This report tells the story of one such tragedy. It examines the life and death of Paige, an Aboriginal girl from British Columbia who never received the nurturing or protection she deserved. As a result, she died of an overdose shortly after her 19th birthday in Vancouver's Downtown Eastside.

The Representative has taken the unusual step of using Paige's actual name in this report, because it is important to acknowledge that this is the story of a real girl, a real person – a person who deserved much better from the society in which she briefly lived. Her life was one of incomprehensible suffering, and how she felt as she searched for love, acceptance, learning and safety, is not entirely known. But we must put ourselves in her place to learn how to stand beside and support children who are vulnerable, to provide a different life for them – one which most British Columbia children enjoy, but those such as Paige can only imagine.

Paige's story is a difficult one to tell, perhaps the most difficult report this Office has ever undertaken. The Representative is extremely grateful to Paige's family for their participation in this investigation and their willingness to share information and insights. This family has suffered loss across the generations and we can only offer this report in the spirit of ending the trauma such families experience again and again. The Representative recognizes that it has taken tremendous courage for the family to share this story and hopes that the resulting report will help prevent such tragedies in the future.

The Representative also recognizes there are dedicated staff working with children such as Paige and that telling her story can cast a pallor of blame on individual staff and can traumatize these individuals. That is not the intent of this report. We thank those who work in social care and child welfare, but it is time to own the dysfunction and disarray that resulted in a failure to save Paige. The purpose of this report is to focus on changing the pathway that Paige's life took in order to prevent other girls from a similar fate.

Related RCY Reports and Activities

(All reports available at www.rcybc.ca)

Several reports by the Representative have explored the well-being of Aboriginal children and framed the key challenges:

- *Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl* (2014)
- *Out of Sight: How One Aboriginal Child's Best Interests Were Lost Between Two Provinces* (2013)
- *Much More Than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care* (2013)
- *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children* (2013)
- *When Talk Trumped Service: A Decade of Lost Opportunity for Aboriginal Children and Youth in B.C.* (2013)
- *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm* (2012)
- *So Many Plans, So Little Stability: A Child's Need for Security* (2011)
- *Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Children* (2011)
- *Growing Up In B.C. Joint Report with the Office of the Provincial Health Officer* (2010)
- *No Shortcuts to Safety: Doing Better for Children Living with Extended Family* (2010)
- *Housing, Help and Hope: A Better Path for Struggling Families* (2009)
- *Kids, Crime and Care: Youth Justice Experiences and Outcomes: Joint Report with the Office of the Provincial Health Officer* (2009)
- *Amanda, Savannah, Rowen and Serena: From Loss to Learning* (2008)
- *Health and Well-Being of Children in Care in B.C.: Educational Experiences and Outcomes* (2007)
- *Health and Well-Being of Children in Care in British Columbia: Report 1 on Health Services, Utilization and Mortality: Joint Report with the Office of the Provincial Health Officer* (2006)

In addition to these reports, the Representative:

- made a submission to the Truth and Reconciliation Commission titled *Aboriginal Children: Human Rights as a Lens to Break the Intergenerational Legacy of Residential Schools* (2012);
- presented a paper at the International Summer Course on the Rights of the Child in Moncton, N.B., *Making Human Rights Relevant to Children* (2012); and
- as a member of the Canadian Council of Child and Youth Advocates, released a *Special Report, Aboriginal Children – Canada Must Do Better: Today and Tomorrow* (2011)

Executive Summary

Every professional who works with British Columbia's most vulnerable children – from those in child welfare, to those in education, health care and justice – has a clear responsibility to do everything in their power to ensure the proper care and safety of those children.

When that responsibility is not fulfilled over the 988 weeks that constitute childhood, the results can be disastrous. Such was the tragic case for Paige, an Aboriginal girl who, sadly, was treated with what the Representative for Children and Youth can only describe as professional indifference. Paige – an outgoing, funny, bright girl who loved animals – died in April 2013 of a drug overdose in a communal washroom adjacent to Oppenheimer Park in Vancouver's Downtown Eastside. She was just 19-years-old.

Children who have been maltreated are more likely to develop emotional, behavioural and psychological problems. The psychological effects, or "trauma," of persistent maltreatment include isolation, fear and loss of the ability to trust others. Long-term consequences for those who experience severe and prolonged maltreatment often include alcoholism, drug abuse, smoking, suicide and certain chronic diseases. Paige was no exception. Friends and family watched as this engaging young woman with a typical adolescent interest in fashion and make-up became overwhelmed by the enormity of her life challenges.

B.C. has a great interest in preventing maltreatment and protecting children from it. The consequences of maltreatment pose a major social and economic burden to our society. This understanding of the state's duty to protect children, and its duty to support more economically and socially appropriate policies to lessen the burden of maltreatment on fellow citizens, is now well-known.



Paige's story reveals the massive gap between our understanding of the effects of trauma and the systems at the front line – the social workers, police, school staff and health care providers. Professional standards of care were not upheld in how Paige was treated. This raises intense concerns about the professional judgment of those in the system and the stewardship by governments of all levels of those duties. Her suffering is detailed in this report and it will sicken every reader to know that this happened in Vancouver, under the watchful lens of a social services system that should have done better.

Paige was not just another maltreated, abused or neglected child. She was an Aboriginal girl left in a known situation of danger – in Vancouver's bleak and unforgiving Downtown Eastside (DTES), an environment where even some of those working in social services refused to venture because it was not safe for them.

The treatment Paige received will shock British Columbians. What is more tragic is that hers is not the only case the Representative has seen and it will not be the last one unless we seriously change our approach from one of indifference, massive spending without corresponding results and no consequences or accountability for further traumatizing already maltreated children.

Child welfare systems exist to protect individual children from harm. They do not exist to place children in danger, or to further punish those children by allowing them to continue down a path of psychological trauma leading to complete self-destruction. Sadly, Paige's story makes the Representative wonder if, in the case of children in the DTES, child welfare has been turned upside down. Paige's passing went without any scrutiny. Any opportunity for learning from her life would have been lost without this report.

This is one of the most troubling investigations the Representative's Office has ever conducted. It is a startling example of a collective failure to act by multiple organizations and individuals within those organizations who should have helped Paige and in fact had multiple opportunities to do so. Instead, far too often, social workers and the child welfare system in B.C. failed to protect her from her own mother and harsh environments in the DTES; educators failed to keep this bright child, who showed so much early promise, attached to school; health care workers, police officers and the legal system often failed to follow up and in some cases even notify her social workers. For this girl, the system and those who work in it failed as a whole in their duty to care for and protect her.

In essence, Paige's story is one of how professional indifference to her life circumstances continually left her – and at times even actively placed her – in harm's way. This indifference contributed directly to her untimely death.

This is a child who should have been permanently removed from her mother's care at an early age. She was the subject of no less than 30 child protection reports during her 19 years, involving allegations of domestic violence, neglect and abandonment. Her mother was actively using alcohol and drugs and there were no signs of that behaviour abating. Paige was repeatedly returned to her mother by the Ministry of Children and Family Development (MCFD) despite glaring and unavoidable evidence that this was not a healthy, nurturing or safe environment for any child and wasn't ever likely to be.

As a result, Paige's life was a case study in chaos. By the time she was 16, she had moved no less than 40 times, between residences with her mother, foster homes, temporary placements and shelters. After her mother moved them to the DTES in September 2009, Paige lived with her in toxic environments and moved another 50 times, living in various homeless shelters, safe houses, youth detox centres, couch-surfing scenarios, foster homes and a number of Single Room Occupancy (SRO) hotels.

From the time of her birth she felt the effects of a mother troubled by severe substance use issues. Despite this, Paige showed compassion toward others from an early age, reaching out to one foster parent's special needs child and helping other classmates in school. However, not surprisingly, she began abusing alcohol and drugs at a young age herself. Both mother and daughter eventually succumbed to overdoses, with Paige's mother dying on Oct. 30, 2014.

But before Paige's death, there were many opportunities for child welfare to intercede and to alter her otherwise predictably tragic life trajectory. Sadly, most of those opportunities were not seized upon.

School might well have made a difference in Paige's life, had she been able to remain attached to one long enough for its positive influences to take hold. She was evaluated early on as a bright student with promise, but after 16 school transfers through multiple communities in B.C., and with a chaotic home life that limited her attendance to sporadic at best, her education stalled in Grade 10.

The justice system might also have helped find a solution, or at least started Paige down a new path. During the first three years after moving with her mother to the DTES, she was involved in more than 40 police files, mostly for public intoxication or disturbances involving alcohol. One officer told the Crown counsel that Paige needed *"some form of intervention, hopefully by the court, or she may be hurt or killed while on a binge."* That intervention never came.

Paige also had many contacts with the health care system – when she ended up in the Emergency ward or detox after being found unconscious or incoherent at least 17 times and also during her visits to Vancouver-area hospitals to terminate unplanned pregnancies on three separate occasions. Follow-up care was spotty at best and communication among hospitals, police and MCFD was inconsistent, at times non-existent. She was often discharged without an after-care plan, back to a place of danger, with incredible physical and emotional suffering.

Social workers and MCFD as a whole had by far the most and best opportunities to help Paige as well as the lead responsibility in law and policy. The ministry mishandled her file from the very beginning, failing to adequately assess the risk to her as an infant and then continuing to return her to her mother's care rather than pursue other more viable options. One of the best options – an aunt and uncle who were actively interested in caring for her and with whom she had developed a bond – were inexplicably never seriously considered as a placement option, even though they could have offered Paige connection to family, culture and stability – her rights under child welfare legislation in B.C. Indeed, she left her cats in their home because her own homes in the DTES were not safe enough for pets.

The role MCFD played in Paige's life could best be described as haphazard. A total of 17 different social workers across B.C. had responsibility for her file before she aged out of care at 19, fearful and utterly unprepared for what lay ahead. Despite her involvement with MCFD for virtually her entire life, only one ministry worker developed what could be considered more than a rudimentary relationship with Paige. There was little trust or connection between this girl and the multitude of MCFD staff who intersected with her.

Social work practice seemed to overlook the obvious risks that Paige's mother posed to her well-being, even leaving Paige in her mother's care when her mother was being sought by police for extortion, unlawful confinement and uttering threats. And once Paige was moved to the DTES, files and interviews with workers show that actual contact with her or her mother was minimal. The MCFD approach to Paige placed the responsibility on her to seek help, rather than the ministry actively seeking opportunities to intervene on her behalf. This approach – of noting the dangers, but not intervening – left her to live in squalid SRO hotels, potentially dangerous shelters or on the street.

The Representative finds it incomprehensible that MCFD could somehow determine that shelters and SROs in the DTES were suitable for any child, in particular Paige. This was a girl with little to no support from her mother. In fact, she was often forced into the role of being a young carer – looking after an addicted parent – with no resources and no help. Her pathway through trauma after trauma is especially deplorable because everyone knew how dangerous the situation was for her. They chose not to act.

More to the point, Paige was an Aboriginal girl, living in a neighbourhood which has been notoriously cruel to Aboriginal women and girls. Her mother was drawn to the DTES from the Interior of B.C., following a pathway well known to child welfare and police agencies. At the very same time Paige resided in the DTES, Justice Wally Oppal was conducting his inquiry into the victims of Robert Pickton, a serial killer who preyed on girls and women from this downtrodden and dangerous place, many of them Aboriginal. The SROs in which she lived were avoided by some workers as too dangerous to visit. This was a place of “known harms,” and a place to which Paige was continually allowed to return.

Aboriginal children are disproportionately represented in the B.C. child welfare system, comprising more than 50 per cent of children in care despite making up only about eight per cent of the child population. Aboriginal children are seven times more likely to come into care than non-Aboriginals. As such, B.C. has strong legislation and policy in place to offer special protection to Aboriginal children. But this was not enough to help Paige.

Indeed, the Representative believes that despite this strong legislation and policy, there is too often a distinct lack of strong follow-through by professionals when it comes to Aboriginal girls such as Paige. This has been evident in other recent RCY reports detailing the plight of Aboriginal children, including *Lost in the Shadows* (2014), *Out of Sight* (2013) and *Who Protected Him?* (2013), all stark examples of Aboriginal children receiving far less than the standard of care called for by law and common decency.

Paige's files are rife with examples of situations in which workers seemed to throw up their hands and declare: ‘What can we do?’ rather than doing everything that was within their power. When one considers the trends exposed in the Representative's prior reports, this professional indifference is evidently ingrained and needs to be immediately changed.

If a parent in B.C. had treated their child the way the system treated Paige, we may be having a debate over criminal responsibility. Yet there appears to be systemic resistance to naming this problem. The Representative speculates whether this is the face of institutionalized racism and a system that discounts the value of some children's lives in B.C.

Methodology

The *Representative for Children and Youth Act (RCY Act)*, see Appendix A) requires MCFD to report all critical injuries and deaths of children who have received a reviewable service in the year leading up to the incident.

The Representative conducts an initial screening of these incidents to determine if they meet the criteria for review under the *RCY Act*. If an incident meets the criteria, it is reviewed to determine if a full investigation is warranted.

Downtown Eastside (DTES)

The DTES is one of Vancouver's oldest neighbourhoods and home to many of the city's most vulnerable populations, including the mentally ill, people who use drugs and survival sex workers.

The 2014 City of Vancouver Social Impact Assessment for this community noted *"High rates of mental illness and addiction persist and are difficult to treat – a problem exacerbated by poverty, homelessness, poor housing conditions, histories of trauma and the lack of a continuum of care that emphasizes choice and client-centred care."*

The most recent census data shows that the area has one of the lowest per capita incomes of any urban area in Canada, along with the highest homeless population in the city. SRO housing is often the last option before homelessness, and this form of housing is concentrated in the DTES.

High levels of crime and violence are also a persistent problem. Violent crime in the DTES increased by 36 per cent between 2006 and 2011. In 2012, 16 per cent of all reported sexual assaults in Vancouver occurred in the DTES, although the area only houses three per cent of the city's population.

Aboriginal women remain particularly vulnerable. The Missing Women Commission of Inquiry noted in 2012 that more than 60 missing and murdered women were taken from this neighbourhood, one-third of those being Aboriginal.

Maternal health outcomes in this neighbourhood lag behind the provincial averages, and more than half of all children in the DTES begin Kindergarten with vulnerabilities that impact their readiness to start school.

Two reports of critical injuries to Paige were received by the Representative. The first was received on May 10, 2011, shortly after the injury had occurred. This report triggered a broader review of Paige's circumstances by the Representative. The second critical injury report, sent to the Representative on Oct. 29, 2013, after the investigation had already begun, concerned an injury that had occurred 17 months earlier. The review of the first incident resulted in the Representative determining that a reviewable service or the policies or practices of a public body may have contributed to her injury and that a full investigation was necessary.

Paige had involvement with MCFD from birth until she aged out of care in May 2012 at 19. This investigation, however, has focused on her later years and particularly the three-year period during which she lived in the DTES.

Numerous files and documents were reviewed in the course of this investigation. Records were sought and obtained from MCFD, the Royal Canadian Mounted Police (RCMP), the Vancouver Police Department (VPD), schools, physicians and community agencies. (See Appendix B for a detailed list.)

Interviews with members of Paige's family, MCFD social workers and staff, police, school district staff, physicians, foster parents, youth resource staff, community agency staff and the managers and staff of emergency shelters and SRO hotels were conducted in accordance with s. 14 of the *RCY Act*. The recorded evidence was either sworn or affirmed. More than 100 interviews were conducted. (See Appendix C for a detailed list.)

The Representative's Multidisciplinary Team¹ was briefed on the progress of the investigation, and provided advice and guidance. Additional experts in the field of child protection and child and youth development were also consulted.

In the interest of administrative fairness, agencies and individuals that provided evidence to this investigation were also given an opportunity to review the draft report and provide feedback on the facts.

¹ Section 15 of the *RCY Act* provides for the appointment of a Multidisciplinary Team (see Appendix D) to assist in this function, and a regulation outlines the terms of appointment of members of the team.

Chronology

Birth to Age Three

Paige was born in May 1993 in Kamloops when her mother was just 16-years-old. The mother's own childhood was chaotic. Her parents struggled with substance use and domestic violence issues. She was frequently cared for by other family members, shuffling from place to place when her parents were unable to look after her. She left home at 14 and lived with multiple partners before Paige was born.

Paige and her mother lived with Paige's father on an on-again, off-again basis. MCFD was involved with the family as soon as she was born and removed her from her mother three times during the first year of her life.

Supervision Order

This is a court order that allows a social worker to supervise a child's care in the family home. An MCFD social worker can apply to court for an order that the ministry supervise a child's care if the ministry has grounds to believe that the child needs protection and that a Supervision Order would be adequate to protect the child. A Supervision Order usually has a provision for removal of a child if the parent is unable to follow the expectations of the order. The safety from harm that a Supervision Order provides is only as effective as the actual social work supervision component when the child is back in the home.

The first removal took place when Paige was five-months-old, after she had been left alone locked in her mother's apartment while her parents were having a fight out on the street several blocks away. She was returned less than a month later under a Supervision Order, but was removed temporarily and returned to her parents twice during the next seven months. Protection concerns centred on the parents' transient lifestyle, drug and alcohol use and domestic violence.

Despite further child protection reports made to the ministry about neglect, alcohol use and domestic violence, MCFD did not conduct an in-depth assessment of the mother's capacity to parent.

In January 1995, when Paige was 19-months-old, MCFD offered an Intermittent Care Agreement to her mother. This permitted the mother to leave Paige with a ministry foster parent for a few days each month if she was feeling stressed by pressures of parenting. Although the mother used this service for nine months, and Paige had been enrolled in a local daycare program, there were no supports in place to assess or address her mother's substance use problems. Her mother appeared to be focussed on completing her high school graduation requirements, but not improving foundational parenting skills.

In December 1995, when she was 2 ½-years-old, Paige was referred to pediatric specialists at BC Children's Hospital (BCCH) by her family physician because of concerns about her vision. She underwent eye surgery several months later. While she was first at BCCH, Paige was diagnosed with symptoms consistent with Marfan syndrome, a genetic disorder of the connective tissue that affects the skeleton and

many organ systems including the lungs, eyes, heart and blood vessels. She was referred to the BCCH Cardiac Clinic, where she was diagnosed with heart problems related to this syndrome.

Voluntary Care Agreement (VCA)

A Voluntary Care Agreement supports and assists parents to care for a child when they are temporarily unable to do so. A VCA ensures a child is in safe care without legally removing a child from a parent's custody. The parent with custody retains guardianship while MCFD provides the day-to-day care of the child and has the parent's agreement to place the child in an approved child care resource, such as a foster home. The parent agrees to take certain steps to remediate the problems that have caused the parent's inability to care for the child. Time limits are in place regarding the amount of time a child may remain in care via a VCA. A parent may withdraw the child from MCFD's care at any time, regardless of any promises the parent may have made and subsequently not followed. It is therefore critical for the social worker to review whether the conditions of a VCA have been met when the parent removes the child from the MCFD placement as, frequently, a condition of a VCA is for a parent to improve his or her capacity to provide adequate and safe care for the child when returned home.

When Paige was three, her mother called the MCFD office in Kamloops and requested that Paige be taken into care under a Voluntary Care Agreement (VCA). She told the ministry that she did not have anything to offer her daughter, and wished to have her adopted into a home that would provide her with more opportunities than the “*welfare life*” that she would give her.

This first VCA collapsed almost immediately when her mother changed her mind and pulled Paige out of care, a pattern that would repeat itself over the next several years.

Paige's Father

Paige's father was 20-years-old when his daughter was born. Paige's young mother had already been living away from her family for two years and the young parents had moved in together before their daughter was born.

The parents' relationship was rocky. The mother stopped drinking alcohol when she became aware of the pregnancy, but the father continued to use both alcohol and drugs. Their fights often became physically violent, with neither parent seeming able to disengage, even with their baby in the home. Police were called to the home several times after complaints of either loud partying or fighting.

The father moved out of the home during the first year of Paige's life, but continued to visit. It is believed that the couple reconciled many times only to repeat the same pattern of fighting and separating.

The father was never identified to MCFD as having First Nations ancestry, although there is some indication that he moved on and off an Interior First Nation reserve. His alcohol and drug use precluded the ministry from considering him as a possible long-term caregiver. He did have access to his daughter and occasionally cared for her for a few hours at a time during her early years when he was staying in his sister's home. He agreed to enrol in parenting and relationship counselling, but did not follow through.

When Paige was still less than one-year-old, her father assaulted her mother. The mother fled the home, leaving Paige with her father. He took Paige to a local women's shelter right away, saying he could not care for her. He was later charged with assault and convicted. Paige was removed from her mother's care for the second time.

Paige's father remained on the sidelines for the remainder of his daughter's life. There was sporadic contact but, with his substance use continuing and the mother and daughter's continual moves, he did not take an active part in caring for her. During the periodic court proceedings, the father was served with court documents and legally represented whenever he could be found. By the time Paige was 10-years-old, her father had effectively disappeared and had very little further involvement in her life.

Further Protection Reports

Prior to Paige entering school, her day care made a protection report to MCFD that she was arriving unkempt and with poor hygiene. The daycare also noted that she was using sexualized language and acting out in a sexualized manner with her peers. The daycare staff observed that Paige seemed preoccupied with her mother's health and well-being and had told daycare staff, *"I'm worried about mommy."* Paige was just two-years-old when she first expressed this anxiety.

In February 2000, when Paige was almost seven, the MCFD office in Kamloops received a report that her mother was using crack cocaine in front of her daughter and that there was no food in the home. Social workers found that the report was accurate and

Young Carers

One of the aspects of growing up in a family where there is parental mental illness and/or problematic substance use is the additional responsibility a child may be forced to take on as a caregiver for the parent. Paige felt a deep responsibility for the well-being of her mother. As one worker involved in the child's life after her move to the DTES put it, staff were aware that the child's role was *"to kind of look after her mom."* She said this was not an uncommon dynamic amongst parents and children in the DTES:

"I can't tell you how many kids ... come to look after their parents and want to be with their parents – who else is there? I mean... there is nobody. They want to be with their parents and they look after their parents. And rightly or wrongly, you cannot prevent that. We've talked a lot with kids about 'When your mom or dad starts using, where can you go? What are your plans?' Now, most of them want to stay and make sure [their parent] doesn't die. That's the big fear – 'my mom, my dad, my aunt is going to die.'"

Children in these young carer roles must deal with the issues of growing up in a family where there is a great deal of disruption and distress. They also learn early that their own needs are often secondary to the needs of their parent. This can have serious negative consequences for a child's self-image, teaching them that they are not important. The stress of taking on this responsibility can contribute to school difficulties even in bright children, high levels of anxiety and depression, a lack of a sense of self, social isolation, feelings of helplessness and hopelessness and the misuse of substances. Children in these circumstances spend more time worrying about their parent and less time learning the skills they need to successfully negotiate their transition into young adulthood. They rarely receive the support they require.

Child in the Home of a Relative program (CIHR)

Prior to March 2010, MCFD social workers used this program to provide financial assistance to a relative in whose home a child had been placed when the child's family was unable to care for the children in their own home. In most cases, the parent would remain the legal parent and guardian of the child. In June 2010, the Representative released her report *No Shortcuts to Safety: Doing Better for Children Living with Extended Family*, which recommended significant changes to the CIHR program, including more extensive screening of adults in a prospective home. The CIHR program stopped accepting applications in March 2010 and was replaced by the Extended Family Program. Criminal checks of all adults in a relative's home where a child is placed are now mandatory.

The Representative notices a significant decrease – almost 50 per cent – in the numbers being served through the new out-of-care options that replaced CIHR and questions the reasons for this decrease.

Paige was removed from her mother's care. Paige was placed with her maternal grandmother in a ministry-supported Child in the Home of a Relative (CIHR) arrangement. This arrangement was made despite the ministry's awareness of previous substance use and domestic violence issues in this home – issues that had previously led MCFD to dismiss using the grandmother's home as a safe home for Paige.

Even with these documented concerns, MCFD file records do not show any safety checks on the other adults known to be sharing the grandmother's residence at the same time, including the grandmother's boyfriend.

After Paige returned to live with her mother in February 2001, MCFD received a report that the grandmother's boyfriend had molested her during the time Paige and her mother had been living together in the grandmother's home. In response to this allegation, Paige faced anger and disbelief from a key family member. The report was investigated by police and MCFD, but no charges were laid after Paige recanted her initial disclosure of abuse.

Three further child protection reports were made between 2000 and 2003, alleging that Paige was being exposed to her mother's drug use. The ministry repeatedly closed the file based on the child being assessed as safe in the CIHR arrangement with her grandmother, even though her mother, regardless of her substance use, had unsupervised access to Paige in the home.

Altogether between June 1998 and June 2003, a total of five separate reports were made to MCFD about the mother's ongoing issues with alcohol and drug use and Paige's exposure to situations of family violence.

Multiple Moves

Paige moved between her mother's care, family placements and various foster homes in Kamloops and Fort St. James 15 times between the ages of three and 13.

On Oct. 15, 2002, MCFD entered into a second VCA with the mother, who was in crisis again and presenting as agitated, hostile and impulsive. The mother said that she wanted Paige in care for two months in order to access a treatment program for her own drug and alcohol issues.

Seven days later, the mother went to Paige's school and took her home. Despite recognizing that the mother suffered from chronic substance use issues and that she had been unable to commit to treatment, Paige was again assessed as being safe and MCFD

closed the family file. Her mother's inability to stay in treatment was a pattern repeated throughout Paige's life.

In March 2003, Paige, now nine, came into MCFD care by means of a VCA for the third time so that her mother could attend an alcohol and drug treatment program. Her mother abandoned the treatment program within 24 hours and again took Paige out of care a few days later. Despite the obvious risk, MCFD conducted no immediate child safety assessment.

Paige was removed again from her mother's care six months later after her mother left her with a former foster parent. Paige was placed in a different foster home, but this placement was also short-lived. Within weeks, the mother fled with her to the mother's aunt's home in Fort St. James. Paige's ministry file and *CFCS Act* court file were in the process of being transferred from Kamloops to where she and her mother had since moved. The Kamloops social worker wrote to the new social worker:

"[The mother] continues to struggle with her drug addiction. I'm wondering if she has the capacity to change over the next short while. We continue to see [Temporary Custody Orders] and extensions but it's becoming, at least in my view, a situation where a CCO may be in the child's best interest. That's your call obviously but given my short involvement with the mother and her history, I just don't hear anything that indicates she's actually on the path to wellness."

Although initially content to leave Paige with the aunt, MCFD subsequently agreed to the mother's request to return Paige to her care under a six-month Supervision Order in September 2004. This occurred in spite of MCFD's awareness that the mother had not attended a treatment program for her addictions.

Prior to the expiry of the Supervision Order in March 2005, MCFD completed a risk assessment that concluded the mother was abstaining from alcohol and drug use. This conclusion was based solely on the mother's statements to this effect. Social workers completed no collateral checks (inquiries directed at others, including professionals, with knowledge of the family) and did not request a drug test. Paige was now 11-years-old.

On Jan. 13, 2006, the local police department in Kamloops called MCFD to report that a warrant had been issued for the mother's arrest for extortion, unlawful confinement and uttering threats. Police told MCFD that the mother was using crack cocaine and had been residing with her daughter in a known crack house. During that time, Paige had been withdrawn from school and the family's whereabouts were unknown to MCFD. MCFD records fail to document what, if any, efforts were made to locate Paige following this police report.

Another report was made to MCFD on March 1, 2006, indicating that Paige and her mother had stayed overnight with an acquaintance because they were homeless. According to the report, the mother was cooking crack cocaine over the stove in the presence of her daughter. MCFD could not locate Paige at this time.

In early March 2006 a photograph of the mother was placed in the local Kamloops newspaper in which the mother was identified as being on “Canada’s Most Wanted” list. Shortly afterwards, she was located and arrested. Paige told her teacher that when police had come to arrest her mother, she had hidden because she did not want to be sent to a foster home. The teacher gave Paige the phone number for Aboriginal Family Services and asked that she pass it on to her mother.

Three weeks later, her mother again left Paige with her former foster parent in Kamloops and disappeared before MCFD staff could come to the home. The mother and child had been staying wherever they could, as they had once again been homeless. Paige was interviewed and said that her mother had been using crack cocaine for a long time and that she had kept this information from social workers in order to protect her mother. Paige was once again removed from the custody of her mother and placed in an emergency foster home, pending the development of a more permanent plan.

The stability of this emergency foster placement was immediately jeopardized when the mother located the home and began to keep a constant watch on the property. She sat on a park bench facing the foster home and spent hours each day watching the foster home, displaying erratic behaviour and yelling threats to the foster family and her daughter. She would lie down on the lawn outside Paige’s window at night and be found sleeping there in the morning. She appeared oblivious to the terrifying effect that her behaviour was having on the other children and family members in the foster home.

Despite the circumstances, Paige formed a significant attachment to this foster family. However, when her mother’s behaviours made this placement unsafe and unmanageable, MCFD moved her to another foster home four months later. The move and separation further traumatized Paige, who had been enjoying a short interval of stability. She was now nearly 13-years-old.

While in the foster home that her mother had been watching, Paige had told her First Nations school counsellor that she was feeling depressed, having thoughts of self-harm and thinking of suicide. She also revealed that she had been using alcohol and illicit drugs but wanted to quit. She reported that she was experiencing sleep problems, anxiety and continual worries about the well-being of her mother. These concerns were reported to MCFD, but failed to trigger any response.

Mental Health Act (MH Act)

S. 28 of the *MH Act* authorizes police to apprehend a person who is acting in a manner likely to endanger that person’s safety or the safety of others and who is apparently suffering from a mental disorder. Police must immediately take the person to a physician (most often the Emergency department of a local hospital) for further assessment and possible involuntary committal, referred to as “certification” under the *MH Act*.

The mother was seen in a hospital Emergency room in July 2006. The attending physicians noted that she had a lengthy history of poly-substance dependence (heroin, cocaine and methadone) and appeared to present with a substance-induced mood disorder. She was also showing symptoms of a severe personality disorder with anti-social traits. Physicians noted she had self-reported that she was supporting herself through sex work and the collection of drug debts. The prognosis for her recovery was assessed as poor. She was involuntarily committed to hospital

and certified under the *Mental Health Act (MH Act)*) a number of times over the following three months.

Near the end of 2006, Paige's mother persuaded her to leave her foster placement and accompany her to Fort St. James without the knowledge of MCFD. They moved into the mother's aunt's home. Confronted with this new reality, MCFD agreed to place Paige with the aunt in an out-of-care arrangement under s. 41(1)(b) of the *CFCS Act*. This arrangement included an agreement that Paige would return to live with her maternal grandmother if living with the mother's aunt did not work out. MCFD agreed to this arrangement despite the 2001 report alleging that the grandmother's boyfriend had molested Paige in this home.

MCFD records indicate that, during early March 2007, the mother was living on the streets in another northern community and was unable to maintain a stable residence due to her addictions. Six weeks later, on April 22, 2007, Paige's placement with the aunt broke down when Paige and her mother alleged that the aunt was abusing Paige.

On June 27, 2007, MCFD in Kamloops again returned Paige to the custody of her mother under a six-month Supervision Order. The mother had been able to rent an apartment and assured her social worker that she had not used crack cocaine since the end of March. Efforts to verify this assurance were stymied by her refusal to attend mandatory drug screening. This refusal failed to trigger further follow-up by MCFD.

A few days after being returned to her mother's care, Paige and her mother met with an alcohol and drug counsellor. The counsellor believed the mother was impaired and observed that she was highly agitated. The mother yelled at her daughter that she was smoking too much marijuana and Paige yelled back that her mother was spending all her money on crack.

Following this meeting, the counsellor advised MCFD of her high level of concern for Paige. The counsellor concluded that: *"The child is going to follow in her mother's footsteps if she remains living with the mother."*

In July 2007, when Paige was 14, she told her mother that she was hallucinating after smoking marijuana. Her mother took her to the local hospital to be assessed.

Two weeks later, Paige was again taken to the hospital by her mother. Her mother had found her late at night, partially unclothed and passed out in some bushes surrounded by a group of young males. Paige was highly intoxicated. Hospital staff were concerned she might have been sexually assaulted, but she denied that any assault had occurred.

In August, the mother advised MCFD that her daughter was getting *"drunk and stoned"* and that they were again moving to another community. This contact was noted in ministry files, but no action was taken to assess Paige's safety.

The following month, MCFD received a report from a homeless shelter in Fort St. James advising that it had just evicted the mother and child, now 14, after finding a crack pipe in the mother's belongings. The mother had previously been banned from this shelter due to her aggressive behaviour and drug use.

Paige and her mother had been living on the street prior to their stay at the shelter. They had shuffled back and forth among several Interior and Northern communities in the previous four months. MCFD records indicate that their whereabouts were unknown for several weeks and that the social worker responsible for their case had left the ministry during the same time period. Due to staffing issues, there was no social worker assigned to this high-risk file between Oct. 16, 2007 and Nov. 26, 2007. The report from the homeless shelter was concluded when a courtesy home visit and file transfer request was made to the Northern ministry office in Fort St. James, where the mother and daughter had again landed.

On Nov. 28, 2007, the MCFD social worker responsible for the file observed:

“The mother is most likely using, has not complied with services, has moved and not planned with the ministry. However the child has been removed in the past and this was not successful. The mother was aggressive, difficult to work with; sabotaged every available placement for the child. The child wanted to be with her mom and so a supervision order was sought ... but has not been effective or reduced section 13 [CFCS Act child protection] concerns.”

Youth Agreement

A Youth Agreement is a legal agreement between MCFD and a youth, most typically between the ages 16 to 18, who is affected by an adverse condition such as severe substance abuse or sexual exploitation and is unable to live at home or with another family or adult. The purpose of the agreement is to help such youth gain independence, return to school, or gain work experience and life skills.

However, there are six criteria that must be filled in order for a youth to proceed with a YA. As such, these criteria are not attainable by many vulnerable youth who may have the capacity to live independently. Conversely, many youth who are assessed as eligible are placed on YAs before they are ready to live independently.

Despite these articulated concerns, MCFD closed the file in December 2007.

On June 24, 2008, Paige, now 15, was placed with another female relative in the Fort St. James area following a report that her mother had again physically abused and abandoned her. In an exception to MCFD policy, a Youth Agreement (YA) was put in place as the relative was not eligible under the CIHR program because of previously-documented safety concerns. Paige had expressed an unwillingness to stay in any other ministry placement. A YA arrangement allowed the ministry to fund some of Paige’s personal and medical needs, including transportation to specialist medical appointments in other communities, while Paige lived in a home that had been proven to be unsafe in the past.

While she resided in this home, MCFD was notified of Paige’s increasing use of alcohol and other substances; in one case, this resulted in her hospitalization. The social worker reminded Paige of the strain the drinking placed on her internal organs and she agreed to work on abstinence. Paige was attending counselling with a local community service agency focused on this and her other social/emotional issues.

While Paige was being supported by the YA, her social worker took the opportunity to ensure that her medical needs were reviewed and treated. Over the six-month period of the YA,

Paige was taken to cardiology and ophthalmology appointments at BCCH in Vancouver, medical geneticist appointments in Prince George and dental and optometry visits in Vanderhoof. This social worker was also instrumental in obtaining funding for Paige to obtain a new heart medication that was not available under the Medical Services Plan. In keeping with the cardiologist's recommendation, the social worker also ensured that a Medic Alert bracelet was obtained for Paige.

In November 2008, Paige told her social worker that she had spoken to her mother who was now living in Penticton. Her mother told her not to visit her at Christmas, as she was *"not doing well."*

Paige visited her mother three months later. During the visit, she made the decision to return to live with her mother and her teenage uncle, who was also living in the home.

With Paige returning to her mother, the YA was terminated on March 12, 2009. MCFD's only further involvement was the creation of a safety plan directing Paige to stay with relatives in Penticton or contact MCFD if living with her mother became unsafe.

The reunification lasted only a few days. Paige came home to find her mother was gone and that all of the family's possessions and clothing were piled on the front lawn of the apartment building. Her mother had been evicted for failing to pay the rent. Paige contacted an aunt who arranged bus tickets for the two teenagers to come to her home in Fort St. James. The mother's whereabouts were unknown.

On July 18, 2009, the ministry was contacted by the hospital in Penticton. Paige had been taken there by ambulance after being found extremely intoxicated. The hospital was unable to locate her mother. Paige told hospital staff that her mother was on a *"bender"* because her own mother (Paige's maternal grandmother) had recently died from a drug overdose.

Paige discharged herself from hospital when she was told that her mother was coming to get her. No efforts had been made to engage the mother or Paige in any services to address their respective drug and alcohol dependencies. With her return to live with her mother, Paige's YA was cancelled, and the file was closed.

On Sept. 1, 2009, the mother advised her financial assistance worker that she was planning a move to the Vancouver area.

Paige and her Mother Move to the Downtown Eastside

On Sept. 5, 2009, Paige, now 16-years-old, and her mother relocated to Vancouver's DTES. At this point, the mother had moved at least 84 times since Paige's birth. Continuing this pattern of transience, Paige would move more than 50 times during the next three years, among homeless shelters, safe houses, youth detox centres, temporary accommodations with relatives and friends, two MCFD foster homes and various DTES hotels.

On Sept. 19, 2009, Paige was abandoned by her mother at a safe house in East Vancouver. An MCFD After Hours social worker came to the house and, rather than

Taking Charge (of a child/youth)

A Take Charge Notice is a less disruptive measure whereby, under s. 25 or s. 26 of the *CFCS Act*, MCFD can provide time-limited care of a child or youth without parental consent or a formal removal in the following circumstances:

- When a child is found without adequate supervision and it is determined that he or she requires immediate supervision and care
- When a child or youth is lost or has run away from his or her home and the individual responsible for the child cannot be located or the child refuses to return home.

When MCFD is taking charge of a child, all reasonable efforts must be made to notify or locate his or her parent(s). When necessary, a child is taken to a safe place such as the home of a family member or friend, a day care, a foster home or a hospital. MCFD must inform the parent(s) that it has been looking after the child under a Take Charge Notice and has consented to any necessary health care services. A child must be returned to his or her parent(s) as soon as possible and, in most cases, within 72 hours.

The child or youth is not required to be returned to the parent(s) if an agreement has been made with the parent(s) under another plan to provide day-to-day care of the child or youth to ensure his/her safety or if there is a removal order because the child or youth would be unsafe if returned to his or her parent(s).

removing Paige from the custody of her mother, completed a temporary Take Charge Notice and took her to a local Aboriginal youth safe house.

The After Hours social worker interviewed Paige at this time and described her as “*a very polite young woman.*” Paige told the social worker that she wanted to get her life back on track by going to school and getting an education. She said that she was not currently using alcohol or drugs and that she was tired of moving all over the province with her mother. She had all of her belongings as well as her mother’s in suitcases, backpacks and garbage bags.

The family’s closed MCFD file was transferred to the Vancouver ministry office and re-opened for more comprehensive follow-up. A social worker went to the safe house to speak to Paige and further assess the situation.

This worker also heard from Paige that she was tired of the frequent moves and her mother’s drug use, and that she wanted to go to a local high school. She indicated that her mother was on the methadone program, but that relatives had recently seen her in the DTES on a regular basis and were concerned about her drug use. Paige acknowledged being stressed about the current situation with her mother and admitted to having had thoughts of suicide 18 months earlier.

Paige suggested several family members in Vancouver with whom she could potentially stay. An aunt and uncle who she felt particularly close to were not considered appropriate. This determination was based solely on an allegation that the aunt and uncle had an adult son with alcohol dependency and violence issues. No further exploration of this potential placement occurred. Paige returned to her mother, who was now living in a transition house in New Westminster.

On Sept. 21, 2009, a few weeks into the school year, Paige and her mother went to the office of a local high school and requested that Paige be registered for Grade 10. The school counsellor who registered her described her as a very charming girl who was excited to start school.

During the registration process, the mother told the school that her daughter suffered from a heart condition. The school counsellor told RCY investigators that she was shocked that there was no documentation in Paige's school file of her having any medical issues. She described the child's education history as a "traumatic school experience" and stated:

"The file is unbelievable, the amount of times she was sent home, doing drugs at about grade five, smoking pot, and, you know, a couple of times she's come into school, I think, late, and when we talked with her, mom's boyfriend had been arrested at the apartment, or mom had been. You know there was just turmoil after turmoil."

This counsellor said that school records showed multiple calls to MCFD and she questioned why there had been such minimal legal intervention to protect Paige, who she described as being "really keen to be a student, but attendance was an issue because mom would act out wherever they were staying."

On Sept. 24, 2009, After Hours was advised that Paige had been discharged from a local youth safe house after she returned to the facility intoxicated. Police took her to Vancouver Youth Detox. A social worker called her mother, who said that she was willing to remain at a local homeless shelter with her daughter. When interviewed by the Representative's investigators, the social worker responsible for the file had no specific memory of why he did not go to the shelter during this time to speak to the mother or to assess Paige's safety.

Paige and her mother subsequently moved to a transition house in New Westminster. Paige travelled each day from the transition house in New Westminster to her school in East Vancouver until she was forced to leave the transition house because her mother's frequent absences had lost them their placement.

There was no contact between the ministry and Paige in October or November 2009.

The high school Paige was attending completed an Individual Education Plan (IEP) for her on Oct. 29, 2009. The plan described Paige as being resilient, hardworking, independent and having a positive attitude. But by now, she was attending school less than 25 per cent of the time.

On Nov. 20, 2009, Paige went to BC Women's Hospital to have an unplanned pregnancy terminated – her first of three pregnancy terminations during the next three years. In each of these instances, an adult in her life accompanied her to these appointments, including her mother, a foster parent and a DTES outreach worker. The Representative can only imagine how devastating these experiences would have been for Paige.

Sometime shortly after the November 2009 pregnancy termination, Paige and her mother went to Royal Columbian Hospital where Paige received emergency care for bleeding and severe abdominal pain.

In early December 2009, MCFD received a call from a youth safe house. Paige had arrived there indicating that she had been left alone for several days and did not know

Single Room Occupancy (SRO)

An SRO is a form of housing in which one or two people are housed in individual rooms (sometimes two rooms, or two rooms with a bathroom or half-bathroom) within a multiple-tenant building. The term is primarily used in Canadian and American cities. SRO tenants typically share bathrooms and/or kitchens, while some SRO rooms may include kitchenettes, bathrooms, or half-baths. Although many are former hotels, SROs are primarily rented as permanent residences for adults on low income or those who were formerly homeless. Although SROs are adult-only facilities, Vancouver's DTES SROs have been known to turn a blind eye to age.

her mother's whereabouts. Later that same day, she told staff that her mother had been arrested and was in cells at the Vancouver Police Department. Two days later, Paige left the safe house to search for her mother and consequently lost her spot in the facility.

On Jan. 14, 2010, MCFD received a report that the mother was now residing at an SRO in the DTES. Paige's whereabouts were unknown. The manager of the hotel indicated that the mother was actively using crack cocaine and they would not allow Paige into the hotel. The caller said that the mother had left Paige standing out on the street in front of the hotel. A social worker spoke with staff at the youth safe house where Paige had previously been staying and was told that she had not been at the shelter since Dec. 6, 2009.

Six days later, the ministry social worker responsible for this intake requested that a Reconnect social worker attempt to find Paige at the SRO hotel. Rather than

directing that her immediate safety be assessed, the social worker asked the Reconnect worker to: *"Tell her to call me if she is interested in looking at independent living options, other supports, or referrals to services."*

MCFD talked to the mother on Jan. 26, 2010. She said that Paige had been living with her at the SRO hotel. The ministry had a telephone conversation with the mother summarized in the file as: *"Mom claims to be clean and looking for housing outside the DTES."* No social worker met with Paige or her mother and the report of the active crack cocaine use was not addressed. Paige was not interviewed and her mother was not asked to complete a drug test. She and her mother then relocated to a shelter in New Westminster and the file was closed. Documentation by the team leader in the file states: *"Close file. Mom and daughter are accessing community supports in New Westminster. No request for MCFD services."*

On April 25, 2010, the ministry received a report from another transition house in New Westminster relaying that the mother had been discharged due to abusive behaviour towards her daughter and shelter staff. The caller stated that the mother had called her daughter a *"fucking little bitch"* and threatened to *"beat"* her.

Reconnect

Reconnect is the name for a weekly group meeting of community youth outreach workers. Youth outreach staff share information about and identify high-risk youth living in or frequenting Vancouver to develop safety plans for these youth. The group facilitator (from the Yankee 20 program – see text box) then connects with field social workers, service providers, police and parents (who are often in communities outside Vancouver) to coordinate and implement safety plans and services for individual youth.

The caller said she believed Paige and her mother might be back living at the SRO hotel in the DTES.

MCFD classified this report as requiring a response within five days, but no action was taken until almost two weeks later when a report was received from another DTES transition house. Staff advised that Paige and her mother had been staying there but had failed to return the previous night. The mother subsequently phoned to say that she had spent the previous night in jail; as a consequence she had been discharged from the transition house. A staff member at this transition house advised the ministry of their concern for Paige as she seemed to have assumed a care-giving role with her mother. Staff described the mother as unstable and volatile.

A social worker found Paige and tried to explore alternate living arrangements with her. Paige agreed to stay at a women's transition house without her mother and this plan was supported by MCFD. Paige was interviewed about her living situation, but there was no indication on the ministry file that the reported maltreatment by her mother was explored. The social worker responsible for the file had no recollection of having asked Paige about her mother's threat of physical abuse.

MCFD file documentation stated: *"The youth is unwilling (except on one occasion) to improve her living situation. Unfortunately the child prefers to stay with her mother."* The team leader stated: *"Youth not willing to leave situation with Mom and not open to any ministry services."*



The Balmoral SRO hotel

Yankee 20

Yankee 20 is the police call sign for a unit staffed by a police officer and an MCFD social worker. The unit attends to situations involving high-risk youth in Vancouver and operates during daytime hours, four days a week. The Yankee 20 unit collaborates with other youth-serving professionals and parents of missing and high-risk youth to develop intervention strategies and safety plans for youth. Yankee 20 also assists child protection workers in applying for protection orders.

The ministry advised the joint Vancouver Police Department and MCFD response team (known as Yankee 20), Under Age Income Assistance and the Reconnect program of Paige's situation, and closed the file. The social worker involved at this time noted in the file:

"Youth has no fixed address, moving between transition houses with her mother for many months. Mother battling drug and alcohol issues. It is very unlikely that the mother's situation will change."

During the course of this ministry assessment, medical records from St. Paul's Hospital indicate that Paige arrived at the Emergency department on May 10,

2010 with an infection and severe stomach pain. These symptoms were attributed to unsanitary and dangerous living conditions and her heavy alcohol use.

Chart notes from the hospital social worker indicate that Paige and her mother had been homeless since December 2009 – a period of five months. The hospital social worker attempted to locate housing for them by calling all the shelters for females in the area. Due to the mother's history of violent behaviour in each of these shelters, they were denied admission.

On June 10, 2010, an email was sent from one DTES community agency to another, copying MCFD, providing an exact location of where Paige was now living and advising MCFD that:

"We have some concerns about a youth that has been seen around the DTES lately. Mom deals crack and has a room at the Balmoral (#223) as of today."

MCFD did not respond to this report.

On June 22, 2010, Paige was formally withdrawn from her high school because she had not been attending and the school had been unable to locate her.

On July 7, 2010, after sharing Paige's photo at a Reconnect meeting, MCFD was again contacted by a community agency and told of Paige's whereabouts: *"Mom is a known crack user. The child is living with mom at the Balmoral. The child looks after mom."* A week later, the reporting agency contacted the MCFD social worker and asked: *"Any word from the child in the past week?"* The social worker replied: *"No word from the child at all. The child never reached out to MCFD directly nor has her mother. I closed my file due to no contact/no accessing of services."*

Despite the MCFD file being closed in July 2010, community agencies went to the Balmoral Hotel on several occasions in August in an effort to find Paige. She was "profiled" – meaning information about her was shared – at a Reconnect meeting on July 14, 2010. A DTES youth-serving agency report to the MCFD social worker on Aug. 26, 2010 stated: *"Outreach has been trying to look for her and an outreach worker stopped by the Balmoral but she wasn't home. I will keep encouraging people to look for her and hopefully at some point get her into your office."*

The Mother Overdoses

On Aug. 31, 2010, MCFD received a report that Paige was still living with her mother at the SRO hotel in the DTES. The caller reported that the mother had been taken to St. Paul's Hospital 17 days earlier for a possible drug overdose.

Medical records show that this overdose actually occurred on July 26, more than a month prior to this report. Paige and her teenage uncle had called 911 saying they had found Paige's mother unconscious on the floor of her hotel room. The mother had been smoking crack cocaine and injecting heroin. The uncle started CPR until paramedics

arrived to find the mother not breathing and without a pulse. She was defibrillated three times on the way to St. Paul's Hospital and admitted to the Intensive Care Unit.

There are references in the hospital chart to Paige being present at her mother's bedside during her admission and to Paige being frustrated and overwhelmed by the situation. Her mother was aggressive and physically threatening to hospital staff while in ICU and Paige would intervene to encourage her mother to cooperate. Although the social history on the chart documented that the mother lived at the Balmoral Hotel with her daughter, hospital staff did not report this information to MCFD.

On Aug. 5, 2010, the mother was certified under the *MH Act* by the attending psychiatrist who noted:

"33-year-old female with history of poly-substance abuse who presents with personality changes and organic brain injury syndrome post arrest. Patient is inappropriate and disinhibited. Would be a safety risk if she were to leave the hospital."

The final discharge report completed by the hospital on Aug. 13, 2010 concluded that the mother had suffered a hypoxic brain injury during her overdose episode. Despite this, she left the hospital against medical advice and before any long-term follow-up treatment could be arranged. The discharge summary stated:

"[the mother] left the hospital against medical advice; we hope that she will follow up at some point with her family physician."

The next day, the mother was located by Vancouver Police and was again certified under the *MH Act*. Meanwhile, Paige was left living with her teenage uncle at the Balmoral Hotel during the month her mother spent in hospital.

When the Aug. 31 report to MCFD was initially received, the team leader directed Paige's social worker to find her and assess her safety. Despite this direction, no efforts were made to find Paige. On Sept. 13, 2010, MCFD received another report advising that Paige and her mother had been evicted from the hotel. Pet cats had been left behind and Paige had called extended family to help care for them.

On Sept. 19, 2010, Paige agreed with an MCFD proposal that she stay in a youth home in North Vancouver and attend an addictions treatment program. The following month, MCFD sent a letter of support to the Ministry of Human and Social Development (now known as the Ministry of Social Development and Social Innovation) stating:

"MCFD strongly recommends that the child receive underage income assistance at this time. This youth has been staying with her mother for approximately one year in a series of transition homes, and hotels such as the Balmoral Hotel, in the DTES. For the first time since I started to work with this youth one year ago, this youth has shown a willingness to leave her mother and make a better life for herself."

The intake was closed with the following notation from the social worker: *“As there has been no work done with the mother and all indications have been that the mother will not work with MCFD or its services, this family service file will be closed and all work with the child will be done through the child service file.”*

On Oct. 11, 2010, Vancouver Police found Paige on East Hastings Street in the DTES, extremely intoxicated. Police took her to Vancouver Youth Detox, which advised MCFD that it could only hold her bed temporarily. MCFD response to this is unclear, but it appears that Paige stayed temporarily at a North Vancouver safe house for several days after this incident.

Support Services Agreement Signed

On Oct. 15, 2010, Paige’s mother signed a Support Services Agreement providing consent for MCFD to provide services to her daughter. Under the terms of this agreement, Paige remained in the legal custody of her mother.

Three days later, Paige was required to leave the North Vancouver safe house because she was not a North Shore resident. She moved to a safe house in East Vancouver. Two days after this, she went to Emergency at Vancouver General Hospital with a severe skin infection on her right hand, untreated scabies and head lice. Although notified, MCFD did not see Paige at the hospital. She was later discharged to an outreach worker.

On Oct. 28, 2010, Paige was again found by police staggering alone along a sidewalk on East Hastings Street. Police escorted her to Vancouver Youth Detox, who advised MCFD. The ministry did not come to speak to Paige or assess her safety and well-being.

The lack of personal contact between Paige and her social worker characterized MCFD involvement from September 2009 until Nov. 5, 2010, when the file was transferred to a new social worker. When asked about the frequency and quality of contact, her first social worker stated: *“Very, very little and it’s typically just reviewing the memos that were coming in or on the file at the time. It wasn’t direct contact.”* This social worker could not recall meeting with Paige’s mother once during the 14 months he was responsible for her daughter’s file.

On Nov. 5, 2010, North Vancouver RCMP reported to the ministry that Paige had been found highly intoxicated and would be kept in police cells. Her new social worker picked her up from cells and placed her in a DTES youth safe house.

There was then no documented contact between Paige and her social worker until three months later on Feb. 15, 2011, other than a few notes placed on her Reconnect file.

Reconnect minutes from Nov. 10, 2010 state:

“Was seen drinking at Oppenheimer Park. Concerns that she is drifting further away from being able to engage in a youth agreement. Encourage her to come and see her social worker at Cambie.”

Paige's case was again discussed at a Reconnect meeting on Nov. 17, 2010. Notes from this meeting state:

"Try to get her in to see her social worker at 550 Cambie. Concern that her intervals of drinking are becoming closer together. Was seen drinking in Oppenheimer park."

A Jan. 12, 2011 file notation supports Paige in an effort to obtain Underage Income Assistance. The MCFD social worker states:

"This youth has a mom who is on the street and has basically abandoned her. The child was also living on the street for a long time. She is a sweet girl with a major alcohol problem."

During this three-month period without any documented ministry contact, police were again involved with Paige, although this was not reported to MCFD. On Jan. 22, 2011, police received a call from a gas station attendant advising that Paige came in saying that she had been assaulted by six unknown females. Paige suffered bruising to her face and was examined by paramedics at the scene. Police spoke to her uncle, who they mistakenly believed was her guardian, and advised him of the incident. Paige was told to call police if she was able to remember the incident the following morning. She was sent to her uncle's home in a taxi, and the police file was concluded. The confusion around Paige's guardianship meant that MCFD was not advised of this incident, and no follow-up or support was offered.

On Feb. 9, 2011, the following information about Paige was distributed to outreach workers and community agencies at a Reconnect meeting: *"Be aware that she has a medical condition Marfan syndrome. Can create heart stress so be aware that if she is drinking or if you find her unconscious to call 911."*

A ministry Integrated Case Management meeting, involving professionals representing a number of child- and youth-serving agencies, was organized for Paige on Feb. 15, 2011. At this meeting, Paige requested a seven-week addictions treatment program at a DTES youth-serving agency, followed by an alternate education program at a local high school. Notes from this meeting state that her social worker would be following up on this request. Paige was still moving between relatives, friends and a youth safe

house. MCFD records indicate that her maternal aunt and uncle were in attendance at this meeting and expressed an interest in having Paige live with them.

A community professional advocated on the family's behalf for a Kith and Kin Agreement to be explored, but they were told by the social worker: *"That's really hard to do. That's not going to happen."* Paige stayed with her aunt and uncle frequently as they were caring

Kith and Kin Agreement

Under s. 8 of the *CFCS Act*, a Kith and Kin Agreement may be made with someone who has an established relationship with a child or has a cultural or traditional responsibility towards a child. This person must have been given care of the child by the child's parent. The agreement may provide for MCFD to contribute to the child's support while the child is in the person's care.

for her pet cats. When she wasn't staying with them, she visited them on an almost weekly basis during her three years in the DTES. There is no indication that the option of residing with this family permanently was further explored by the MCFD social worker.

On March 10, 2011, Paige was found passed out on a sidewalk in East Vancouver. She told paramedics she was 17-years-old and that her parents lived in the Prince George area. She was assessed as having acute alcohol intoxication, was given IV fluids and discharged to a DTES youth shelter. The incident was reported to MCFD, but no record could be found of MCFD taking any action with respect to this incident.

Less than a month later, on April 6, 2011, MCFD heard from a youth detox centre that Paige had completed a seven-day detox program and was again living at a youth safe house. MCFD did not attempt to contact her.

On April 15, 2011, Paige was located by paramedics in a basement suite in East Vancouver after neighbours called 911. The police report indicates that Paige was found slumped over, slurring her speech and heavily intoxicated. She was with a 14-year-old friend, who was naked and covered in blood. Paige was treated at VGH Emergency and then discharged to her friend's parent.

She gave the police information about the 23-year-old male who provided the alcohol and assaulted her friend. Later, she expressed concern that her safety would be jeopardized for being a "rat." A Yankee 20 social worker suggested that the MCFD worker responsible for the file meet with Paige to talk about this incident. There is no indication that such a meeting occurred.

On April 30, 2011, Paige was registered in an Aboriginal alternative school in East Vancouver in an attempt to salvage her Grade 10 academic year. She attended just three times before the end of the school year.

On May 8, 2011, Vancouver Police received a 911 call regarding Paige. A young female complainant advised that her uncle had brought home three very intoxicated females from the DTES and wanted to "*take advantage*" of them. The complainant said that her uncle was an employee at a DTES hotel and regularly brought home girls from the DTES. The complainant initially stated that one of the girls had been assaulted.

By the time police arrived at the residence, the three girls had left in a cab. The cab was located and paramedics found Paige covered in vomit. She was taken to VGH by ambulance to be treated for extreme intoxication. Police interviewed one of her companions who denied that a sexual assault had occurred. Police then went to VGH and were advised that Paige did not appear to have been sexually assaulted. Police did not interview the subject of the complaint, nor was Paige interviewed about the incident due to her level of intoxication. The file was concluded with no follow-up interviews of the three girls.

Police told the Representative's investigators that they did not complete these interviews because the complainant stated she was not certain a sexual assault had occurred. The

complainant recanted her initial sexual assault complaint when police attended the residence to question her uncle.

On May 9, 2011, MCFD forwarded a reportable circumstance report – the only one the Representative’s Office received prior to the commencement of this investigation – which stated: *“Paige is trading sex for alcohol with older men.”* It is unclear from file documentation where this information came from or what efforts were made to assess this reported exploitation. The report also stated that Paige’s mother *“is still on the streets and presently lives at the First United Church.”*

Paige was also living from shelter to shelter with her mother *“until she decided to do her own thing. Paige is trying to get on a youth agreement but has a serious alcohol problem.”*

On May 10, 2011, MCFD met with Paige and a family friend with whom she had been temporarily living. Paige was asked about attending treatment. She said that she would think about this, and MCFD concluded its involvement with respect to the reportable incident. Later the same day, Paige was again found by paramedics passed out on a sidewalk on East Pender.

Reportable Circumstance Report

This is a report provided to the RCY by a public body responsible for providing a reviewable service to children and youth, as required by sec. 11 of the RCY Act. A Reportable Circumstance Report is made after a critical injury or death of a child who was receiving, or whose family was receiving, the reviewable service at the time of, or in the year previous to, the critical injury or death.



First United Church homeless shelter

Three days later, the family friend called MCFD to report that she had dropped Paige off at the First United Church, as she wanted to look for her mother. MCFD After Hours called the church to advise them that Paige had been dropped off there. They also contacted a standby youth worker from a local youth agency to request that they follow-up with Paige to find her alternate shelter accommodation. Later that same night, the Vancouver Police Department called to notify After Hours that they had located Paige intoxicated and would be taking her to Youth Detox.

On June 1, 2011, MCFD heard that Paige was living at an SRO hotel located above a DTES bar. The next day, the ministry held an Integrated Case Management meeting with Paige's youth worker, social worker, Yankee 20 youth social worker and workers from various community agencies. The notes from this meeting state: *"Social worker to get mom's consent to bring the child into care and find appropriate housing."* Conflicting MCFD file information shows Paige staying with her mother at the First United Church homeless shelter intermittently between May 13, 2011 and June 12, 2011 although this would have been contrary to shelter rules.

On June 16, 2011, Paige went to BC Women's Hospital for her second pregnancy termination. Four days later, Burnaby RCMP found her highly intoxicated and sleeping on a sidewalk. Paramedics took her to Burnaby General Hospital. Neither the police nor hospital advised MCFD of this incident.

Two days later, Paige entered a local Aboriginal youth recovery program, where she remained until Aug. 27, 2011. This two-month period was the most stable living situation she had experienced since her move to the DTES almost two years earlier. It lasted until she went out on a day pass and met up with one of her "bros," a former associate from the DTES. He gave her \$300 and told her that her mother was homeless again. Staff at the recovery program said that Paige went to find her mother and gave her the money she had received from her street friend, keeping only \$10 for herself. After this incident, she left the recovery program and did not return.

For the next two months, there was no documented ministry contact with Paige, despite there being an open file and a Support Services Agreement in place.

Paige Asks to Come into MCFD Care

On Nov. 7, 2011, Paige called MCFD asking if she could come into care. Her mother was now homeless and living on East Hastings Street. One week later, the mother agreed to a VCA and Paige was placed in foster care. The social worker who met with the mother to sign the VCA observed that she was *"high on drugs."*

Paige's first placement lasted only a week. On Nov. 19, 2011, the foster parent called MCFD to advise that Paige and a friend were outside her residence intoxicated and fighting. She said she was feeling very embarrassed about this scene happening outside her home and was worried about the neighbours' reaction. Police arrived and determined that the girls were not fighting but were intoxicated and yelling at each other. They took Paige to police cells due to her level of intoxication and later called her foster parent to

make arrangements to release her back to her care. This foster parent called After Hours saying that she was not prepared to have Paige back and that plans would need to be made to move her out.

Between Nov. 22 and Dec. 9, 2011, Paige was listed on MCFD records as missing. However, medical records show that during this time, she was admitted to the Emergency departments at two hospitals for severe intoxication, neither of which were reported to MCFD. Also during this time, Paige applied to a local alternative school, attended sporadically, and was eventually removed from the program.

On Dec. 3, 2011, paramedics found Paige on the ground in a park in East Vancouver, after she reportedly drank two 26-ounce bottles of vodka. The Emergency physician made the following assessment:

“This young woman is dangerously intoxicated and has significant medical concerns. She is unable to make independent decisions without putting herself in jeopardy. She requires medical care, and ongoing assessment and treatment for her own safety.”

Paige was given antipsychotic medication and Ativan and discharged the following day with no treatment plan. Although MCFD was informed of this incident, there is no documented response.

Almost two weeks later, on Dec. 16, the social worker sent the following alert:

“The child is in care via a VCA, Mom is homeless on skid row. The child has been awol for approx. 3 weeks. The child is staying at her aunties house but if things break down she may call. Safe Houses are also familiar to the child. The child has a severe drinking problem.”

Transit police found Paige two days later at a downtown SkyTrain station severely intoxicated and unconscious. She acknowledged consuming a mickey of vodka and an unknown quantity of methamphetamine and was taken to hospital by paramedics. She was discharged the following day to her uncle, who was listed on her chart as next of kin. There is no indication that MCFD was notified, despite her social worker’s contact information clearly documented in her medical chart.

On Dec. 19, 2011, a DTES youth safe house advised After Hours that Paige had arrived there and was planning to spend the night. MCFD did not go to the safe house, despite the earlier alert sent by Paige’s social worker.

From this date until early January 2012, Paige drifted between detox centres and safe houses while in MCFD care. It is unclear why her social worker did not attempt to contact her and assess her safety on the occasions when information about her location was received. When asked about this, the worker told the Representative’s investigators that she would usually just wait until Paige came into the ministry office to meet with her, which would typically occur a day or two following an incident or report of her whereabouts. Since Paige was on a VCA, the worker was able to offer her food vouchers and bus tickets.

Paige Placed in a New Foster Home

On Jan. 4, 2012, Paige was placed in a new foster home. Ten days later, staff at Vancouver Youth Detox called MCFD to report that police had brought her to the unit after finding her passed out on a transit bus. The foster parent agreed to keep her home available for Paige, but was concerned about the impact that her behaviour would have on the other children in the home. Detox later advised that Paige had started to yell and scream at staff, bang on walls and continue to escalate. Police took her to cells for the night.

Emails between Paige's social worker and other MCFD staff on Jan. 17, 2012 discussed the appropriateness of Paige's placement with this particular foster parent. Her social worker wrote: *"I told her [the foster parent] that I did not want to place the child in a resource and then be told that her behaviour was too problematic and that she would have to move. This caregiver seems to be unprepared in very many ways."*

Despite these concerns, this placement proved to be the most stable environment that Paige experienced during this period. Even with continued drug and alcohol use and absences from the foster home, it appears that Paige felt safe enough with this foster parent to talk about her fears and to always return home. She would advise her foster parent when she was using drugs and always asked to go back to her foster home when she was discharged from detox or treatment.



DTES street with Balmoral Hotel

On Jan. 21, 2012, Paige was found by North Vancouver RCMP unconscious on a transit bus. She was arrested for being intoxicated in a public place and was carried off the bus. She regained consciousness once she was in the fresh air, but was unable to tell police her name or where she lived. While being walked to police cells, she kicked the police officer who was accompanying her in the leg and was subsequently charged with assaulting a police officer and released. MCFD was notified of this incident, but there is no documentation of any response.

In his Crown narrative, the police officer stated:

"[The child] has been involved in more than 40 police files since September 2009. All of these files are disturbances, most of which involve liquor. [The child], by all accounts, is an alcoholic. She is often found sleeping in public places, semi-conscious from alcohol consumption. [The child] does not appear to be able or willing to take care of herself. [The child] needs some form of intervention, hopefully by the court, or she may be hurt or killed while on a binge."

Eventually, in the summer after she turned 19, Paige received a conditional discharge with 90 days probation.

On Feb. 9, 2012, Paige went to BC Women's Hospital for her third pregnancy termination.

A week later, a complainant called New Westminster Police to say that Paige was intoxicated and passed out in the hallway outside his apartment door. She was arrested for being intoxicated in a public place.

On Feb. 28, 2012, Paige was referred to the Vancouver Inner City Youth Mental Health Program through St. Paul's Hospital. This referral was made by an outreach worker through a local youth day treatment program. Paige requested mental health support for severe alcohol-induced anxiety, but was unable to follow through.

A week later, Paige was found intoxicated and unconscious on a Vancouver street. She had consumed an unknown quantity of alcohol and cocaine, and was later certified by an Emergency physician under the *MH Act*. Paige's foster mother came to the hospital and sat with her at her bedside. The Emergency physician recorded the following observations about Paige: "*So severely intoxicated is a high risk to self and I am unable to assess mental status.*" MCFD was notified, and Paige was later discharged and escorted by Vancouver Police to cells.

On March 28, 2012, Yankee 20 was advised that Paige was missing from her foster home and could possibly be at an SRO hotel with her mother.

On April 6, 2012, Merritt RCMP informed After Hours that they had found Paige intoxicated in the middle of a road. She had travelled to Merritt to reconnect with family. Paige was taken to hospital and later sent back to Vancouver.

A new MCFD social worker was assigned to Paige's file in April 2012. This worker contacted a local youth outreach agency and Yankee 20 on April 17 with the following information:

"The child is about to turn 19 and she is quite unstable right now ... if you see her please encourage her to go home and plan for transition ... Youth had a one month transition period with this worker. Youth has serious addiction issues. This worker is new to her case and he has three weeks to open an underage income assistance file and secure housing for her post 19."

Some efforts were made to help Paige during her last few months in MCFD care. A transition worker from a local youth agency was asked to help her find an appropriate place to live when she left care. Reconnect minutes show that efforts were being made to get her a mentor and to encourage her to attend an appointment with a drug and alcohol counsellor. The new social worker who had inherited the file advised the Representative's investigators that Paige had a drug and alcohol counsellor through the Nexus program, although it was later discovered that she had not actually attended any appointments with this counsellor. The referral to this addictions counsellor was made by Paige's outreach worker from a local youth-serving agency.

An MCFD closing recording on Paige's file stated:

"The child is one month from turning 19 and unfortunately she is still binge drinking heavily and appears not to be overly concerned about having anywhere to live at age 19."

However, an email from the foster parent to the MCFD social worker on March 5, 2012 stated that Paige's "*anxiety builds as her move out date approaches.*"

Paige Ages Out of Care

Paige remained in her last foster home for four months until she turned 19 on May 1, 2012. The next day she moved from her foster parent's home to accommodation for Vancouver-area youth at risk. No ministry social worker attended to check the appropriateness of this living situation, and Paige's file was closed.

The last social worker to have her file told the Representative's investigators that he was not aware of any MCFD practice standards that required a worker to observe the living circumstance of a child leaving care.

After Paige was discharged from care at age 19, there was a marked deterioration in her ability to cope.

Outreach staff told the Representative's investigators that Paige began using crack cocaine and meth in June 2012, about a month after her exit from MCFD care. In February 2013, she began injecting heroin. She confided in her outreach worker about her drug use, but hid it from everyone else.

According to this outreach worker, Paige did not want to tell her mom she was injecting heroin because she didn't want to disappoint her. She also disclosed to this outreach worker that she was dealing drugs for some older males she referred to as her "*bro's*," had run up a costly drug debt and had to "*work off*" this debt.

A psychiatric assessment of Paige was completed on March 7, 2013, the result of a referral to the Inner City Youth Mental Health Team. Paige met the criteria for generalized anxiety disorder and was possibly also experiencing Obsessive Compulsive Disorder traits. Paige was prescribed Citalopram to assist with the management of her anxiety and Quetiapine to address her insomnia. This was the first and only psychiatric assessment Paige ever received.

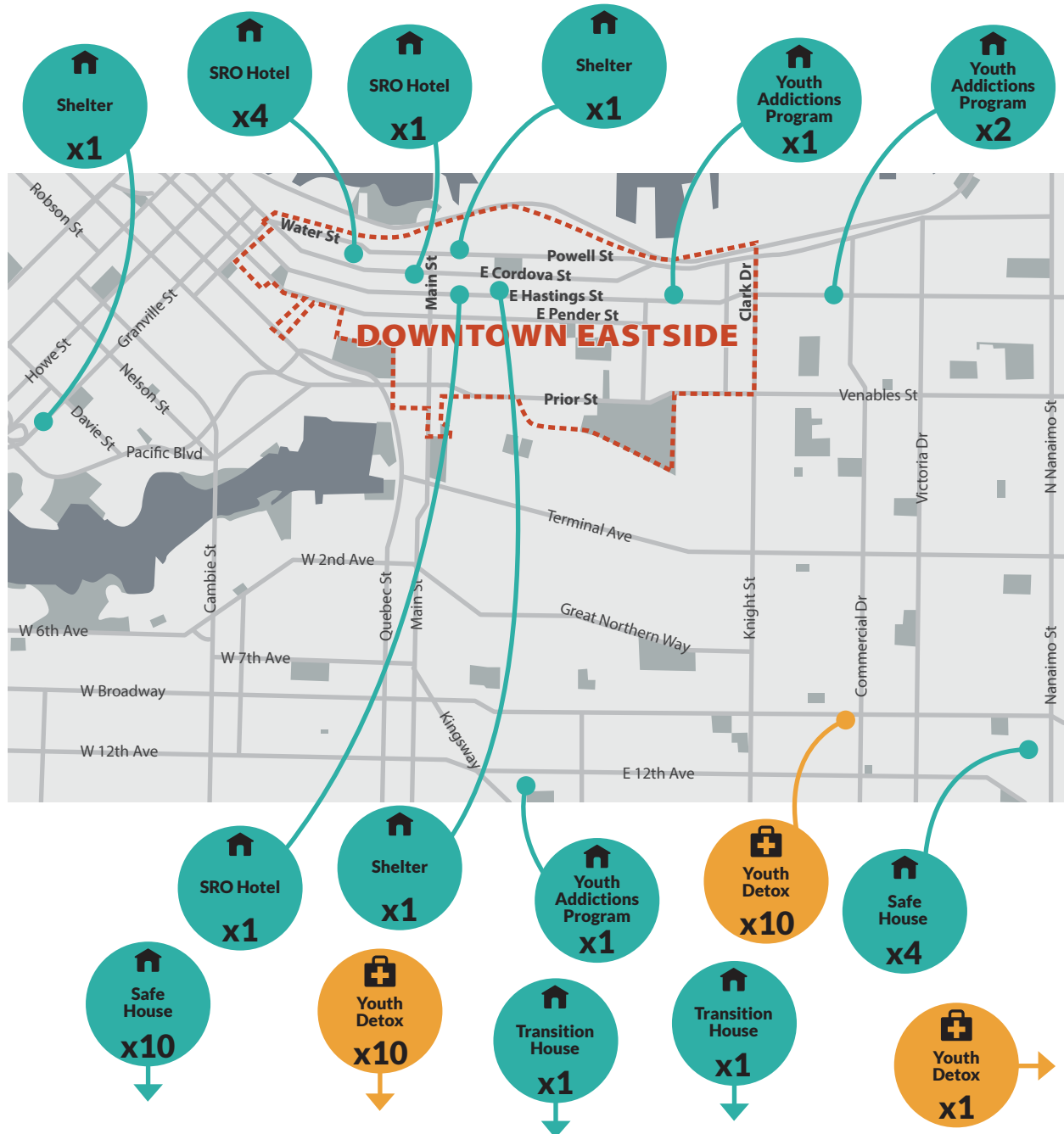
A follow-up appointment was arranged for April 4, 2013. Paige did not attend this appointment. She died of a drug overdose 20 days later in the communal washroom of a supportive housing complex adjacent to Oppenheimer Park in the DTES.

Between leaving MCFD care and her death just 11 months later on April 24, 2013, Paige had been admitted to Emergency on four occasions for extreme intoxication.

Eighteen months later, Paige's mother died in her DTES SRO hotel room of a drug overdose.

Constant Turmoil: 50 moves in 2½ years

September 2009 to May 2012



Additional Accommodations:

Paige also spent several days in Vancouver police cells, Merritt RCMP cells and hospital Emergency wards, and for periods of time was missing all together.

Analysis

Overall Finding: Despite the absolute predictability of this tragedy, the child protection system, health care system, social service agencies, the education system and police consistently failed in their responsibility to this child and passively recorded her life's downward spiral. The social workers tasked with caring for Paige clearly foresaw what would inevitably happen to her but seemed unable or unwilling to do what would have been necessary to alter the trajectory of her life. They failed to register or respond to the compounding trauma in her life and provided no meaningful assistance, leaving her in a dangerous situation that led to her death. Any supports offered were utterly inadequate to address the scope and scale of her life challenges, which included being the victim of regular abuse, neglect and maltreatment, having serious mental and physical health needs largely unmet and high-risk use of alcohol and substances to self-medicate her horrific pain.

The Representative is unable to understand the pervasive system-wide professional indifference to this young Aboriginal girl when the challenges to her vulnerable cohort were so well-known to the ministry and other professionals. The system has no learning from this tragic death and shows little insight into its responsibility for her or other youth in similar circumstances.

During the first three years of Paige's life, the ministry received seven child protection reports involving domestic violence, neglect and child abandonment. Paige was removed from her mother's care three times, only to be returned under varying degrees of ministry supervision.

Assessment of Risk

MCFD is mandated to ensure that the children of B.C. are provided with protection from abuse and neglect and supported in alternate living arrangements when parents are unwilling or unable to protect or provide safety for their children. Accurate assessment of risk is a crucial foundation to ensuring that adequate interventions are provided. Risk assessment considers the likelihood that severe maltreatment will occur over the longer term (see box).

Risk Assessment

MCFD Risk Assessments measure specific risk factors such as:

- Nature and severity of previous maltreatment
- Characteristics of the family environment (e.g., domestic violence)
- Caregiver characteristics (e.g. substance abuse)
- Child characteristics (e.g. age, problem behaviour)

Some children in a family may be at higher risk for maltreatment due to their age, gender, or disabilities. Each risk factor is given a rating and social workers consider the combination of ratings to assess overall risk. Then overall risk is generally classified into levels such as low, moderate and high.

Source: Knoke, D. & Trocme, N (2004). *Risk assessment in child welfare*. Centre of Excellence for Child Welfare. Retrieved from <http://cwrc.ca/sites/default/files/publications/en/RiskAssessment18E.pdf>

Paige suffered extreme trauma throughout her life as a result of MCFD's failure to adequately investigate the more than 30 serious child protection reports it received and intervene effectively. Assessment of risk was minimal, deeply flawed and either ignored or totally misjudged the ongoing and chronic jeopardy which characterized Paige's day-to-day life. The risk factors were overwhelming and yet the ministry interventions were either absent or entirely inadequate to protect her.

Assessment of risk to a child must be thorough and take into account a variety of markers and indicators that help predict future risk of harm. If the assessment is not comprehensive in scope, its accuracy will be in doubt. Risk assessments are used as a prime predictive tool to accurately inform a social worker's decision-making when determining the risk of harm to a child and what interventions are necessary to mitigate the risk.

When Paige was five-months-old in October 1993, as part of the protection investigation, the social worker completed the ministry-required risk assessment which informed the decision to remove Paige from the legal custody of the parents. Yet with no apparent change in the circumstances, she was returned a few days later.

A further risk assessment was undertaken when Paige was again removed in March 1994.

Three months later, in June 1994, another assessment was completed leading to Paige once again being removed. All three removals were characterized by Paige being abandoned by her parent or parents, along with family violence, alcohol abuse and continuing transience.

Nevertheless, despite Paige's vulnerability, her history of abandonment, her mother's own history of being brought up in an alcoholic and abusive home and being abandoned by her parents, and the multiple other indicators of risk of harm, Paige's mother was described by the social worker as follows:

"When she parents the child she does a superb job of meeting her emotional and physical needs."

The Representative fails to understand how any rational person charged with protecting a child could reach this conclusion. It is as if the worker had no understanding of child development or the pathways for Aboriginal children impacted by neglect, family distress, mental illness or addictions, and demonstrated willful ignorance or indifference, or both.

In May 1995, following a further report of neglect and Paige's concerning behaviour, another investigation was opened and a further risk assessment was completed. Paige was seen in her daycare. Her mother indicated that domestic violence continued to be present in the home.

The risk assessment touched upon the previous concerns. But once again, the chronic dysfunction in Paige's home, although alluded to in the assessment, did not result in a closer look at the plight of this child and the capacity of the mother to safely parent.

In December 1995, another report was made to the ministry and a further risk assessment completed. Once again, the context of Paige's life was overlooked in the face of the mother's denial that anything was seriously amiss. The risk assessment form was completed but the risk of harm was neither comprehensively assessed nor actively managed.

Another protection report made by the RCMP in March 1996 again led to a risk assessment. But in the face of the mother's unwillingness to accept ministry services and her denial of the documented protection concerns by the RCMP, the risk assessment, while highlighting the ongoing nature and pattern of the safety issues, completely failed to spark any ministry action beyond an offer of protective services. As Paige was inexplicably found to be "*immediately*" safe, potential ministry protective action was curtailed.

In June 1998, the mother contacted the ministry requesting support. She was feeling "*worn out*" with caring for Paige and asked that her daughter be placed in a foster home. This followed the mother having expressed feelings of depression the previous year. She had also been referred by the ministry to a mental health counsellor. The request for support once again did not launch a fuller assessment even though the mother did acknowledge sporadic drug use in addition to her alcohol use. The mental health status of the mother was also not considered, nor was her ongoing capacity to provide adequate care and emotional support for Paige.

Opportunities to rigorously assess past and current harm to Paige continued to be missed as the social work focus remained on keeping Paige and her mother together, regardless of the cost of a lost childhood.

It was known by the ministry in February 2000 that the mother was being prescribed methadone. A report was also made to the ministry at the same time alleging that the mother was smoking crack cocaine while her daughter was in the house sleeping.

The ensuing protection investigation found that Paige was in need of protection and that her parent was unable to care for her. Paige was placed with her maternal grandmother under a CIHR agreement. A comprehensive risk assessment was not completed despite the overwhelming jeopardy that Paige had faced while in the care of her mother.

The ministry was advised by the mother in early 2001 that she had been in a treatment program for her substance dependencies. She wanted her daughter back and was seeking financial assistance. This information did not result in the ministry reassessing the risk of harm to Paige if she again lived with her mother, nor did it require an assessment of parental capacity. Thus Paige was again reunited with her mother with no ongoing safety plan to monitor the status of her mother's substance use.

In October 2003, the assigned social worker in Kamloops completed a risk assessment in the wake of Paige being removed from her mother's care again. The social worker used a newer and more thorough assessment tool, the Comprehensive Risk Assessment (CRA). This tool required a deeper scrutiny of the factors that informed the risk of harm to children than the earlier one. Though narrative in scope, it also attempted to weigh the various influences that had been found to predict susceptibility of harm to children.

Paige's removal was triggered by her mother's abandonment of her, her ongoing substance use issues and her avoidance of the assigned investigating social worker.

The CRA, completed Oct. 27, 2003, found Paige to be at high risk of further harm if she was returned to her mother's care.

Two more CRAs were completed during the following year in Fort St James. They concluded that the risk had significantly diminished, as the mother had gained enough stability to engage somewhat with her social worker and had briefly found employment. She also attended a few sessions with an addictions counsellor.

However, the mother did not enter an addictions treatment program, and avoided substance use screening. There were reports of her active use of crystal methamphetamine during this time. When Paige was legally returned to the mother in September 2004, the mother stopped going to counselling. The family file was closed the following March when the Supervision Order expired. The Representative's investigation found no documentation in the MCFD files that the mother ever complied with drug-testing requirements.

The next CRA was completed in Kamloops in July 2007, with a finding of Paige being at medium risk of further harm.

The last risk assessment on the file from July 2008 was never fully completed. Nevertheless, there is a telling comment in the mental/emotional ability to care for child category. The social worker wrote:

"It is uncertain if the parent has any mental/emotional deficits and to what extent they may impact parenting. The parent displays very erratic behaviours; one day she is reasonable to communicate with and the next she is yelling obscenities."

The parent had by this point remained the primary caregiver to her daughter for more than 15 years.

The Representative fails to understand how, based on the ministry's own standards and policies, and knowing what it already did about the mother's behaviours, that this situation was allowed to continue.

Child Safety Investigations

The ministry investigations into Paige's safety focused on using what the ministry terms "*less disruptive measure*," or a desire to not use removal and attempt to work with a parent on a child's safety. When Paige was removed, she was speedily returned to the parents or solely to the mother with inadequate means of ensuring her ongoing safety.

The mother presented as hostile and evasive to the investigating social workers. Multiple times, the social workers closed off the investigations with the threat that more intrusive action would be taken the next time a report was received. Meanwhile, Paige continued to be left with, or returned to, her mother by MCFD without any comprehensive plan of

monitoring or ensuring her safety. It was as if each subsequent worker ignored previously gathered information, however limited, in earlier reports.

It is evident that scant use was made of collateral information to inform risk assessments and risk decisions. The Representative's investigation noted only one *CFCS Act* s. 96 request for information in MCFD files. Information respecting the mother's request for crisis grants, her evictions, loss of damage deposits, changes of residence, rent monies not being paid to landlords and aggressive behaviour in income assistance offices was never obtained and reviewed by the ministry.

The mother's arrests were frequently unknown to MCFD as police reported only a fraction of the contacts they had with the family. The ministry did not request crucial information that would have revealed the extent of her police involvement.

Paige was rarely seen or interviewed by the ministry and access to the places where she lived was frequently blocked by the mother. Risk decisions were made with little appreciation of the ongoing trauma to which Paige was exposed.

During her childhood and early adolescence, there was a constantly changing complement of social workers investigating the many protection reports. By the time Paige aged out of care, 17 different workers across the province had been responsible for her. Only one social worker spent enough time with her to develop a more than rudimentary relationship. The absence of a long-term and trusting connection would prove a consistent barrier to Paige's acceptance of any suggested interventions.

As her mother's mental and physical condition deteriorated, Paige felt an increasing responsibility to care for her, while at the same time neglecting her own needs. For Paige to be safe and to benefit from any placement, she needed to know that her mother was being helped.

One of the changes to B.C.'s child welfare legislation in 1996 was the inclusion of the concept of "*likelihood of harm*." This change permitted social workers to assess and act upon not just an immediate evidence of harm to a child, but to include an analysis of past parental behaviour to better assess the potential for ongoing child abuse and neglect. Time and again, Paige was left with or returned to her mother with no evidence of diminishment of risk to her. Files were closed prematurely and the mother was permitted by default to continue placing her daughter in increasing jeopardy.

That the mother was not immediately under the influence of narcotic drugs or alcohol appeared to be assessed as an indication that Paige would be safe. Thorough and fact-informed investigations of the protection reports and family circumstances could have brought an end to this revolving door and the irreversible harm to Paige.

Paige's mother disrupted and sabotaged Paige's placements, both those with extended family and those with ministry foster families. This behaviour should have triggered a number of ministry responses that would have protected the placements and provided longer term stability. Instead, the mother was allowed to terrorize the foster parents

with no apparent consequences. Although her motivation may have been a desire to reunite with her daughter, she appeared to have little ability to regulate her emotions and actions. This presented a chronic risk to Paige's safety and well-being and often placed on her responsibility to manage her mother's behaviour and protect herself.

Prior to concluding intake reports and closing files, best practice requires evidence that the risk of harm to the child has diminished and that an adequate safety plan is in place to identify if or when a child requires safety interventions and further planning.

While it may have been the ministry's view that it was preferable to ignore or overlook the mother's evasive or obstructive behaviour in an effort to elicit her cooperation, the mother's parenting remained dangerous and destructive. It is incomprehensible that this could be ignored time and again over the years.

Between January 1997, when Paige was four-years-old, and October 2002, when she was nine, 10 child protection reports and requests for family services were made to MCFD.

The mother's alcohol and drug use was a factor in almost every intake report and family services request and yet the impact of these addictions on Paige was rarely given more than a cursory look. Although the ministry repeatedly asked the mother to take dependency treatment programs, she was unable to stay clean and sober for more than a few days. No confirmation was found in the MCFD case files that she was ever able to complete a treatment program. By framing her mother's problems as solely addictions related, MCFD ignored her substantive mental health and trauma-related challenges and the abuse Paige experienced by being exposed to the behaviour of a parent who is an active and chronic substance user.

MCFD Child and Family Development Service Standard 17: Concluding a Child Protection Investigation states:

"To conclude an investigation, decide whether the child needs protection, by:

- *Considering relevant information collected during an investigation*
- *Examining the strengths and risks of the family, using a standardized culturally appropriate assessment tool*
- *Considering what role natural helpers and informal supports can play in keeping the child safe, and*
- *Consulting with others who are familiar with or have specialized knowledge of the child's circumstances."*

With no safety measures in place, and MCFD intake files prematurely closed, there was no mechanism to reassess child safety despite what was clearly ongoing high-risk circumstances. Paige and her mother were thus frequently out of sight, their circumstances and place of residence unknown until another complainant stepped forward to furnish a new set of concerns to MCFD.

Finding: Health care professionals, hospitals, police, outreach workers and staff at shelters and SROs repeatedly failed in their duty to report child protection concerns to the ministry, as required by s. 14 of the *CFCS Act*, when a child is in need of protection.

Despite the cynicism expressed by some witnesses about the ministry's ability to effectively respond, failure to report is an offence under the *CFCS Act*. The repeated failures to act on this legal duty meant that critical information was not made available to the ministry workers responsible for Paige, even though this information could potentially have triggered some intervention or response.

The ministry repeatedly failed to provide reports to the Representative as required by s. 11(1) of the *RCY Act* about the multiple critical injuries sustained by Paige while she was in ministry care or receiving ministry services.

The Representative has previously drawn attention to the widespread non-compliance with the legal duty of all citizens to report to MCFD if they believe a child needs protection as defined in s. 13 of the *CFCS Act*.

In *Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl*, the Representative made a recommendation directed to the College of Physicians and Surgeons and the College of Registered Nurses about reminding their members of this statutory responsibility. This recommendation has been taken and seriously implemented. The Representative also recommended that the Attorney General of B.C. review the reasons for the lack of enforcement of these provisions of the *CFCS Act* and that steps be taken to promote compliance. There has been no implementation of this recommendation.

One glaring example of this failure to report in this case involves the then-named Ministry of Social Services (now known as Ministry of Social Development and Social Innovation), which provided financial assistance to both mother and daughter during the periods when Paige was not in MCFD care. The financial assistance workers were aware of the mother's medical condition and disability designation including her depression, neurological issues and addictions. They were aware of the continual evictions due to non-payment of rent, moves from community to community and the mother's chronic cycle of addictions, erratic and violent behaviours and attempts and failures to complete treatment programs. However, income assistance workers never made a protection report to MCFD, despite knowing that the mother was responsible for the care of her vulnerable child.

The more serious pattern is that of front line professionals failing to report to MCFD. One specific such example occurred in April 2010, after Paige and her mother fled the DTES to a transition house in Surrey. Transition house staff had concern for Paige after she had spoken to counsellors in their program for children who witness abuse. A staff member later told the Representative's Office "*we didn't phone [MCFD] this time – in this particular case. I asked everyone, why hadn't we done that – and I think once this woman left, it just got totally like missed.*" The justification given was that there were other more high-

risk situations happening in the transition house at the time, and obvious concerns around Paige's safety went unreported.

Multiple contacts with health officials, hospitals, police, community service agencies, emergency shelters and others did not result in reports to MCFD as required by s. 14 of the *CFCS Act*. Non-professionals likewise appeared unaware of their responsibilities to report under the same section. S. 11 of the *RCY Act* places a duty on a public body that is providing a reviewable service to report to the Representative of any critical injury or death of a child who is receiving such a service (see Appendix A). In this case, this would put primary responsibility on the ministry to be reporting the repeated traumatic events in Paige's life to the Representative.

To have received only a single such report prior to the commencement of this investigation is deeply disturbing to the Representative, as it demonstrates neglect of a fundamental part of the oversight mechanism for child welfare in this province. Had the Representative been receiving even a fraction of the reports that should have been generated, these would have been carefully reviewed and brought forward to the attention of senior ministry staff. Without this information, the Representative was unable to perform her statutory duties.

Finding: Repeated changes in child protection policy and expected practice often left social workers confused about what actions they should take in order to ensure this child's safety. For Aboriginal children and youth in particular, politically influenced changes to the ministry's agenda contributed to an institutional reluctance to provide effective interventions, resulting in predictably disastrous consequences for the children they were supposed to serve. This includes an acceptance of the DTES as an acceptable venue to raise a child – a completely unconscionable choice with the level of known harm and danger in that location.

Paige was born in 1993. To provide a more complete picture of what was occurring for her, it is helpful to understand the changes to child welfare practice that were occurring at the same time. During her life, the guiding principles and philosophy of MCFD oscillated between the light touch of the "least intrusive" approach and a child-centred approach that emphasized child protection.

The child welfare legislation in force at that time in B.C. – the *Family and Child Services Act (FCS Act)* – had been under intense scrutiny and review and was in the process of being rewritten. The *FCS Act* was to be replaced by new legislation that incorporated evolving social work practice with an emphasis on the rights of children, families and Aboriginal peoples.

The *FCS Act* was replaced by the *CFCS Act* in 1996. The philosophical underpinnings of this new legislation encouraged the building of new relationships based on family strengths and community engagement. This reflected the broader institutional realization of the immense damage that had been done to Aboriginal families as a result of the residential school system and apprehensions of Aboriginal children.

The *CFCS Act* emphasized the rights of children and parents, mandated the use of the “less disruptive measure” in child welfare interventions and recognized the unique needs of Aboriginal families. Although its guiding principles made the safety of children the paramount consideration, it also emphasized the use of support services to the family unit as the preferred environment for the upbringing of a child.

Following the legislative changes, the ministry introduced a revised policy and procedures manual in 1996. This highlighted the legislative requirements for the ministry to explore and access extended family and kinship as well as Aboriginal communities as alternatives for caring for Aboriginal children who could not remain in their own homes. These same principles were enshrined in ministry standards in an attempt to ensure clarity around the duty and responsibility of working with Aboriginal families and communities.

Ministry social workers involved with Paige and her family during the early years of her life characterized the child welfare system as being in disarray as the ministry struggled to adopt these new practices. Around the same time, the ministry introduced a new computer system that many workers found initially challenging.

Ministry workers involved with this child and her family during this period of time recalled the over-riding practice concern during Paige’s early years as being focused on the use of the less disruptive measures. They also remembered a court environment that they perceived as reluctant to support the removal of children from their families, preferring instead the use of Supervision Orders to protect child safety. One worker said:

“I do recall that ... the child would be returned because the judge wasn’t happy with the way things went down or the person had a good lawyer and – the Report to Court was basically dismissed and the judge would say ‘I’ll return under a supervision order’.”

There were also significant external factors that had a profound influence on child welfare practice. In 1995, the *Gove Inquiry* into the death of five-year-old Matthew Vaudreuil offered a stinging critique of the ministry’s child protection work and concluded that the “protective” services offered to the family were directed more to the benefit of the mother than the safety of the child. One social worker observed:

“... and then post-Gove, I think social workers removed more [children] under, I’m going to say, some degree of apprehension about not removing, and what you heard a lot of was ‘I’ll remove the child and let the judge make the decision’.”

Although the *Gove Inquiry* may have again shifted the practice focus from family support to a more activist and child-centred approach, the ministry was also bolstering other less intrusive measures, including family group conferencing and mediation. This was followed in 2003 by the introduction of the Family Development Response as an alternative to investigation in ministry child protection issues. Another new set of Child and Family Development Service Standards was developed and released to staff in 2003 and then a revised edition was released the following year.

Family Development Response

This is an approach to child protection reports that may be taken after the results of an assessment show the risk of harm can be managed through the provision of intensive, time-limited support services. It includes a strengths-based assessment of a family's capacity to safely care for a child and provision of support services, instead of a child protection investigation.

It is impossible for the Representative not to conclude in this investigation that there was a direct connection between MCFD's repeated failures to intervene to provide safety and stability for Paige and these significant swings in provincial child protection practice. Repeatedly, numerous deputy ministers, chiefs and others have stated their desire to reduce the number of Aboriginal children in care. Paige's short life should be considered a stinging rebuttal to that political posturing – the real issue is to eliminate or reduce the abuse and neglect of Aboriginal children. The well-being of children should remain the ministry's – and indeed everyone's – focus. Finding placements within extended families is an essential tool, as is a real working relationship with communities.

What is clear is that workers during key periods in Paige's life were confused by the shifts in emphasis in child welfare and uncertain about what they were expected to do. One worker told the Representative's investigators simply "*We don't know where we stand.*" The Representative believes many still remain utterly confused about how to support children such as Paige.

Permanency

Finding: The ministry's ongoing failure to appreciate the profound risks to this child resulted in her experiencing compounding abuse and trauma. Rather than leave her to experience continuing abuse and neglect, the appropriate child welfare response would have been to remove her permanently in her early years or to provide long-term and meaningful support that would have connected her to extended family, her culture and school. These connections could have disrupted the pathway she was on leading to her death.

Of particular concern to the Representative is the lack of action by the ministry to pursue a potential family placement offered by Paige's aunt and uncle in East Vancouver.

This option was not explored by the ministry despite the fact that these family members were prepared to provide a home. As members of her Aboriginal community, they would have been better able to provide key cultural support that was not provided in Paige's eventual non-Aboriginal foster care placements. These placements were contrary to existing ministry policy which mandated the placement of an Aboriginal child with an Aboriginal family whenever possible. This type of cultural support would have strengthened Paige's resilience.

After Paige and her mother were evicted from the Balmoral Hotel, the aunt and uncle cared for Paige's pet cats. Paige visited her cats at their apartment on a weekly basis during her three years in the DTES. The aunt and uncle were rare constants in her life, as evidenced by their ongoing relationship.

MCFD CHILD AND FAMILY DEVELOPMENT SERVICE STANDARDS

CFS Standard 2: Children and Families from Aboriginal Communities

To preserve and promote a child's Aboriginal heritage and connection to his or her Aboriginal community, the following must be involved in all significant decisions when determining the child's Aboriginal connections, heritage and descent, and when assessing, planning and providing services for the child:

- the child
- the child's family
- the child's extended family
- the child's Aboriginal community
- the identified delegated agency and any other community agencies involved with the child and family, and
- any significant people identified by the child and his or her family or Aboriginal community.

MCFD POLICY

From initial contact and throughout the period of involvement with a child and family, involve the Aboriginal community to:

- identify the strengths within the Aboriginal community and heritage of the child and family
- identify extended family members
- identify, plan and deliver services that are culturally appropriate and accessible
- provide information to help strengthen and support the Aboriginal child's home and in turn help ensure his or her safety and well-being
- participate in the development and implementation of plans of care that will preserve the child's cultural identity
- ensure that review processes are sensitive to cultural perspectives and are carried out in ways that are culturally appropriate
- identify and develop an appropriate out-of-care living arrangement for the child, and
- reunify Aboriginal children who have been removed from their homes and communities with their extended families and communities.

When interviewed, the aunt and uncle told the Representative's investigators that they had met with Paige's social worker and suggested a plan to get a larger apartment so Paige could live with them. The worker made a cursory visit to their apartment and provided grocery vouchers when Paige stayed there.

The aunt and uncle were treated only as an informal placement, called when Paige was picked up by police or released from hospital.

When asked about the rationale for not supporting this family placement, the assigned social worker told the Representative's investigators that the aunt and uncle were not proactive in requesting this. She described the aunt as timid and soft spoken, and said that was common among her Aboriginal clients. She interpreted this as meaning that the aunt was not overly interested in having Paige reside with her. The social worker had no recollection of the family ever requesting financial support to obtain a larger apartment so Paige could live with them, although file notes made at the time include this statement: *"Aunt and Uncle would like to move into a two bedroom with her."*

A senior staff member at a DTES non-profit agency told the Representative's investigators that this social worker was resistant to placing Paige in this home. She noted consistent *"pushback"* from MCFD, recalling that the social worker suggested that the *"family's just sort of – seems to be asking for money, this isn't the best place, and*

CFS Standard 20: Placements When a Child Comes into Care

Give priority to placing a child with extended family, consistent with the child's best interests and need for stability and continuity of lifelong relationships.

In addition to the above, if a child is Aboriginal, always give priority to placing the child within the child's Aboriginal cultural community. If the extended family or community cannot safely assume the child's care, give priority to placing the child with another Aboriginal family outside the child's Aboriginal cultural community.

If these placement priorities are not possible, make every effort to place the child in a location:

- where he or she can maintain contact with relatives and friends
- in the same family unit as the child's brothers and sisters
- that will allow the child to continue in the same school, and
- that will allow continued contact with his or her cultural community.

If an Aboriginal child is placed in a non-Aboriginal home, provide him or her with opportunities to maintain positive contact and involvement with the Aboriginal community or establish relationships with an alternative Aboriginal community or urban Aboriginal organization close to where the child lives.

it's better for her to go into care or go into a day type program or some other program." The rationale provided by the social worker was that she did not want to put the effort into formalizing this family placement for Paige until she had addressed her drinking problem. The agency staff member advocated for the family placement and suggested, to no avail, that a day program for Paige would not address her basic need for stable housing.

Instead of being placed with her aunt and uncle as a core placement with additional supports for education and treatment, Paige spent three years shuffling between shelters, detox facilities and SRO hotels, an outcome apparently acceptable to her social workers.

The Representative believes that the Aboriginal community will be deeply troubled with the almost non-existent cultural supports and connections for this child and the gross disregard for the legislation,

standards and policy that were put in place in 1996 in response to serious historical practice issues. The inability to work effectively with this Aboriginal family demonstrates the continuing failure of the ministry to implement these long-standing standards and policy in a meaningful way for families and workers. Clearly, effective oversight and accountability are lacking throughout the child protection system, resulting in ineffective and inconsistent application.

Having strong and enduring cultural connections is an important protective factor. It is likely that if Paige had been supported in retaining strong connections to her culture and extended family then her physical and mental health would have improved. The importance of a child remaining connected to his or her culture must not be overlooked by service providers.

Paige lived with her Aboriginal family, mother, grandmother and extended family for some significant periods of time. She attended an Interior Indian Friendship Centre day care and was referred to First Nations school counsellors and special programs while in elementary school and beyond. However, Paige's frenetic life and continual dislocations

Young Wolves Lodge

Young Wolves Lodge was a five-bed, 16-week voluntary residential treatment program in the Vancouver area (closed in March 2015). Clients were young Aboriginal women ages 17 to 24 who had substance misuse issues and were homeless, or at imminent risk of homelessness. Young Wolves Lodge embraced First Nations ceremonies, traditions and teachings, incorporating them with a holistic clinical approach to best support youth by guiding, teaching and empowering them. This program was a service of the Urban Native Youth Association and provided a comprehensive range of services to youth, including:

- Alcohol and drug education, Alcoholics Anonymous and Narcotics Anonymous meetings and other relapse prevention resources
- On-site counsellor and post-treatment planning
- Planning and transitional support towards independent living.

would have made it impossible to develop any sense of continuity, predictability and deep rootedness.

During her years in the DTES, Paige had one very short period of attachment to a resource service that appeared to understand the needs of the cohort and be a positive reflection of culture. She lived at the Young Wolves Lodge from July 12 to Aug. 27, 2011, participating in a residential treatment program.

A supervisor of this program told the Representative's investigators that Paige responded positively to the First Nations healing modalities used in the program and he was struck by the fact that she functioned so well in the program:

"We have a structure and I was really surprised that she stayed ... people say she stayed at the Wolves longer than any place else. I think it was the engagement between her and the staff ... and the spirituality part."

The program supervisor sensed that Paige had a deep pull towards her mother and talked about facilitating visits with her mother at the Lodge.

"We talked about her mom coming up to the Lodge and spending time with her, but we never got to that point because of the incidents that happened next."

While on a day pass from the Young Wolves Lodge, Paige was told by a street person that her mother was homeless. This news completely destabilized her. Her mentor at the program told Representative's investigators that:

"A guy who she met up with said that her mother was homeless ... I think it snowballed from there because she felt that she needed to take care of her ... that's how strong the bond was."

Despite the culturally relevant stability offered by this program, it was not sustainable for Paige. She left the program to find her mother and never returned. This could have been a source of resilience if she had remained there. This program was not sufficiently supported in the health, education or child welfare system. It was closed in March 2015 due to withdrawal of funding.

Education

Finding: The education system's passivity mirrored that of the child protection system. School could have been a protective factor that changed this child's life pathway. Instead, despite her potential and motivation to learn, she was allowed to drift away from her connections to school with predictably negative outcomes.

All indications are that this child was bright and motivated to learn. Her early school years showed real signs of promise. Unfortunately, her mother's transience and her chaotic home life meant almost constant disruption to her education. Paige experienced 16 school transfers in multiple communities before finally abandoning school entirely.

Paige's educational achievement was sabotaged by her life. From a bright, engaged and creative small child who achieved remarkably well in school, there was a gradual lessening of her ability to engage. Her quiet calls for help are documented in her behaviour. The schools she attended worried about her. They identified the barriers to her success, her lack of academic gains and her gradual social disintegration. Her teacher wrote the following comment on her Grade 7 report:

"It is with heavy heart that we write the child's report card. Her numerous absenteeism and frequent tardiness makes it difficult to grade her with any accuracy."

While there is documentation that indicates that the ministry was advised of particularly egregious situations that Paige disclosed about the events in her home life and about her personal safety, there is little to suggest that the ministry and the school system ever collaborated beyond the immediate presenting situation on a plan to keep Paige safe.

Grade 7 appears to have been a watershed year for her. In her first term, her teacher commented that despite her frequent absences she was still able to keep her grades at a C+ to B level. Her Grade 7 report card comments neatly captured her situation:

"The child is a bright student whose life outside school makes it almost impossible for her to reach her academic and behavioural potential."

Violence at home, police involvement and the arrests of both Paige's mother and her mother's boyfriend put even further pressure on Paige. She began coming to school exhibiting signs of drug use. Her Aboriginal school counsellor asked MCFD for a mental health referral for her and, in the meantime, an assessment conducted by the school resulted in Paige being designated as having "moderate behaviour/mental illness," which resulted in the creation of an IEP for her.

A review completed a few months after the creation of the initial IEP reflected Paige's increasingly challenging behaviour and resulted in her being re-designated as being in need of "intensive behaviour support." The lack of documentation suggests the requested mental health referral did not take place, possibly because the mother took Paige back to their home community in the meantime. Paige's circumstances meant that a referral was unlikely to ever actually occur. Meaningful and accessible mental health supports being present in the school itself could have provided some of the assistance she required.

In the context of continual moves, Paige was unable to firmly re-establish herself in any school setting for the next three years. After she and her mother arrived in the DTES, subsequent attempts to re-enter the school system were unsuccessful. Although a Vancouver high school counsellor described the girl as “*charming*” and “*excited to start school*,” and her teachers found her “*resilient, hardworking and independent*,” her life circumstances quickly overcame her. Even enrollment in an alternative program focused on Aboriginal students failed to engage Paige and allowed her to drift away.

Although education should have been a primary concern for MCFD and an easy predictor of Paige’s future success, her prolonged absence never triggered a response appropriate to the seriousness of the situation. No one went to find her and the Representative is of the view that this cohort of Aboriginal children living in unstable situations is seen on the school grounds but is too often allowed to drift away from actual learning.

Service Delivery and Child Protection Practice Issues in the DTES

Finding: Despite the expenditure of hundreds of millions of dollars annually by more than 200 health and social service agencies in the DTES (a community of only 18,000 people), no one familiar with this dangerous and disordered environment could conclude that living here would have anything but disastrous consequences for this vulnerable young Aboriginal girl. Paige was left for three years in conditions that no reasonable person would find acceptable for their own child. Tolerance of this situation represents an abject failure of leadership and policies by governments at all levels.

On Sept 27, 2010, Wally Oppal QC was appointed to head The Missing Women Commission of Inquiry, examining police practices in relation to women, many

Aboriginal, who had gone missing from the DTES between 1997 and 2002. This Inquiry would repeatedly highlight the enormous risks faced by girls and women such as Paige. Despite this, the ministry took no meaningful action to safeguard her from these well-documented risks.

Between the ages of 16 and 19, Paige drifted through more than 50 locations, mostly in the DTES – among homeless shelters, safe houses, youth detox centres, temporary accommodations with relatives and friends, two ministry foster homes and various DTES SRO hotels.



Looking down a DTES street

Service Delivery

Paige had three different child protection social workers during her time in the DTES. A lack of personal contact and meaningful engagement typified the relationship between her and her social workers during this time. When asked about the frequency and quality of contact, her first social worker said:

“Very, very little and it’s typically just reviewing the memos that were coming in or on the file at the time. It wasn’t direct contact.”

This social worker could not recall if he ever met with the mother during the entire time he was responsible for the case, a period of 14 months. A review of the file shows no indication that this ever happened.

The second ministry social worker who was assigned to the case clearly articulated to the Representative’s investigators that she did not attempt to engage the mother in any parental risk-reduction services.

The Representative’s investigators were advised by this social worker that she met with Paige about 50 times and with her mother at least five times. However, minimal documentation of this was found in the file despite clear requirement of social workers to document all contacts. This particular lack of documentation reflects negatively on the workers and the quality of their supervision. Accurate documentation is essential for continuity of care as workers routinely change. Meetings with Paige were characterized by the worker as centred on asking her if she was interested in coming into care or attending treatment. Paige typically responded with indifference and focused on ongoing concern about the well-being and whereabouts of her mother.

Also concerning was that shelter staff told Representative’s investigators that they failed to make reports on a number of occasions, in part because of Paige’s age (then 16), but primarily because of the perceived lack of response from the assigned social worker. Personal contact with her assigned social worker was rare and the responsibility for initiating that contact was inappropriately placed almost entirely on Paige. One shelter worker said:

“They didn’t come to the shelter, everything was done through letters and correspondence – they never visited the program or met the staff to find out what was going on. They didn’t seem that interested.”



Entrance to the Stanley Hotel

The Representative notes that this pattern of repeated failures to report child protection concerns to MCFD is a chronic problem across the province, most recently highlighted in her February 2014 report *Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl*. The *CFCS Act*, which governs child welfare in B.C., places a legal duty on every citizen who believes that a child needs protection to report that concern to MCFD. The repeated failures to report glaring child safety concerns involved health, police, community service agencies and DTES SRO hotels.

The incomplete picture of Paige's situation created by these repeated failures to report was exacerbated by the ministry's over-reliance on contracted outreach service providers to monitor her circumstances.

MCFD social workers advised the Representative's investigators that they designated primary responsibility for face-to-face contact with their youth clients to contracted outreach staff. However, they advised of an ongoing concern with lack of reporting back by some of these designated workers responsible for direct service delivery.

One social worker stated:

"I think the problem may be the coordination of my eyes on the street ... and ensuring that information gets back to me, is that process of disseminating information – and receiving it back – and so they may have been sighting either the mother or the child, but not necessarily communicating it back."

The ministry Yankee 20 social worker only physically met with Paige on one occasion, after she had turned 19. When interviewed, social workers confirmed that it is not uncommon for specialized units such as Yankee 20 to be aware of a high-risk youth's presence in the DTES, but to not physically ever see them. Youth cases could be discussed at Reconnect meetings, but those same youth may not be directly served or seen.

Paige appeared to be served by multiple services and agencies, yet in reality she was missed and not served. Multiple agencies were "involved" with her, some directly, but many on only a superficial level as a referral. Repeated references were made throughout the file to Paige having various counsellors, and it was later confirmed by Representative's investigators that she had actually never met with any of these people.

On occasion, outreach workers were asked to attend DTES SROs to search for Paige, in lieu of the delegated social worker. These requests were neither frequent nor timely. Nobody made consistent efforts to search for and directly observe Paige and her situation.

When responsibility for physically searching for Paige was delegated to outreach workers, this approach was hampered by worker concerns about their own safety inside many of the SRO hotels. The Representative's investigators were told:

"We try not to go into hotels because it is such a safety concern."

“You’re sending us into some kind of situation where we have no idea what’s going on. That’s not our job, and a lot of passing off their job onto us.”

The Representative finds it appalling that workers would be reluctant to enter certain hotels because of well-founded concerns about their personal safety while having the knowledge that Paige was living there.

Equally problematic was that responsibility for initiating contact with her assigned social worker was placed almost entirely on Paige. Given the known danger she faced and the daily struggle for survival she was facing, this approach was cruel and essentially shifted blame for her abuse onto her.

Multiple reports were made to the assigned MCFD social worker by contracted agency staff, police and After Hours advising of her current location. It is unclear why the social worker with responsibility for her did not attend to these locations to speak to her and assess her safety each time. When asked about this, her worker stated that she would usually just wait until Paige came into the ministry office to meet with her.

The ministry file was closed at one point during Paige’s first year in the DTES with the following reasoning:

“No word from the child at all. The child never reached out to MCFD directly nor has her mother. I closed my file due to no contact/ no accessing of services.”

Regardless of the ministry file being closed, community agencies went to the Balmoral SRO hotel on several occasions in an attempt to locate Paige, and she was “profiled” at a Reconnect meeting. The Reconnect worker indicated that this did not mean contact; it simply meant sharing of information about Paige. A DTES youth-serving agency report to the last assigned ministry social worker stated:

“Outreach has been trying to look for her and an outreach worker stopped by the Balmoral but she wasn’t home. I will keep encouraging people to look for her and hopefully at some point get her into your office.”

During interviews with contracted agency staff, the Representative’s investigators found that there were no formal written reporting requirements between outreach and MCFD. Outreach workers were only required to record “contacts” with clients, which could



A man walks past an SRO hotel in the DTES

include just a brief sighting of a client in the DTES. Paige's primary outreach worker stated to investigators:

"We don't do [daily] reports ... we only do critical incident reports, so if the child were to go to the hospital or I called an ambulance for her. We only contact social workers if there's a concern for a kid. We do stats, but there's nothing – specific."

Over-reliance on contracted outreach service providers and sporadic ministry engagement with Paige continually left her at risk in what can only be described as dangerous conditions with known harms. This was a downloading of child welfare responsibility to a youth-serving agency unburdened by the legislative requirements of the *CFCS Act*.

Child Protection Practice

The ministry's perception that DTES SRO hotels were in any way appropriate living conditions for a child was nothing less than shocking. The Representative's investigation found that there was an element of "norming" of these deplorable living conditions by social workers assigned to this child's case.

When the mother and her child arrived in the DTES, the ministry advised Yankee 20 that Paige was staying with her mother at the Regent Hotel. This worker described the hotel as:

"... a nightmare"... some rooms have doors, some don't ... I can't even describe it. You wouldn't let animals live in there. It's so dangerous and it's so many people in a room and like a room with just a mattress on the floor and no door. You know, and bathrooms that don't work. Like all manner of things in bathtubs that you don't even want to look. So we went in there and I mean, people will always say, 'Oh, yeah, there are a mom and daughter here,' but nobody can tell you what room."

Paige's MCFD social worker in the DTES noted that she had met with the mother at Pigeon Park, the First United Church and at an SRO hotel. The same social worker had observed the room that Paige and her mother stayed in and described it as an eight-foot by 10-foot room with a small hot plate and a single bed that Paige and her mother shared. There was a communal bathroom down the hall that was shared with the other residents.

Shelter staff also reported that Paige stayed at the First United Church with her mother on a number of occasions prior to new rules coming into effect in 2010 that prohibited minors. Conditions at the First United were described by ministry staff as overcrowded and dangerous. Shelter staff advised that there could be upwards of 300 people sleeping there per night lined up in rows along the floor and sleeping on top of and under the church pews. Despite shelter policy to the contrary, residents often engaged in intravenous drug use and, on one occasion, a dead body was found under a blanket.

Staff advised that there was no policy at the time with regard to minors:

“There was probably a number of minors that went through there without us knowing because basically we didn’t take names – the doors were left open, you could just walk in.”

Shelter staff were very familiar with Paige’s mother, and observed her mental health deteriorating to the point where she talked about hearing voices. The mother was found on one occasion curled up in a corner hiding under a bunk bed, afraid that someone was coming to kill her. The mother later became involved in an incident in which she stabbed two shelter resource workers with a used needle when they intervened in a fight between the mother and another resident.

Staff advised that although Paige did not stay overnight with her mother after the rule change, she visited the church shelter multiple times looking for her mother. She was described as “... innocent – she just looked so sweet – she just didn’t belong there.” Staff said that when Paige came looking for her mother, she appeared anxious and worried.

When interviewed by the Representative’s investigators, several shelter and SRO hotel staff acknowledged under-reporting and reluctance to report child safety issues. Reports were made to MCFD only because they were mandatory, not because they believed Paige would be well-served.

Family members related that on one occasion Paige was hidden in a large suitcase and transported into a room in the Regent Hotel in order to avoid detection by front desk staff.

“They put her in a big suitcase, and they lugged her up the stairs – they had to get a man to help, and he said, ‘What have you got in here, a body?’ not knowing that the child was in there.”

The use of transition houses and shelters as the sole protection response in isolation of primary risk factors was wholly inadequate and continued to leave this child at risk.

A pattern of delayed response time to protection reports, a lack of attention to the mother’s mental health and addictions issues, and premature closing of the file, typified service delivery to Paige during her years in the DTES.

When the mother and daughter first arrived in the DTES, an initial report was received indicating that Paige had been left by her mother at an East Vancouver safe house. A cursory interview of Paige was completed. She disclosed that her mother was using drugs and that she was tired of the frequent moves and her mother’s drug use.

This was clearly a child who needed and wanted a stable place to live, yet there is no indication in file documentation that a foster care placement was discussed with her. The only risk that was addressed in this instance was the reported abandonment. A social worker called the mother, who said that she was willing to remain at a local shelter with

her daughter. No social worker attended the shelter to speak to the mother about her addictions or to assess Paige's safety. This involvement was concluded with the following notation by the social worker:

"No further contact with youth and/or mother. Neither appeared very interested in accessing services. MCFD's contact is generally at the initiative of MCFD, not the youth or mother seeking assistance. This intake to be closed."

This thinking is confusing and contrary to basic practice standards. This report was not a request for support by the mother or youth, but rather a protection report from a homeless shelter that a child had been abandoned by her mother. Furthermore, when there are outstanding protection concerns, a parent refusing service is not grounds for concluding a protection report – in fact, this actually heightens the risk.

Following this first contact with the family in the DTES, there was a hiatus of two months with no contact between the ministry and Paige until she resurfaced at a safe house saying that she had been alone for several days and did not know her mother's whereabouts.

This was now the second time that Paige had been abandoned during this social worker's involvement with the mother, who was demonstrating a continuing inability to care for her daughter. Paige herself was articulating a desire for a more stable life. This would have been an ideal time for a social worker to engage her in a stabilization plan as she had not yet become entrenched in the DTES.

During 2010, MCFD received three child protection reports concerning Paige while she shuffled between two SRO hotels, six transition houses and five safe houses. She was also listed as having no fixed address on eight occasions.

These child protection reports detailed active drug and alcohol use by the mother, abandonment and physical and verbal abuse. Two of these reports were inappropriately coded as a request for support services, and therefore did not trigger a child protection response. Reports to the ministry included her mother leaving Paige standing out on the street in front of the Regent Hotel while her mother was using crack cocaine inside, and another report of the mother overdosing in the Balmoral Hotel. MCFD response to these reports was delayed and Paige was never interviewed.

The one child protection report that was properly coded was not investigated with any adequacy. This report from a shelter advised that the mother had been discharged due to abusive behaviour towards staff and her daughter. The caller stated that the mother called her daughter a *"fucking little bitch"* and stated that she was going to *"beat"* her. The mother went on to tell Paige that she should just put her in foster care or leave her at a transition house.

The caller reported that during their stay the mother had abandoned Paige on numerous occasions despite warnings from the staff not to leave her alone. The mother was clearly using drugs and alcohol. On one occasion, she admitted to staff that she had been drinking in the shelter bedroom and handed over an empty bottle of vodka to

staff. Observations were also made of the mother having difficulty getting out of bed, appearing exhausted, and falling asleep in her food.

This intake was given a five-day response time, yet no action was taken until two weeks later. Paige was interviewed about her living situation, but was not asked about the reported maltreatment by her mother. The mother was never seen or interviewed.

All three 2010 child protection reports were concluded without a solid plan for Paige, and not once was the mother asked to complete a drug test. In one instance, the ministry concluded its involvement after a telephone conversation with the mother. File documentation notes: *“Mom claims to be clean and looking for housing outside the DTES.”* Another report was concluded with the following notation in the file: *“Youth has no fixed address, moving between transition houses with her mother for many months. Mother battling drug and alcohol issues. It is very unlikely that the mother’s situation will change.”*

A further social work practice issue identified by the Representative’s investigation was the minimal attempts made by MCFD to engage this child’s mother.

When interviewed about this case, the first DTES social worker stated that he saw Paige’s allegiance to her mother as a significant barrier to stabilizing her. He stated that he focused his efforts instead on trying to stabilize the mother, given that he believed Paige wasn’t going to leave her mother. Despite this rationale, minimal efforts were made to actually work with the mother. This strategy to engage the mother in services consisted of a few phone calls and a referral to an addictions counsellor, which the mother did not follow through on. The social worker responsible for Paige held the belief that, given her attachment to her mother, removing her would be pointless due to the high likelihood that she would abandon a foster placement. This social worker had no specific memory of ever meeting with the mother, despite the mother continually being labelled by this worker and others as “resistant to services.”

Minimal attempts were made to engage Paige’s mother, resulting in Paige feeling she alone was responsible for her mother’s care. The Representative believes this dynamic could have been averted if Paige saw the ministry social worker reaching out and providing supports to her mother, thereby freeing Paige from this responsibility.

A DTES outreach worker articulated this dilemma to the Representative’s investigators as follows:

“We have to make relationships with parents even though they don’t really want to make relationships with you.”

Youth-serving agencies all spoke of the desire felt by many of the youth they were working with to remain connected to their biological parents, regardless of the personal risk to themselves in the DTES. Social work practice that recognizes this would likely prove more successful in enhancing the outcomes of vulnerable children and youth. Although the parental bond and the requirement to work with parents is recognized and embedded in policy, this doesn’t always transpire in actual practice, as was the case with Paige. A lack of

clarity about a social worker's role with parents can create a situation where removal of a child is potentially over used or supports are inadequate when children are not removed.

Transition Planning

When youth in care reach their 19th birthdays, they are considered adults and no longer eligible for protection under the *CFCS Act*. In April 2014, the Representative released a report on the need for youth to have improved longer-term support as they move from care to independence. *On Their Own: Examining the Needs of B.C. Youth as They Leave Government Care* examined the challenges for youth leaving care and the poor outcomes for many of these youth.

It was made clear in that report that successful transition depends on thoughtful and timely development of a plan that fully takes into account the needs of the child.

While successfully transitioning to adulthood is important for every child in contact with the ministry, it is even more so for youth such as Paige, struggling with a lifetime of adverse experiences and trauma. Unfortunately, the planning for her transition can at best be described as rushed and cursory. At a time when it was critical for her well-being that Paige be actively assisted in making the transition to adulthood, she was virtually ignored, provided with only minimal support.

One of the early problems with providing effective services to Paige and her mother was their transience in the DTES and the challenge this appeared to pose for the social workers who were responsible for Paige. In describing this challenge to the Representative's investigators, one social worker stated:

"You know, it's one of those things with the Downtown Eastside that it's basically you – you drive around. I mean you've done that and it just – they appear and they don't appear. And as quickly disappear and you have no idea where they went."

This worker also advised the Representative's investigators that it was "absolutely" common for her and her team to be aware of high-risk youth in the community for an extended period of time and yet never actually see them.

As it got closer to Paige's 19th birthday, this worker explained that MCFD's primary focus was to escalate its attempts to actually locate her, and then arrange for housing and other supports.

Just prior to aging out of care, Paige was able to achieve some stability via a VCA. In her first Vancouver-area foster home, she was placed in a semi-independent living situation with a foster parent who was unwilling to work with her on her alcohol use, having stated that, "One of the caveats about placement in our home was that we needed it to be a sober home." The foster parent agreed to the placement despite her admitted awareness that Paige had a history of alcohol use; that she had just left a residential treatment program prior to successful completion; and that, at the time of the placement, she was not receiving any

support whatsoever for her substance use. This foster parent also told the Representative's investigators that she agreed to the placement even though she thought Paige *"would be better served in a treatment program where she could really – where she'd be contained during the day and night."* The placement ultimately broke down in less than a week.

Paige achieved some stability in her final Vancouver-area foster home, having been placed with a foster parent who was aware of her substance use issues and was more willing to provide support. Although the foster parent confirmed her willingness to care for Paige, she told the Representative's investigators that she *"got blindsided"* by the extent of the issues related to her alcohol use. She also told investigators that the social worker failed to provide much background information on Paige's childhood and the possible root of her issues.

This foster parent cared for Paige for the four months leading up to her 19th birthday and corresponding exit from ministry care. As a key participant in Paige's brief transition-planning process, the foster parent believed *"there was a real immaturity that I saw there,"* and that Paige *"definitely was not ready"* to live independently as of her 19th birthday.

The foster parent described Paige as being very anxious about her upcoming departure from ministry care, advising the Representative's investigators that:

"I was reminded a lot to, you know, put up a calendar and remind her that she had a timeline and I'm still a little bit conflicted about that. On the one hand you want the youth to know that they've got to do some things to get prepared to move out. On the other hand you're literally reminding them every day of the pending doom ... and some of them are absolutely petrified."

When discussing his role during this crucial period of time, Paige's MCFD social worker stated that it was standard practice (at least in his ministry office) to delay transition-planning for high-risk youth. He advised that *"If someone is quite high-risk we leave it 'til last three months or so or the last month to plan,"* and noted that *"we didn't have any social housing [for this child], and then we finally got it near the end."* When asked by the Representative's investigators what would have happened if housing had not been secured, he stated *"that's the scary part of it all"*, and explained that transitioning youth without housing *"usually couch surf"* or stay in adult shelters.

The foster parent advised that her resource worker was strict about the 19th birthday service withdrawal, and *"kept saying, okay, you know, this youth is done, this is finished you know, this is the cut-off day."*

An MCFD closing recording on Paige's file stated: *"The child is one month from turning 19 and unfortunately she is still binge drinking heavily and appears not to be overly concerned about having anywhere to live at age 19."* However, Paige told the foster parent that she was still receptive to seeing a therapist or psychiatrist and commented again on her night terrors, sweats and sleep paralysis. She also said she felt extremely anxious a lot of the time. An email from the foster parent to the MCFD social worker on March 5, 2012 stated that Paige's *"anxiety builds as her move out date approaches."*

When asked whether Paige was offered any counselling for her anxiety about leaving care, this foster parent told the Representative's investigators that although she requested this from the social worker, Paige *"didn't get anything."* The foster parent said that the transition-planning process was primarily focused on securing housing for Paige, rather than on her emotional or mental well-being, noting: *"I'm not pointing fingers. I'm just saying I said, you know, that she needs some help and she wants it. But I think the push was just like, you know, she's going to turn 19, let's get her an apartment or, you know stabilize her first."*

Paige's social worker said he had limited knowledge of her mental health or well-being beyond her substance use issues, and advised the Representative's investigators that her mental health *"was not a theme"* that stood out to him during his involvement in her life, and that *"it wasn't worrisome."* This ignorance of the trauma and maltreatment she faced, and her likelihood of having serious health consequences in adulthood, is stunning.

When asked whether she thought it would have been beneficial for Paige to remain in foster care beyond her 19th birthday, the foster parent said *"yes, absolutely,"* and noted that she would have been willing to continue to provide a home and ongoing support for her if such an option had been possible.

On the day Paige was to move from the foster home to her own apartment, at the direction of MCFD, the foster parent packed up all of her belongings in garbage bags and left them at Paige's school. School staff members were not privy to this plan, and were surprised at being asked to store the belongings.

Paige moved from her foster parent's home to an apartment in a building for Vancouver-area youth at risk. No ministry social worker visited to check the appropriateness of this living situation, and her file was closed.

The social worker responsible for Paige during her last weeks in care told the Representative's investigators, correctly, that he was not aware of any ministry practice standards that required a worker to observe the living circumstance of a child exiting from care. He also said that he would not have been able to visit Paige's housing placement because the move happened the day after her 19th birthday, when he was no longer responsible for her file.

Paige escalated to using crack cocaine and methamphetamine in June 2012, about a month after she left MCFD care.

Shortly before her 19th birthday, the ministry assigned a designated transition worker to help the girl prepare for the upcoming withdrawal of MCFD services. The transition worker described her mandate to Representative's investigators as *"to get them independent as soon as possible,"* but noted that this goal was problematic for Paige because *"there would be so many ups and downs in her planning because of her addiction and because of behaviour, that it was very difficult to plan for her, or keep a plan."*

This worker discussed the structural limitations of the youth-serving system, noting that: *“The ministry and all the youth supports out there are really just trying to – are really just maximizing what’s available to them. There’s so little. Like everyone is just fighting over scraps.”* She also discussed the limitations of service withdrawal when youth reach the age of majority, describing this as follows:

“But, like, we’re all gone at 19, right? There’s nothing we can – we can be there in the background for you, for, like, emotional support, but there’s nothing we can actually really do for you. And [Paige] and so many of the other youth are so relationship-based that it’s just like devastating for them, right? So I can see why [Paige] continued to slip further than she already was, right, because it’s not just housing, but all the supports and everything that go with it. They’re just kind of free-floating out there, you know what I mean? Like you kind of realize what you don’t have when it’s all been pulled out from under you. Was she able to really work on life skills and budgeting and all these kind of things when she’s shooting heroin? Like no, right, she’s just not there.”

The child protection system failed utterly to prepare Paige for adulthood and her brief experience of adulthood was self-destructive and fully predictable. The transition process was not a process – it was a passing of responsibility and an indifference to her circumstances. The ministry’s hasty, last-minute attempts to plan for her transition left her abandoned and addicted with none of the crucial supports she desperately needed. It is impossible not to contrast this with the plans and expectations most British Columbians have for their own children to see them educated and well-prepared for independence.

Recommendations

The Representative is troubled by the fact many professionals and others involved on the front lines seem to regard poor outcomes for Aboriginal children and youth as inevitable, justifying this by blaming these children for being “service-resistant” or inappropriately placing the onus on the child or youth to seek help when they are already traumatized, abused and effectively abandoned to fend for themselves on the street. This normalization of unacceptable outcomes and indifference perpetuates the cycle of intergenerational trauma that characterizes the lives of many vulnerable Aboriginal children, including Paige. Even when they seek service, there is no coherent system of care available to them. The Representative has made numerous recommendations pertaining to Aboriginal children, families, communities and services in 15 previous reports (see Page 4). Based on Paige’s pathway, and the fact she did not receive the services that she required, the Representative makes the following recommendations:

Recommendation 1

That the Province of British Columbia, led by the Ministry of Children and Family Development, respond forcefully to the persistent professional indifference shown to Aboriginal children and youth by many of those entrusted to work in this field, including some social workers, police, health care workers and educators. The Province and MCFD must also show a greater commitment to permanency for Aboriginal children and renewed efforts to work with family members when a parent cannot provide stability or safety for a child.

Details:

MCFD to take immediate steps to ensure that

- The Director of Child Welfare commence an immediate review of all the files of children and youth in care or receiving reviewable services who either reside in or frequent the DTES and immediately connect with those children, particularly those known to be living out of the parental home. A report from this review, including services offered, safety plans, and whether or not those working with these children and youth are aware of their duty to report to be presented to the Representative.
- Full and appropriate child protection investigations be conducted for children and youth identified in the above process as being at risk of harm, ensuring that family engagement reflects an Aboriginal-sensitive lens to supporting extended family members willing to assist.
- Structured Decision Making tools for Aboriginal children and youth be child-focused and that the desire to keep a child with a parent does not override protection concerns and the need for safety, which must be paramount.
- Mental health screening tools are immediately applied to assess the potential needs of any Aboriginal child or youth when taken into care, or with the consent of the parent during a safety assessment. Tracking and reporting on these children and youths' access to services to be made public.
- Timely decisions are made with respect to safety and permanency in the case of all Aboriginal children and youth in care. MCFD to develop a clear fund to support Aboriginal extended family members to allow them to do kinship care. This should allow for appropriate housing and adequate investment to ensure that a child at risk can be raised in safety and with adequate levels of food, shelter, clothing and readiness for school achievement.
- Enhanced transition planning is offered for Aboriginal youth who are aging out of government care, with the recognition that these youth may require particularly robust services including foster care and other supports that extend beyond the age of 19. Aboriginal girls in care who are at risk of drug overdose, involvement in survival sex trade, and poor school attendance to be offered extension of foster care to 24 years of age.
- Education on the effects of intergenerational trauma and evidence-based strategies to disrupt these patterns is added to the core training curriculum provided to all MCFD staff.
- MCFD provides an annual public report specifically on the reported abuse, neglect and maltreatment of Aboriginal girls and young women involved with the ministry for each year, with detailed breakdown by region, age and service provided.

Report from Director of Child Welfare to be presented to the Representative by Sept. 30, 2015.

First annual public report to be released by May 31, 2016.

It is obvious to the Representative that, despite the expenditure of enormous amounts of public money in the Downtown Eastside, services for vulnerable children and youth in this area remain balkanized and do not function effectively.

Recommendation 2

That MCFD, the Ministry of Health, and the City of Vancouver conduct an urgent review of the current provision of services – including child protection, housing, health care and substance use treatment – to vulnerable children in Vancouver's Downtown Eastside. This review should be informed by an accurate picture of the circumstances of children and youth living in or frequenting the Downtown Eastside and the social service agencies currently working with children in this area and it should be based on best research into the effects and mitigation of intergenerational trauma.

Details:

- The City of Vancouver, Ministry of Health, Vancouver Coastal Health Authority, BC Housing and MCFD to analyze numbers of children and youth in care in the area, needs of these children, an inventory of service providers currently working in the Downtown Eastside and the gaps in the services provided. Detailed lead service responsibility is necessary and a full accounting of this inventory is required to both the Representative and the public.
- The City of Vancouver, Health and MCFD to follow up that analysis with timely creation and implementation of an action plan, including detailed public reporting on outcomes for the children and youth in this area.
- MCFD to take immediate steps to ensure that no children or youth in care or receiving services from MCFD are living in SROs. The City of Vancouver, in conjunction with MCFD, to coordinate regular inspections of SROs to ensure compliance with these rules.
- MCFD to explore the creation of a form of secure care, with all appropriate legal safeguards, that would allow for the apprehension of vulnerable children and youth whose situation places them at an unacceptable level of risk and the subsequent safe placement of these children in a service that will respond to their trauma and high risk of self-harm.

Analysis to be presented to the Representative by Sept. 30, 2015.

Action plan to be presented to the Representative by Dec. 31, 2015.

*In her report *Lost in the Shadows*, the Representative called for the Attorney General to review the reasons for a lack of enforcement of the CFCS Act in B.C., and take steps to promote compliance, if necessary. The Representative fails to understand what action was taken at the level of the Attorney General as there has been no direct follow up on this issue since that report was issued on Feb. 6, 2014.*

Recommendation 3

That the Attorney General of British Columbia provide the public with a clear explanation as to why agencies and service providers are persistently permitted to fail to report harm and abuse, as was the case in Paige's experience, contrary to the *CFCS Act*.

Details:

- The Attorney General to report annually on the number of investigations and prosecutions for this offence, as well as other actions taken to ensure compliance with the legislation.
- The Attorney General to detail the number of cases brought forward by the Director of Child Welfare for attention and investigation.
- Individual professional bodies governing those who work with children and youth – including but not limited to social workers, health care workers, educators and police – to begin applying professional sanctions to members who have failed to report instances of neglect or abuse.
- The Attorney General and Director of Child Welfare to embark on a substantial and meaningful public awareness campaign emphasizing that no person should fail to report suspected child abuse. The campaign should educate the public on what specifically constitutes child abuse and promote an active approach rather than one which allows bystanders and professionals to continue to accept the status quo.

First annual report to be presented to the Representative by Sept. 30, 2015.

Draft public awareness campaign to be presented to the Representative by Oct. 31, 2015.

Legal Duty to Report

S. 13 of the *CFCS Act* sets out when a child is in need of protection. In cases where any member of the public has reason to believe that a child needs protection, s. 14 of the *CFCS Act* is in effect:

14 (1) A person who has reason to believe that a child needs protection under section 13 must promptly report the matter to a director or a person designated by a director.

14 (6) A person who commits an offence under this section is liable to a fine of up to \$10,000 or to imprisonment for up to 6 months, or to both.

Recommendation 4

That MCFD, the Ministry of Education through its own initiative and with its partners, and the First Nations Education Steering Committee work together to create a system that ensures attendance at school by all Aboriginal children in the care of MCFD is closely monitored and encouraged, that MCFD actually fulfills its role as an active and engaged parent with regard to the education of these children, and that the Ministry of Education and school districts ensure that a flexible and adaptive system, including active outreach to vulnerable Aboriginal children not currently attending school, is in place and appropriately funded.

Details:

- School districts to be required to monitor the attendance of Aboriginal children in care and report any unexplained absence to MCFD.
- If an Aboriginal child in care has an unexplained absence of two days, MCFD to be in contact immediately with the caregiver or family to determine the reason and share this with school authorities so that a plan can be developed to quickly reconnect the child with school.
- Every school district to report annually to the Ministry of Education on Aboriginal children in care who have missed more than five days without an explanation for their absence, and also report to MCFD for those children who are in care, on Youth Agreements or on independent living arrangements through MCFD.
- Schools to develop a comprehensive plan for the successful enrolment of Aboriginal children after extended absences.
- MCFD to reinforce that education is a major component of a child's Care Plan and that any prolonged absence or lack of achievement is monitored and addressed on a yearly basis.
- The Ministry of Education to explore the feasibility of offering monetary incentives to school districts that improve the attendance and graduation rates of vulnerable Aboriginal children.

The first annual reports to the Ministry of Education by school districts to be completed by July 1, 2016.

Recommendation 5

That the Ministry of Health, working with the First Nations Health Authority, take immediate steps to enhance services to vulnerable Aboriginal children and youth, particularly in the Downtown Eastside and within the City of Vancouver.

Details:

- Proper reproductive health services and reproductive education to be provided by Health, ensuring that termination of unplanned pregnancy does not become the substitute for effective contraception in this group.
- Adequate after-care planning and follow-up services to be ensured by Health, including the expansion of outreach initiatives targeted at vulnerable Aboriginal children and youth.
- Female children in care to be offered follow-up appointments with a medical doctor (preferably a family physician) after the termination of a pregnancy so that follow-up service can be provided, including accessible and supportive reproductive education and birth control.
- Intensive drug and alcohol services with an Aboriginal trauma lens and a family-centred model be provided, identifying and creating an appropriate service pathway that involves best practices and avoids further stigmatizing and traumatizing of these vulnerable populations.
- Aboriginal youth addiction services, including secure short-term care, be provided at a high professional standard, with strong after-care, and a focus on education and resilience.

Recommendation 6

That the Ministry of Aboriginal Affairs and Reconciliation, with support from MCFD and Justice, prepare a detailed annual report for the Minister's Advisory Council on Aboriginal Women on every unexpected death of an Aboriginal girl or woman in care, or formerly in care, in B.C. and that a review of urban Aboriginal program funding is conducted.

Details:

- The annual review to be conducted with the goal of identifying the role that neglect, abuse and maltreatment of these women played in their deaths and to make recommendations to government on appropriate actions to mitigate the risk to future generations, with a goal to protect Aboriginal girls and women from the pathways that Paige experienced.
- The annual review to be accompanied by an annual public report of sufficient detail to demonstrate that a serious and meaningful review was conducted, what improvements were identified by members of the Advisory Council and how these recommendations would enhance supports for Aboriginal girls and women.
- Consistent with the Premier's public commitment of June 2014 to end violence against Aboriginal women and girls, the Ministry of Aboriginal Affairs and Reconciliation lead a rigorous review of urban Aboriginal program funding and report to the public on the model, expenditures and services to ensure that provincially supported initiatives are addressing the need for specific services and improving outcomes for the cohort of youth such as Paige.

The first report to the Advisory Council to be completed by Dec. 31, 2015.

Report of urban Aboriginal program funding to be released by Dec. 31, 2015.

Conclusion

Given the significant child welfare concerns raised by this investigation into the short life of Paige, the Representative believes that MCFD, and the provincial government as a whole, should do their utmost to ensure that lessons are learned – and that learning is incorporated into approaches and services going forward.

The Representative believes that MCFD should require all staff to read this report and also provide ministry-wide training opportunities to encourage learning from Paige's story. The Ministries of Health, Education, Justice and Aboriginal Relations and Reconciliation, as well as Vancouver Police and social service agencies that work in the DTES are encouraged to do likewise.

Professional indifference will only change when we actively challenge the practice of turning a blind eye to the abuse and neglect of Aboriginal children and youth. This should not, and cannot be allowed to occur.

The negative and dangerous pathways for Aboriginal girls that the Representative has witnessed and reported on in her work can be changed, but only if we change our expectations, practices and outcomes. That change will never truly come if indifference remains the standard of care.

Appendix A: *Representative for Children and Youth Act*

Part 4 – Reviews and Investigations of Critical Injuries and Deaths

Section 11 – Reviews of critical injuries and deaths

- (1) After a public body responsible for the provision of a reviewable service becomes aware of a critical injury or death of a child who was receiving, or whose family was receiving, the reviewable service at the time of, or in the year previous to, the critical injury or death, the public body must provide information respecting the critical injury or death to the representative for review under subsection (3).
- (2) For the purposes of subsection (1), the public body may compile the information relating to one or more critical injuries or deaths and provide that information to the representative in time intervals agreed to between the public body and the representative.
- (3) The representative may conduct a review for the purpose of identifying and analyzing recurring circumstances or trends to improve the effectiveness and responsiveness of a reviewable service or to inform improvements to broader public policy initiatives.

Section 12 – Investigations of critical injuries and deaths

- (1) The representative may investigate the critical injury or death of a child if, after the completion of a review of the critical injury or death of the child under section 11, the representative determines that
 - a. a reviewable service, or the policies or practices of a public body or director, may have contributed to the critical injury or death, and
 - b. the critical injury or death
 - i. was, or may have been, due to one or more of the circumstances set out in section 13 (1) of the *Child, Family and Community Service Act*,
 - ii. occurred, in the opinion of the representative, in unusual or suspicious circumstances, or
 - iii. was, or may have been, self-inflicted or inflicted by another person.
- (2) The standing committee may refer to the representative for investigation the critical injury or death of a child.
- (3) After receiving a referral under subsection (2), the representative
 - a. may investigate the critical injury or death of the child, and
 - b. if the representative decides not to investigate, must provide to the standing committee a report of the reasons the representative did not investigate.
- (4) If the representative decides to investigate the critical injury or death of a child under this section, the representative must notify
 - a. the public body, or the director, responsible for the provision of the reviewable service, or for the policies or practices, that may have contributed to the critical injury or death, and
 - b. any other person the representative considers appropriate to notify in the circumstances.

Appendix B: Documents Reviewed for the Representative's Investigation

Ministry of Children and Family Development Records

- Mother's family service file
- Child's child service file
- Grandmother's family service file
- Foster parent resource files
- Child's aunt's family service file
- Child's reportable circumstance reports

RCMP and Police Records

- Vancouver Police records
- North Vancouver RCMP records

Medical Records

- Child's medical records – 7 hospitals, medical clinic
- Mother's medical records – 3 hospitals
- Child's PharmaCare records
- Mother's PharmaCare records

Ministry of Social Development Records

- Mother's file
- Child's file

BC Coroners Service Records

- Coroner's report for child

Ministry of Education Records

- Child's school records, Kindergarten to Grade 10

Legislation, Regulations, Standards and Policy

- *British Columbia Child, Family and Community Service Act* (1996), Victoria, B.C. Queens Printer
- *Child Protection Response Policies, Chapter 3* (April 2012 & July 2014 Revisions)
- *The Risk Assessment Model for Child Protection in BC* – MCFD
- *Mental Health Act* (1996) Victoria, B.C. Queens Printer
- *Child and Family Development Service Standards* – MCFD
- *Guidelines for Provision of Youth Services* (October 2002)
- *Standards for Youth Support Services and Youth Agreements* (August 2013)

Appendix C: Interviews Conducted during the Representative's Investigation

- Family Members (6)
- MCFD child protection and management staff (22)
- MCFD foster parents (7)
- Vancouver Police Department (3)
- School staff (2)
- Community agency staff (5)
- Safe house staff (2)
- Corrections staff (1)
- Community agency management staff (12)
- Community mental health clinician (1)
- SRO hotel staff (4)
- Outreach workers (8)
- Regional health authority staff (2)

Appendix D: Multidisciplinary Team

Under Part 4 of the *Representative for Children and Youth Act* (see Appendix A), the Representative is responsible for investigating critical injuries and deaths of children who have received reviewable services from MCFD within the 12 months before the injury or death. The Act provides for the appointment of a Multidisciplinary Team to assist in this function, and a Regulation outlines the terms of appointment of members of the Team.

The purpose of the Multidisciplinary Team is to support the Representative's investigations and review program, providing guidance, expertise and consultation in analyzing data resulting from investigation and reviews of injuries and deaths of children who fall within the mandate of the Office, and formulating recommendations for improvements to child-serving systems for the Representative to consider. The overall goal is prevention of injuries and deaths through the study of how and why children are injured or die and the impact of service delivery on the events leading up to the critical incident. Members meet at least quarterly.

The Multidisciplinary Team brings together expertise from the following areas and organizations:

- Ministry of Children and Family Development, Child Protection
- Policing
- BC Coroners Service
- BC Injury Research Prevention Unit
- Aboriginal community
- Pediatric medicine and child maltreatment/child protection specialization
- Nursing
- Education
- Pathology
- Special needs and developmental disabilities
- Public health

Multidisciplinary Team Members at time of report review, Feb. 2014

Beverley Clifton Percival – Ms. Percival is from the Gitksan Nation and is a negotiator with the Gitksan Hereditary Chiefs' Office in Hazelton. She holds a degree in Anthropology and Sociology and is currently completing a Master of Arts degree at UNBC in First Nations Language and Territory. Ms. Percival has worked as a researcher, museum curator and instructor at the college and university level.

Dr. Jean Hlady – Dr. Hlady is a clinical professor in the Department of Pediatrics at the University of British Columbia's Faculty of Medicine. She is also a practising pediatrician at BC Children's Hospital and has been the Director of the Child Protection Service Unit for 21 years, providing comprehensive assessments of children in cases of suspected abuse or neglect. Dr. Hlady also served on the Multidisciplinary Team for the Children's Commission.

Sharron Lyons – With 32 years in the field of pediatric nursing, Ms. Lyons currently works as a Registered Nurse at the BC Children’s Hospital, is past-president and current treasurer of the Emergency Nurses Group of BC and is an instructor in the provincial Pediatric Emergency Nursing program. Her professional focus has been the assessment and treatment of ill or injured children. She has also contributed to the development of effective child safety programs for organizations such as the BC Crime Prevention Association, the Youth Against Violence Line, the Block Parent Program of Canada and the BC Block Parent Society.

Dr. Ian Pike – Dr. Pike is the Director of the BC Injury Research and Prevention Unit and an Assistant Professor in the Department of Pediatrics in the Faculty of Medicine at the University of British Columbia. His work has been focused on the trends and prevention of unintentional and intentional injury among children and youth.

Dr. Dan Straathof – Dr. Straathof is a forensic pathologist and an expert in the identification, documentation and interpretation of disease and injury to the human body. He is a member of the medical staff at the Royal Columbian Hospital, consults for the BC Children’s Hospital and assists the BC Coroners Service on an ongoing basis.

Sherri Bell – Ms. Bell is the Deputy Superintendent of Schools for School District 61 (Greater Victoria), and chairs Board subcommittees on Public Engagement, Professional Relations and Curriculum Implementation. She has more than two decades of experience working in education, including assignments as a District Principal, Director of Instruction and Associate Superintendent of Schools. She has a Bachelor of Education degree and a Masters of Administration and Curriculum Development.

Dr. Christine Hall – Dr. Hall is the Medical Director of Trauma Services for the Vancouver Island Health Authority and an Associate Professor at the University of Calgary and a Clinical Assistant Professor at the University of B.C. In addition to her training in emergency medicine, Dr. Hall has a Masters degree in clinical epidemiology.

Derren Lench – Chief Superintendent Derren Lench is currently the Deputy Criminal Operations Officer – Core Policing, working at “E” Division RCMP Headquarters in Surrey. He has several Provincial Programs that report to his position including Traffic Services, Critical Incident Program, Operational Communications Centers, Aboriginal Policing, Crime Prevention, West Coast Marine Section, Occupational Safety Officers and the Operations Secretariat. In his role, he works closely with RCMP District Commanders across the Province and liaises with the Province on key issues and priorities. C/Supt. Lench has 33 years of service with the RCMP. He is the Vice President of BC Association of Chiefs of Police, is the Pacific Region Vice-Chair of the National Joint Committee of Senior Justice Officials, and is on the Canadian Association of Chiefs of Police Victims of Crime Committee.

Cory Heavener – Ms. Heavener is Assistant Deputy Minister and Provincial Director of Child Welfare for the Ministry of Children and Family Development. She is the former Head of the Provincial Office of Domestic Violence. She was previously the Director of Critical Injury and Death Reviews and Investigations for the Representative for Children and Youth. Cory has a lengthy career in child welfare in British Columbia and began her career as a child protection social worker 25 years ago.

Pat Cullinane – Mr. Cullinane is the Deputy Chief Coroner of Operations for the BC Coroners Service. Prior to joining the Coroners Service in 2011, he was the Executive Director of Employment Standards for BC. Mr. Cullinane commenced his career as a child protection social worker and has been involved in both conducting and leading complex investigations in various ministries and programs since 1984.

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Legal Duty to Report

S. 13 of the *CFCS Act* sets out when a child is in need of protection. In cases where any member of the public has reason to believe that a child needs protection, s. 14 of the *CFCS Act* is in effect:

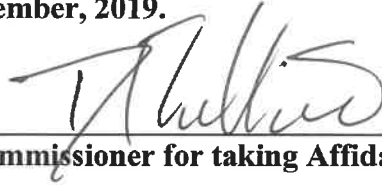
14 (1) A person who has reason to believe that a child needs protection under section 13 must promptly report the matter to a director or a person designated by a director.

14 (6) A person who commits an offence under this section is liable to a fine of up to \$10,000 or to imprisonment for up to 6 months, or to both.



REPRESENTATIVE FOR
CHILDREN AND YOUTH

**This is Exhibit "I" referred to in the
Affidavit of Mary Ellen Turpel-Lafond,
sworn before me, on this 7th day of
November, 2019.**

A handwritten signature in black ink, appearing to read "T. H. H. H.", is written over a horizontal line.

A commissioner for taking Affidavits



REPRESENTATIVE FOR
CHILDREN AND YOUTH

Approach With Caution: *Why the Story of One Vulnerable B.C. Youth Can't be Told*

Special Report

May 2016

May 5, 2016

The Honourable Linda Reid
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Ms. Speaker,

I hereby submit the report *Approach With Caution: Why the Story of One Vulnerable B.C. Youth Can't be Told* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of critical injuries and deaths of children receiving reviewable services.

Sincerely,

A handwritten signature in black ink, reading "meturpelafond", written in a cursive style.

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Craig James
Clerk of the Legislative Assembly

Jane Thornthwaite
Chair, Select Standing Committee on Children and Youth



REPRESENTATIVE FOR
CHILDREN AND YOUTH

Executive Summary

The Representative for Children and Youth (RCY) has completed a total of 16 investigations into the critical injuries and deaths of British Columbia children receiving provincial government services since her Office's inception in 2007.

After each of those investigations, as is called for under s. 16(3) of the *Representative for Children and Youth Act (RCY Act)*, the Representative has released a detailed report – either of an individual case or of an aggregate of similar cases – and made that report available to the public. In all but one of these reports, the Representative has gone to great lengths to anonymize the details so as not to identify the young people who are the subjects of the reports or the communities in which the incidents took place. Nevertheless, the salient details of each investigation – and what can be learned from them – have been made public.

In one such previous report – *Paige's Story: Abuse Indifference and a Young Life Discarded* (May 2015) – our report named the youth. This was a unique report and the use of Paige's name was supported by her family.

The investigation described in the following pages bears many similarities to that of Paige, particularly with regard to the cohort involved – youth in and out of Vancouver's Downtown Eastside (DTES), substance misuse and homelessness all being key factors.

But unlike Paige, or any of the other reports the Office has completed, this one requires a uniquely cautious approach.

After much deliberation, including communication with the Provincial Director of Child Welfare, the Representative has determined that to issue a detailed report on the critical injuries of this particular young person could potentially put the subject at great risk. Therefore, because of the precarious state in which this young person currently exists, this story cannot be told in full.

What follows is a description of RCY's investigation that satisfies the *RCY Act* in terms of the Office's duty to report out on investigations it has conducted but offers far less detail than is typically provided. However, the Representative has provided the Ministry of Children and Family Development (MCFD) an embargoed copy of its full investigation on a strictly confidential basis with the hope that the experiences of this young person in the child welfare system can be learned from and avoided for others in the future.



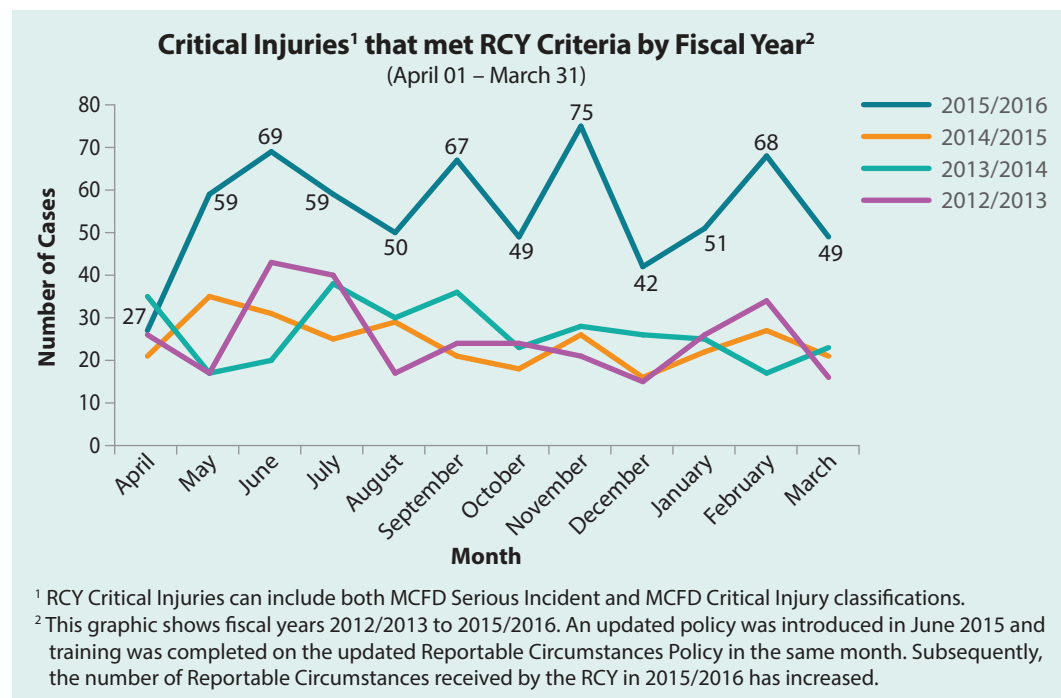
REPRESENTATIVE FOR
CHILDREN AND YOUTH

Background

The investigation into the injuries experienced by this youth began in May 2013, after an analysis of multiple critical injury reports regarding this young person that had been produced by MCFD. The most serious of these was received in the spring of 2012 and detailed a nearly fatal episode of high-risk behaviour.

RCY receives hundreds of reports of critical injuries and deaths every year. Training for ministry staff on reporting critical injuries to the Representative, completed in the spring of 2015, has resulted in an exponential increase in the number of these reports now being received. After the detailed screening of each report, some are subject to further review conducted by the Representative's investigators and research officers.

From the children and young people whose circumstances are the subject of these reviews, a small number – typically three to five per year – are designated for full investigation. Under the *RCY Act*, the initiation of an investigation gives the Representative the power to order the production of documents and to compel individuals to provide testimony under oath.





In the case of the youth who is the subject of this report, RCY received a total of 21 reportable incidents from MCFD between June 2011 and May 2016. In conducting this investigation, the Representative gathered documentary information from a number of sources including hospitals, schools, police departments/detachments, service providers and multiple government ministries. Formal interviews were conducted with 50 people who had a connection to the investigation, including numerous professionals who had been or were currently involved with the young person. Because of the ongoing nature of this investigation, further follow-up interviews were conducted as recently as January 2016. Investigators and advocates from the Representative's Office have been and remain engaged with the young person at the centre of this investigation.

Similarities to Paige's Story

There are some significant similarities between this young person and Paige, the young woman whose life was the subject of the Representative's report *Paige's Story: Abuse, Indifference and a Young Life Discarded* (May 2015). In both cases, professionals significantly underestimated the risk posed to very young children living in volatile households with domestic violence and substance use. In both cases, ministry intervention only came after each of them had experienced enormous trauma that would continue to go unaddressed and impact them for the rest of their lives. Attempts to provide foster placements were likewise short-lived and largely unsuccessful, with the young person being placed in a hotel when first brought into care because no resources were available. This use of hotels to address the lack of residential options in the province was examined simultaneously with the course of this investigation, leading to a joint RCY-MCFD report *The Placement of Children and Youth in Care in Hotels in B.C.* (January 2016). That report stated: "... is clear that the use of hotel placements is an indication of significant shortfalls

Paige's Story

Paige's Story, Abuse, Indifference and a Young Life Discarded (May, 2015) examined the life and death of a young Aboriginal girl who died of an overdose shortly after her 19th birthday in Vancouver's DTES.

The investigation found that the child protection, health care, social service, justice and education systems had consistently failed to protect Paige from the impacts of repeated trauma and continually left her in dangerous situations. Her serious mental and physical health needs went largely unmet and her high-risk use of alcohol and substances was never effectively addressed.

The investigation also found that repeated changes in child protection practice, particularly in relation to Aboriginal children, left social workers confused and reluctant to provide effective interventions. This failure was compounded by the inability of MCFD to provide Paige with any permanency, especially in her early years, in spite of the presence of willing and capable extended family.

Despite a promising start, Paige drifted away from school. Her prolonged absence never triggered a response that could have reconnected her to this critical service. Instead, she ended up in the DTES, living in shelters and SROs, with no effective planning or supports for her transition into adulthood.

The Representative made six recommendations in this report, designed to address the professional indifference shown to Aboriginal children, including the need for an urgent review of child services in the DTES, a call for a review of why so many individuals and agencies failed to report Paige as being in need in protection, the need for changes to support connections to education and health care, and detailed reporting on levels of harm experienced by Aboriginal girls and women.



in other available residential placements, including foster homes, emergency beds, and group homes. Like Manitoba, B.C. must begin an immediate process to close the service gaps and develop a clear plan to address these gaps in a timely fashion, with the ultimate goal of eliminating hotel placements entirely. Key to that will be supporting the necessary resource enhancements and implementing processes for more effective use of existing capacity, particularly after regular business hours."

School was a place of significant safety and some stability for the young person who is the subject of this investigation. But as was the case with Paige, despite teachers clearly seeing troubling behaviours and seeking help for the young person, a lack of appropriate supports and a chaotic life outside school made academic success an impossibility. And for both Paige and this young person, Vancouver's Downtown Eastside (DTES) and its notorious Single Room Occupancy (SRO) hotels soon became their new home. Predictably, for both of them, in this environment they soon fell victim to sexual exploitation and substance use. Like Paige, a child welfare system that was premised on a voluntary acceptance of services was unable to provide the assertive interventions that might well have halted this downward spiral. Each of these youth represent a small, but significant, cohort that the ministry struggles to engage with and support.

But for all the similarities between this young person and Paige, there are also very significant differences. This young person received a psychiatric assessment at a very young age, something Paige was unable to access until just prior to her death. But for the young person who is the subject of this investigation, parental refusal to follow-up on the psychiatrist's recommendations meant that this opportunity was lost. Although the ministry may have failed to intervene early in both their cases, by early adolescence, this young person was well-known to professionals in the DTES and at least some of the critical injuries experienced were being documented and provided to RCY. This youth's conspicuous vulnerability seemed to galvanize social workers, community advocates, law enforcement and youth teams to work together to try to provide a degree safety. And unlike Paige, who had only minimal justice system involvement, this young person was well-known to the police and had periods of incarceration in youth justice facilities. This incarceration was not an effort on the part of police and the ministry to "punish" the young person for their behaviours, but was a well-intentioned effort to remove them from situations of imminent risk using the only admittedly clumsy mechanism that was available. The youth justice system was used as a substitute for social services, something that is prohibited by the *Youth Criminal Justice Act*¹ but is nonetheless sometimes still used in practice to prevent life-threatening situations when no services are available.

¹ Subsection 29(1) and 35(5) of the *Youth Criminal Justice Act* provide that detention prior to being sentenced and a sentence of custody shall not be used; "...as a substitute for appropriate child protection, mental health or other social measures".

Ministry Investigation of ACV

Another difference between this investigation and Paige's Story was the placement of this young person with A Community Vision (ACV), a contracted provider of residential services for the ministry. This was a private company that MCFD relied on to provide housing and supervision to some of the most high-risk and vulnerable children. This is the same contracted agency that had been responsible for 18-year-old Alex Gervais prior to his suicide in an Abbotsford hotel on Sept. 18, 2015.

The young person who is the subject of this investigation lived for a period of time in an ACV resource. A ministry investigation in January 2015 revealed numerous concerns about staff behaviour, staff qualifications, drug use, unsanitary conditions and hiring practices with the agency. Among the ministry's findings in the ACV investigation were: *"several ongoing themes regarding caregivers using substances (one overdose resulting in death in 2010), criminal offenses, inappropriate physical discipline, assault of a child in care by primary caregiver, primary caregiver viewing adult pornography, possession of child pornography, conditions of the home, caregivers having sexual relationships in the resource, and domestic violence between the caregivers and their partners."*

At the time of the investigation, ACV was operating 24 homes housing approximately 35 children. As a result of the investigation, the ministry terminated all its contracts with the agency and moved all youth, including this young person, to other placements.

The end of ACV's contract meant that new resources had to be located in a very short time, a challenge for a system already lacking capacity and difficult for the children involved as they struggled with the changes. For the young person who is the subject of the RCY investigation, the initial efforts to stabilize them in a new placement failed and resulted in their returning to an SRO in the DTES. After months without any effective ministry supervision, a compromise was reached that placed the young person with a former caregiver. Although the new placement was an unconventional one and represented a significant deviation from standard ministry practice, the caregiver has maintained a real connection to the young person and may represent the best hope currently available, although meaningful stability remains elusive.

Decision on a Public Report

The most critical difference between this young person and Paige is that this young person is still living at high risk and still engaged with the ministry and others. The current situation can only be described as dangerously unstable. Not a day goes by that the Representative and her staff aren't concerned for this young person's well-being.

After the RCY investigation was completed, a copy of the resulting report was provided to the ministry on Dec. 14, 2015, well in advance of its anticipated release, for the purposes of administrative fairness, providing an opportunity for the ministry to respond to any factual issues.

RCY reports, including this one, are normally written in such a way that all the participants are anonymized and should not be identifiable by the media or others in the community. Although those participating in the investigations, including witnesses, will be aware of who is involved and are outside the control of this Office, to date the Representative is unaware of any significant breaches of privacy occurring as a result of an RCY report release. However, it was during the investigative process of the report on this young person that the Provincial Director of Child Welfare first raised concerns about the public release of this report.

Section 16(3) of the *RCY Act* makes it mandatory for the Representative to report on the outcome of any investigation into a critical injury or death. This reporting has always previously occurred in the form of a document that was available to the public. A departure from this accepted practice is unprecedented and, for those reasons, this more narrowly focused report is being provided to serve accountability purposes and to avoid any inappropriate use of the precedent in the future. Detailed discussions and exchanges with MCFD were undertaken between November 2015 and April 2016, leading to an exceptional conclusion: The Representative is not, at this time, releasing the detailed report of this investigation. Whether the detailed report will be released at a future time will depend on the circumstances.

On Jan. 5, 2016, the Provincial Director wrote to the Representative's Office, stating, in part: *"We believe that the public release of this report and the associating media coverage that may come with it could have negative and potentially dire consequences for [the young person]."* The Provincial Director suggested a meeting to discuss the issue further would be appropriate.

The Representative replied to the Provincial Director on Jan. 21, 2016, welcoming the opportunity for further discussion. At the same time, the young person at the centre of this was experiencing rapid and largely unpredictable changes that were personally destabilizing and very risky. These discussions continued over a number of weeks,

culminating in an exchange of letters on April 11, 2016. The first letter from the Provincial Director included the following:

"The Ministry recognizes that the RCY has a clear legislative mandate for the investigation of individual cases and those investigations provide valuable insights into child welfare services in this province. The investigations inform many of our efforts to improve services to children and families. However, given the unique circumstances of this highly vulnerable youth, I believe the public release of a report about [their] life and the associated media coverage that will inevitably ensue could have negative and potentially dire consequences for ..."

The Representative replied the same day:

"I am in full agreement with the concerns you have raised and with respect to our mutual commitment to protecting the [young person] at the centre of this investigation from further harm. Although there is great value in children in care being able to tell their stories as part of the healing process, there can be, as you point out, attendant risks."

The Representative went on to observe that *"Given [the young person's] fragility, I believe all our efforts should be directed at addressing the hurt and trauma [they] have repeatedly experienced."*

The Representative also urged the Provincial Director to appoint independent legal counsel to safeguard the young person's civil rights.

On April 22, 2016, the Office of the Public Guardian and Trustee, which acts as the legal guardian for all children in care, confirmed to the Representative that it was reviewing the circumstances of this young person to determine the viability of future legal action.

Given the number of similarities between Paige and this young person, the Representative believes that examining the response of the ministry to some of the recommendations made in *Paige's Story* is helpful in understanding the overall systemic response to this particular cohort of young people.

The first recommendation, calling on the Province to respond forcefully to the persistent professional indifference shown to Aboriginal children and youth, included as part of that overall recommendation an immediate review of all the files of children and youth in care or receiving services in the DTES. In response, the ministry began a review of the files and safety plans for those children, focusing on any immediate protection concerns. The review was conducted in three phases and ultimately identified 111 children and youth in this cohort. Forty-eight per cent were Aboriginal and 64 per cent were female. This data supports the previous findings and recommendations of the Representative about this cohort of vulnerable youth in care – many soon to leave care – who are deeply wounded and who have not received the supports necessary to successfully transition to adulthood.



An examination of their risk factors found homelessness or stays in emergency shelters, drug and alcohol misuse, no connection to school or work, mental health issues and youth justice involvement all common in this cohort. Sexual exploitation or intimate partner violence was also a factor for almost a third of this group. Had Paige been alive during this ministry review, she would have presented with every risk factor.

A year after *Paige's Story* was released, the Representative is discouraged that the work done to profile this cohort of vulnerable young people has not yet translated into action, and MCFD has not released the profile of young people in the DTES who are experiencing deep distress and ongoing injuries. Although an inventory of children at risk is a necessary first step, it also highlights the dimensions of the challenge facing the ministry and the need for innovative and effective responses.

In the wake of the release of *Paige's Story*, the ministry announced its intention to establish a rapid-response team in the DTES. This was to be a collaboration between the ministry, service providers, police, Aboriginal service providers and others to provide a coordinated response and enhanced services to youth in this area. Although it took several months for this team to be established, the Representative observes that this group largely consists of individuals who were already meeting jointly and that no new resources have been provided to bolster services. The "team" appears to be meeting but, with no new resources on the ground, and no new youth approach to help them, progress is minimal at best.

The duty to report a child in need of protection was a primary focus in Paige's case, where such reporting was woefully inadequate. Although the young person who is the subject of this RCY investigation was the subject of a number of reports, systematic under-reporting remains of deep concern to the Representative.

An awareness campaign targeting DTES service providers, delegated Aboriginal Agencies, and other community agencies began in October 2015 and has reached more than 8,000 people. And, with not a single prosecution ever launched in B.C. for failure to report a child in need of protection, the Representative was heartened to learn that there is an ongoing police investigation into non-reporting under the *Child, Family and Community Services Act* in relation to Paige.

Professionals interviewed in connection with this case repeatedly raised the issue of better residential services targeting traumatized children and youth, including secure care, as a tool the child welfare system in B.C. requires for those children and youth whose exposure to high risk is otherwise unmanageable. The Representative heard this same message from those who observed Paige's journey through the system. Secure care legislation, in one form or another, currently exists in seven Canadian jurisdictions.

In the case of the person who is the subject of this RCY investigation, incarceration as a result of criminal charges and breach of bail conditions was used as a poor substitute for a proper secure care capacity, but it did provide opportunities for medical assessment and treatment, and the Representative is hesitant to criticize the actions of those who acted with this young person's best interests in mind. Although MCFD has undertaken a review

of secure care, the Representative believes there is an urgent need for public consultation and possible legislative reform on this issue.

Safe/Secure Care

Secure care, as it is commonly called, involves involuntarily placing a youth in a facility, with the intention of generally providing short-term safety and therapeutic care to address mental health and behavioural challenges and/or problematic substance use, while simultaneously offering protection to youth who are unable to keep themselves safe. Most often, the youth has been deemed a danger to self or others.

Currently, holding youth in a facility for these purposes is not legal in British Columbia, with the exception of temporary involuntary detainment when a child is held under the *Mental Health Act* or when a youth has committed a crime. However, seven other provinces in Canada have provisions within provincial legislation for involuntary confinement of children: Alberta, Saskatchewan, Manitoba, Ontario, Quebec, Nova Scotia and New Brunswick. Each of these, except Saskatchewan, has a secure care provision built into basic child protection legislation. Alberta has an additional law that allows confinement of children who have been sexually exploited. The aim of this legislation is the protection of children who have been, or might be, lured into the sex trade.

In addition, Alberta, Saskatchewan and Manitoba have legislation enabling involuntary civil confinement for children misusing drugs or alcohol. Saskatchewan and Manitoba's laws provide avenues for a guardian or other significant person in a child's life to apply to court for an order to confine the child to a secure facility, sometimes called a "protective safe house."

The remaining three provinces and all three territories have no legal provision for confinement outside the youth criminal justice system and mental health legislation. In the absence of secure care legislation and resources, there is a tendency to rely on police to hold youth, albeit for short periods, or to take a young person to hospital. This form of ad hoc secure care often pushes against the intent of the legislation.

Although secure care does not currently exist in B.C., a *Secure Care Act* was approved by the B.C. Legislative Assembly in 2000 but has never been brought into force. The stated purpose was for a) assessing and assisting children with an emotional or behavioural condition that presents a high risk of serious harm or injury to themselves and b) assisting children unable or unwilling to reduce that risk, when less intrusive measures were unavailable or inadequate. Among other things, this emotional or behavioural condition could be demonstrated by substance misuse, addiction or the sexual exploitation of the child.

A re-framed *Safe Care Act* (2009) was drafted, but did not proceed. The legislation targeted youth who were at high risk of serious harm due to severe substance misuse or addiction, or commercial sexual exploitation. In place of the development of secure care, the government of the day directed MCFD to instead develop enhanced voluntary supports and services to better address vulnerable and at-risk youth under the current regulatory framework. This course of action has not produced the desired outcomes.

Conclusion

It is unprecedented for an investigation of this nature to be conducted by the Representative and not released. Reports on the Representative's investigations are one of the few opportunities the public has to observe and reflect on the performance of the child welfare system. The inability to release a report because a young person's situation is so tenuous and fraught with danger is itself an indictment of that system and a sad commentary on residential services, in particular.

However, in these circumstances, the best interests of the young person have to be seen as the defining value in all our work. The risk of further trauma to this young person must be minimized in every possible way.

It would be foolish, however, to assume that the shelving of this investigation means that every one, or even the most pressing, of this young person's issues has been resolved. Like Paige, this young person has had multiple challenges and the response to their situation has been largely inadequate. Unlike Paige, this young person is still living that experience. The quality and accessibility of supports for them falls far short of what is needed. One year after Paige, the Representative would have contemplated a complete revamp of a provincial approach to youth mental health, addictions and homelessness. Sadly, that has not materialized and the Representative is now also dealing with a homeless camp in Victoria that includes MCFD-connected youth.

Although no separate recommendations have been developed for this report, the Representative has shared the entire contents of the investigation with the ministry so that the opportunity for organizational learning is not lost. The Representative will continue to monitor the ministry's progress on the *Paige's Story* recommendations and all work relating to the provision of improved services to this cohort of young people.

This is a difficult situation with very little positive to report, other than to record the Representative's most serious concern for the youth who was the subject of this investigation and the more than 100 others in B.C. who are in a similar situation.



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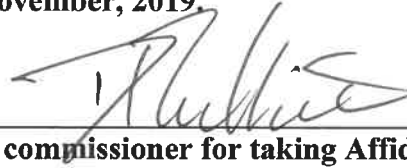
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Rep4Youth



**This is Exhibit "J" referred to in the
Affidavit of Mary Ellen Turpel-Lafond,
sworn before me, on this 7th day of
November, 2019.**

A handwritten signature in black ink, appearing to read "R. H. H. S.", is written over a horizontal line.

A commissioner for taking Affidavits



REPRESENTATIVE FOR
CHILDREN AND YOUTH

Lost in the Shadows:
*How a Lack of Help Meant a Loss of Hope
for One First Nations Girl*

Investigative Report

February 2014

February 6, 2014

The Honourable Linda Reid
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Ms. Speaker,

I have the honour of submitting the report *Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl* to the Legislative Assembly of British Columbia. This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of deaths and critical injuries of children receiving reviewable services.

Sincerely,

A handwritten signature in black ink, reading "meturpellafond", written in a cursive style.

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Ms. Jane Thornthwaite
Chair, Select Standing Committee on Children and Youth

Mr. Craig James
Clerk of the Legislative Assembly

Representative's Acknowledgement

The Representative is extremely grateful to the family of the girl who is the focus of this report for their participation in the investigation and their willingness to share information and insights. The Representative recognizes that this has taken tremendous courage and knows it has not been easy to revisit the tragic circumstances of her life and death.

This family requires ongoing support and compassion, particularly in the wake of the Representative's report being made public. Out of respect for the family, all efforts have been made to ensure that their identities are kept anonymous. The Representative requests that the family's privacy be respected by members of the public and the media.

The Representative is also grateful to the Chief and key members of the First Nations community to which the child and her family belong. Their cooperation and assistance with the investigation was invaluable and their support in reaching out to the family on behalf of the Representative's investigators is very much appreciated. Their information and insight into community dynamics and functioning was essential in understanding the challenges that this family and community face.

In preparing this report, all efforts have also been made to ensure the First Nations community and surrounding municipalities are kept anonymous to protect the privacy of individuals living in the community or working with its children and families.

The Representative recognizes that this community is making significant strides to address issues of poverty, violence, mental health and addictions in the face of ongoing challenges. The Representative urges service providers to work together to support the community in addressing these issues.

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Executive Summary

This report by British Columbia's Representative for Children and Youth tells the tragic story of a 14-year-old First Nations girl who hung herself in the yard of her grandparents' home on a rural B.C. First Nations reserve.

There are 203 First Nations in B.C. and most never have a suicide in a year or over many years, especially by a young person. But some do and, in addition to suicide, they may be grappling with serious issues for children and youth who do not feel safe or lack access to the basic services afforded to other children and youth in the province. Serious issues for the safety and well-being of children occur in every community where parents and families may face struggles with mental illness, addictions and violence.

When systems can work to protect children from harm, support families and reduce the risk of violence and trauma, the resilience of young people to cope with a variety of vulnerabilities in their lives can be improved. Much depends on the services and the approach and the constant need to be evaluating the effectiveness of services to meet the needs of children and youth, understanding that some require significant and highly responsive service.

Suicide and self-harm has been examined in previous aggregated studies and reports by the Representative's Office as well as by a Coroner's Child Death Review Panel. But there are some cases that call out for a more complete investigation, especially when the services that are intended to support young peoples' resilience and emotional well-being are a central part of the circumstances around their shortened lives. Or, as with this case, when there needs to be a light shone on the experience of an individual child to learn all we can about doing more for children such as her.

The story of this girl's short life is painful to learn. The Representative appreciates that many British Columbians will find it unbelievable that what happened to her could be allowed to occur in our province, with its legal and other protections for the safety of children. It is a story of a virtual collapse of a system of services – or more accurately, a story of the shadow cast over the lives of many girls and boys on-reserve where there is no opportunity to bring out what is going on in their lives in a way that connects them to supports or services.

Through this investigative report, the Representative seeks answers as to why this girl didn't receive the help she so desperately needed and what changes can be made to prevent similar tragedies from occurring in the future.

The girl's death came at age 14, after many years of challenge in her life during which she showed great resilience. Her needs were overlooked and unmet more often than not. She was born into a chaotic home, where she lived with the episodically bizarre and threatening behaviours of a mother who had a serious mental illness. The girl struggled with her own cognitive disabilities which were identified early in her school years, although

the reason for her intellectual disability was never investigated, assessed or understood. She did not receive real assistance or proper services to a standard expected in our laws and policies, in part because girls such as her are often overlooked by our service systems.

This girl suffered physical and emotional abuse in her home and her community and it is likely that she was sexually abused within her community by at least one older adult and by a peer. For the most part, she was left to cope on her own.

As she grew up and began to face her own mental health issues, she started acting out toward others, and she began to harm herself in ways that showed deep disturbance. She was frequently punished for her emotional outbursts, and she was expelled from school on occasion. No one looked deeply into what was happening in her life, her capacity to cope or understand her situation, or her personal safety. A frequent victim of assaults, violence and chaos in her home and family, she tried so hard to keep it together.

At the time of her death, she needed extensive dental work, was on medication for dental abscesses and was keeping the paperwork in her room, as it seemed to be expected that she would organize her own care – care she likely would never have received. Because of that, she was in physical pain and discomfort, along with serious emotional distress. All of these burdens were placed on a child suffering a significant intellectual disability that would have made her eligible for Community Living B.C. services as she transitioned to adulthood had she lived anywhere but on-reserve. She received no special needs supports in her home or community.

The Representative notes that one of the key factors in this tragedy was the mother's mental health and its effects on the girl, her grandparents and her younger sister, who all lived together for most of the girl's life. The mother was diagnosed with schizophrenia shortly after the girl's birth. And while she had many interactions with physicians, nurses and psychiatrists, none of them sufficiently explored the physical and emotional risks to her children or to the grandparents posed by her illness.

The mother told doctors and nurses about hearing voices instructing her to harm her daughter, to "*snap her head.*" Despite multiple certifications under the *Mental Health Act (MH Act)*, the mother continued to return to live with her two children in the grandparents' home between 2007 and 2010 without any supports provided to help the family cope. When the grandparents left the mother alone with her daughters, the girl would barricade herself and her younger sister in her bedroom to protect both of them from their mother's unpredictable behaviour. On one occasion, the mother pulled a knife on the girl.

While concern was expressed and noted by medical professionals about the mother living – and being left alone with – her children, this concern was never reported to the Ministry of Children and Family Development (MCFD) despite the clear legislative requirement to do so. These repeated failures to report, whether from fear of retaliation, the perceived inability of the ministry to provide effective interventions, ignorance of the legislation, or a lack of understanding about the potential negative consequences of growing up in a family with parental mental illness, left the girl at enormous risk.

Yet MCFD knew about this child from before her birth as the mother had called the ministry saying she did not believe she could raise her child.

The *Child, Family and Community Service Act (CFCS Act)*, which governs child welfare in B.C., compels any citizen who believes that a child needs protection to report that concern to MCFD. Aside from this clear responsibility to report shared by every citizen of the province, physicians are also guided by their own professional standards and guidelines on reporting.

The Representative is sharing this report with the licensing bodies governing physicians and nurses in the province, and recommends that they inform their members of the findings of this investigation and reinforce their statutory responsibility to report pursuant to s. 14 of the *CFCS Act*.

The Representative also finds that because this First Nations girl lived on-reserve in a rural area of the province, the barriers to her receiving services were far greater than they would have been for a child living off-reserve. For example, the mental health services the girl received were from an Aboriginal agency so under-resourced that trips by a clinician to visit the reserve – more than an hour away – were not possible due to budgetary constraints. This could not even be called a “service” as the contract with a fledgling agency was on its face impossible to meet.

Another barrier to service was the inability of ministry social workers to engage in work on-reserve without being accompanied by a band family support worker. If these over-taxed support workers were unavailable, ministry social workers were effectively stymied. Ministry workers were also acutely aware of the prior threats and acts of violence directed at them when they tried to work on-reserve, and this well-founded fear made it virtually impossible to discharge their mandate to investigate child maltreatment.

A situation developed where no one reported abuse and no one investigated it. This dangerous situation occurred during the period of highest need of this child for safety and services to support her special needs and mental health, and her life was ended by her own hand.

Yet despite the danger in her situation, and what is a deplorable circumstance of systemic failure to actually provide any meaningful services to a child in distress, no one reviewed her case. The Coroner took more than a year to close the file with no recommendations in this case. MCFD decided not to review her case because it appeared to them not to fit the circumstances that would require a review.

The Representative’s Office could not permit this case to pass without review and extensive investigation. There is much to learn here and this tragedy might well have been prevented had we at least tried to provide some service to a child in distress.

In this investigation, both the family and the leadership on-reserve have been welcoming to the Representative and her investigators. The leaders of the community have been explicit that they want to learn to support children and youth better, and are willing to allow us to shine a light on the challenges they have faced so that they can improve services to children and families. The Representative is grateful for this leadership because

difficult discussions will have to occur after this report if we are to put in place a system that actually puts children at the centre of concern. The politics of child welfare need to be replaced by an unflinching commitment to put children first.

In November 2013, the Representative issued a report entitled *When Talk Trumped Service: A Decade of Lost Opportunity for Aboriginal Children and Youth in B.C.* This report has generated a great deal of reflection on whether MCFD has supported actual improvement in the lives of children and youth, or simply set up a sidebar array of contracts to permit exploration of different issues. While this may have created an illusion of meaningful progress on key service issues, it failed to connect to the actual needs of the children and youth, and it led to no systemic change as MCFD had no policy foundation for this *ad hoc* approach.

This report is a sequel to the previous one. What happened here should have been actively discussed and solved long ago. If work was seriously underway, sexual abuse, violence and family crisis would be met with service rather than mostly silence. We should have in B.C. a seamless system for child safety, a system of support for children with special needs and mental health issues, and collaboration to a degree that far exceeds the many fractured relationships we confront in serving children and youth in this province.

It is true that the numbers of children in care can go down dramatically through one simple action – pass responsibility to an agency that lacks capacity and give it no money to provide service, while effectively ignoring the incapacity of MCFD’s staff to meet its mandate in a service delivery area. The numbers of children requiring investigations, supports and interventions will drop immediately and dramatically. This may appear to be good news to the uninformed. Yet children will not be safe or supported. They will be pushed to the shadows and will have no recourse. They will be silenced, ignored and remain in harm’s way.

As the local Aboriginal Agency (LAA)¹ for the girl’s community was in negotiations to become delegated under the *CFCS Act*, the local MCFD office that served the girl’s community was in chaos. The LAA was in negotiations for three years before finally having a delegation agreement in place in November 2012, after the child died. It was another year before a social worker with the agency was delegated to carry out voluntary services under the *CFCS Act*. While this was going on, MCFD was chronically and often critically understaffed with an atmosphere described by staff as “toxic.” From January to May 2011 – the last five months of the girl’s life – there was only one fully delegated social worker on a team that was supposed to include seven. One social worker interviewed during the investigation described her situation this way: “*I was basically doing delegated work as an undelegated social worker for many months ... I was covering my own caseload, I was covering vacant caseloads, and just sort of whatever was coming in ...*”

¹ During the time of the local Aboriginal Agency’s involvement with the girl, the agency was not delegated to provide services under the *CFCS Act*. The agency did not become a delegated Aboriginal Agency until recently, at which time it began providing limited services under the *CFCS Act*. The LAA was contracted to provide Aboriginal Wellness services.

Because this ministry office was plagued by understaffing, spotty supervision and staff terminations, it is hardly surprising that this investigation found that the ministry office in the region repeatedly failed to conduct adequate child protection investigations. In effect, there was no functional child welfare system. The *CFCS Act* was simply not followed. So, in this area of the province, safety for children was absent.

The ministry repeatedly failed to recognize the severity of the girl's situation and, as a result, did not appropriately intervene. Deadlines for follow ups on child protection investigations were repeatedly missed, and clear warnings from a school counsellor about the girl's deteriorating condition went unaddressed. Files were lost, deleted or left open for months or years. No one watched and no consequences followed – there were sick leaves, absences and vacant positions – a continuing situation of chaos where no one stepped in to make sure the mandate of the ministry could be met.

An ongoing challenge for many service providers, not just the ministry, is the ability to attract and retain qualified staff in rural and remote areas. The reality is that some of the most difficult and high-need areas in the province are served by the most junior and inexperienced staff. This report identifies clear shortcomings in resources for the ministry office designated to serve this girl and her family. MCFD had choices – such as creating and deploying a “rapid response” team to those offices where a functioning child welfare system was in jeopardy. The ministry could have sat down with the community, and if faced with threats, it could have taken other actions. MCFD needed to act in the interests of children.

In terms of silence, the absence of any real effort by Aboriginal Affairs and Northern Development Canada (AANDC) to take an active role in fulfilling its fiduciary role to children and youth with special needs or mental health needs living on-reserve is deafening. Even in terms of ensuring that the child welfare system operates – a system it funds and endorses – this investigative report found no concern or leadership by the federal department. That standard is too low given the known risk of harm to girls such as this one.

The *de facto* acceptance of a two-tiered model of service that leaves many of our most vulnerable children underserved requires a vigorous and coordinated response, including participation of the federal government. Yet despite all the years of debate in B.C., we've achieved little progress in ensuring that all children receive real, accountable service. There is no functioning special needs program or child and youth mental health program on-reserve and no plan to fill the gaping void.

In the case of this girl, no one took referrals, offered services, or worked within a policy of equivalence to provincial policies or contracted with provincial service providers.

Let us not forget that we are dealing here with the life of a First Nations girl. We are living in times when we are supposed to be acutely aware of the lives of girls and women and more specifically the pathways to vulnerability for First Nations girls and women that may place their lives at risk. Yet awareness does not bring change without actual safety and support in their lives. This case tells us that we have a long way to go in that regard.

This girl felt no safety as a girl – there was no way to address what she was going through in her community. Her mother did not feel safe either and asked to be moved to a women's shelter when she was pregnant with the girl. There was no focus on the girl's bodily safety and integrity, well-being or security. The lens of gender is an important one and has not been applied completely in this investigation, given the barriers to people talking about sexual abuse, the diminished roles of girls, and the expectation that girls will put up with abuse and neglect and stay silent as will the families and others in their lives.

The Representative knows there are other girls living in circumstances like this girl did and there is an urgent need to build services in a serious way to address sexual abuse, safety and neglect. This girl's life was one of turmoil and, in the face of no service, she made a choice that no child should have to make – she chose to end her life. Her desperation was ignored and she was left with her basic rights to safety and support unmet. While many children in B.C. grow up safe and supported, there are others who do not and MCFD knows well that this problem exists. The consequences of inaction can be seen here – a child's decision to end her life in the shadows of no service.

Introduction

This report is the result of an investigation by the Representative into the suicide of a 14-year-old First Nations girl.

Investigating the suicide of any young person requires careful examination of the services provided to them during their lifetime as well as the environment and experiences that led to such a tragic outcome.

More than this, such an investigation requires deep reflection on a young life cut short. What did we, as British Columbians, lose when this teenager decided her burden was too much to bear? What were the significant factors that contributed to this girl's suicide and, most importantly, how could such a devastating outcome – a family, a community and a province losing this young girl forever – have been prevented?

The death of this girl was reported to the Representative by MCFD three days after it occurred. A thorough review by the Representative was completed on Jan. 10, 2012, and the Representative concluded that an investigation was in order because a reviewable service or the policies or practices of MCFD or other service providers had an impact on the girl's fate.

The girl's death, as the Representative's investigation finds, could probably have been averted had she received the help she so desperately needed during a tumultuous life in which she dealt with her mother's severe mental illness, her own unmet special needs and significant abuse from within her own community.

Why didn't this girl and her grandparents, who were her caregivers for most of her life, get the assistance they required from various child welfare agencies and medical professionals?

Why was this girl seemingly invisible to so many? Why were the traumatic experiences she endured not noticed and acted upon in time to give her enough hope to want to continue living?

These are the key questions this report explores.

The Representative's investigations of child deaths are based on a systemic approach, as recommended by experts in this area:

“A systemic approach to review a child's death provides a change of focus from the conduct of an individual social worker to the more complex factors and interrelationships that invariably surround a child at risk. Child death reviews, regardless of their focus, can be used to improve services or they can be misused to search for a scapegoat ...”²

² Connolly M., Dolan M., 2007, p 10

Any in-depth analysis of the difficult work done by staff on the front lines of the child protection system invariably generates a deep respect for the commitment and heart these people put into their jobs under very difficult conditions. This report is no different. The Representative extends her appreciation to these front-line social workers, health care professionals, mental health workers and school staff. Their participation in the investigation was crucial in determining the circumstances that led to this girl taking her life. It is hoped that this report is received by them as a respectful opportunity for learning.

Within this report, however, there are situations where it becomes clear that errors or misjudgements by individual professionals or their supervisors played a critical role in how events unfolded. To recognize these is an essential part of the learning process so that broader issues of supervision, staffing levels, quality assurance and overall functioning of the child protection system can be improved. This matter was addressed specifically by the Hon. Ted Hughes in his *BC Children and Youth Review*.³

“... The primary purpose for reviewing injuries and deaths of children and youth who are in care or receiving Ministry services is to point the way to continuous improvements in policy and practice, so that future injuries or deaths can be prevented ...

“A secondary purpose ... is one of public accountability ... the government has a responsibility to account to the public as to whether it has met its responsibilities to that child. The purpose is not to assign blame to individuals but to learn from mistakes and understand what went wrong and what went right.”

In assessing the actions of those responsible for keeping this girl safe and healthy, the Representative does not apply a standard of perfect 20-20 hindsight vision when considering what these professionals and service providers did or did not do. The standard applied to these questions is whether their actions were appropriate given the information and circumstances, within existing and known practice and policies in place at the time.

With regard to the girl's seeming invisibility despite her obvious challenges and struggles, it appears through this investigation that very few people outside her immediate family and friends knew a lot about her.

Very few, including members of her small remote community, could provide the Representative's investigators with comments about the unique character or interests of the girl. This may have been a consequence of the fact that she did not trust most adults. Or perhaps her special needs, which made it more difficult for her than most children to communicate, caused her to internalize her problems rather than reach out for help.

³ *BC Children and Youth Review*, Hughes, E.N. (2006)

There were people she trusted – the close friend with whom she confided every detail of her life, and the counsellor at the school, who made the most consistent efforts to get her the help she needed.

We do know she was small for her age, and that she liked listening to music. We know that she took steps to protect her younger sister from the sometimes frightening and violent behaviour of her mentally ill mother.

We do know she loved wrestling and was good at it, representing her school and placing in the top four at a number of tournaments. We know that she had feelings for at least two boys and that she was bullied and sometimes got into fights at school. We know that she liked to post on a social networking site and that she shared the depths of her feelings – “*I should die on u*” – two nights before her death.

We also know she experienced too much pain and not enough hope in her life. And that she died too young.

We can only imagine the grief and overwhelming sense of loss the girl’s family has faced in the years following her death. The Representative would like to extend her deepest thanks to members of the family, in particular the grandparents, for their willingness to share information and insight despite the emotional pain they have endured.

As in all reports investigating the critical injury or death of a child, the Representative weighed the privacy of the individuals involved against the value of sharing some of their personal details. A primary consideration is the privacy of the immediate family. For this reason, the Representative has taken care to withhold their names from this report as well as any information that could readily identify them.

Methodology

The *Representative for Children and Youth Act (RCY Act)* (see Appendix A) requires MCFD to report all critical injuries and deaths of children who have received a reviewable service in the year leading up to the incident.

The Representative conducts an initial screening of these incidents to determine if they meet the criteria for review under the *RCY Act*. If an incident meets the criteria, it is reviewed to determine if a full investigation is required.

This girl's death was reported to the Representative by MCFD on May 25, 2011. After completing a review of ministry and LAA files about the girl and her family on Jan. 10, 2012, the Representative determined that a reviewable service or the policies or practices of a public body may have contributed to her death and a full investigation was initiated. The Representative commenced a full investigation in February 2013.

While the investigation focused on the time frame between October 2008 and May 2011, information prior to October 2008 and extending through June 2012 was fully examined to understand the events leading up to and following the girl's death in May 2011.

Numerous files and documents were reviewed in the course of this investigation. Records were obtained from multiple sources, including RCMP, MCFD, the LAA, school, federal and provincial health authorities, the BC Coroners Service and the former Ministry of Social Development. (See Appendix B for a detailed list.)

Interviews with MCFD staff, LAA staff, RCMP, health care professionals, school personnel and First Nation band staff and members were conducted in accordance with s. 14 of the *RCY Act*. All professional witnesses were ordered to appear for an interview, were sworn in and their evidence recorded. Forty-one interviews, including family, were conducted. (See Appendix C for a detailed list.)

A draft report was provided to the Representative's Multidisciplinary Team,⁴ which is established under the *RCY Act*. The Multidisciplinary Team reviewed the draft report and provided advice and guidance to the Representative based on the expertise of the team members. Additional experts in the field of child protection and child and youth development were also consulted.

In the interest of administrative fairness, agencies and individuals that provided evidence to this investigation, including the girl's family, were also given an opportunity to review the draft report and provide feedback on the facts.

⁴ Section 15 of the *RCY Act* provides for the appointment of a Multidisciplinary Team (see Appendix D) to assist in this function, and a regulation outlines the terms of appointment of members of the team.

Chronology

The Child and Her Family

The girl was born in 1996 to parents who had lived in the same First Nations community all their lives. She never knew her father. The girl, her younger sister and their mother were all cared for by the child's maternal grandparents, who spoke primarily in their traditional language.

The girl's maternal grandmother is a residential school survivor. The grandmother's three eldest children are also residential school survivors. Her two youngest children, including the mother of the child who is the focus of this report, did not attend residential school as it was closed before they reached school age. Instead, they grew up together on-reserve in the family home.

In November 1995, the girl's mother was charged with assault causing bodily harm. She was sentenced to one year of probation with conditions to perform community service and attend drug and alcohol counselling sessions. During these sessions, the mother disclosed that she had been sexually abused as a child and felt unsupported by her family in coping with this trauma.

First Contact with the Ministry

In February 1996, the girl's mother learned that she was five months pregnant with her first child. Now 20-years-old, she struggled with depression and was fearful of her family's reaction to the pregnancy.

On March 12, 1996, the mother contacted the Ministry of Social Services (MSS)⁵ to discuss placing her unborn child for adoption. Her sister was considered a possible placement option for the child. Records indicate that the mother declined band involvement in adoption planning because of her own history of abuse within her community. A residential resource for pregnant women in need of shelter in another town was discussed as a possible option for the mother.

Following the birth of the baby girl in June 1996, the mother decided to keep her. The mother and daughter moved into her parents' home on-reserve, where they remained for the next three years. The child's biological father was not involved in her life and his name was not identified on the child's birth certificate.

In May 1999, following conflict with her parents, the mother left with her daughter and moved to the nearby town. The girl was now nearly three-years-old.

⁵ The Ministry of Social Services' child protection and family services programs moved to a newly created Ministry of Children and Families in September 1996, which became the Ministry of Children and Family Development in June 2001. All are referred to in this report as the "ministry."

Less than a month later – two days before her daughter’s third birthday – the mother was investigated by the ministry for child safety concerns.

While attending to a report of an assault of the mother by her boyfriend, RCMP found the mother extremely intoxicated and unable to care for her child. The boyfriend fled the home. RCMP took charge of the girl, whom they found dirty and crying, and contacted the ministry for assistance. An on-call social worker placed the girl with her aunt for two days.

After a brief meeting with the mother on the night of the incident, the social workers made a home visit to her the following Monday. The mother was advised that her daughter had been examined by a physician. Records from that examination state the child was healthy. The mother confirmed conflict with the grandparents as the reason for moving out of their home. She also stated that quitting drinking would be more difficult for her now that she was living in town.

The next day, two ministry workers drove the mother around the town to orient her to available supports and services. Ministry records note that the mother was not interested in any services and had no plan to quit drinking.

Collateral checks were made by a social worker. A family support worker from the mother’s community advised that she felt the mother and her daughter should be living with the grandparents, as they could ensure the mother was properly caring for the girl. This band worker felt that the mother’s drinking was likely to result in her daughter being removed.

As the mother had no concrete plans to address her alcohol use and there were concerns about the girl’s visibility in the community, the social worker decided to keep the family service file open in order to offer the mother supports. A representative from the mother’s First Nations community was contacted to assist in engaging the mother in services.

A Comprehensive Risk Assessment (CRA)⁶ resulted in a finding of “Moderate Risk” to the child. The subsequent risk-reduction service plan required the mother to attend school and drug and alcohol counselling, to place her daughter in daycare to increase the girl’s visibility and to access parenting and mental health supports.

On Aug. 16, 1999, the mother’s family service file was transferred to another ministry worker for follow up. The risk-reduction service plan was not implemented because the new worker was unable to contact the mother despite three attempts.

On Sept. 21, 1999, the mother moved to a town 500 kilometres away without advising the ministry. Nearly two months later, another new social worker in the previous town learned that the mother was working and the child was in daycare.

⁶ When a child is found in need of protection, a Comprehensive Risk Assessment is used to assess the child’s situation to more fully identify the risk of future abuse and neglect to which a child may be exposed. The ministry’s Risk Assessment Model for Child Protection requires social workers to consider five influencing factors, including parental, child, family, abuse/neglect and intervention influences. In conducting the CRA, social workers are expected to obtain and use all possible relevant information, including reviewing all file information, interviewing relevant family members and collaterals.

Timeline





Following unsuccessful attempts to contact the mother, the social worker concluded that the mother's situation was not high-risk since she appeared not to be in need of services and records indicated that her daughter was in daycare and therefore more visible in the community. The ministry closed the file on Jan. 14, 2000.

A Child of a Parent with Mental Illness

In May 2001, the mother's younger brother died in a car accident. The mother reportedly felt very close to this brother and considered him her "*protector*." The mother's family and band family support worker told the Representative's investigators that her mental health began to deteriorate shortly after his death.

On Aug. 29, 2001, the mother met with a locum at her family physician's office in town. The physician's record notes the mother's disclosure of suicidal thoughts, which included hanging herself. The physician also noted that the mother lived with her parents and her five-year-old daughter. He prescribed an antidepressant, established a verbal contract with the mother not to harm herself and arranged for her to see her regular physician in two weeks.

There is no indication that the doctor had any concerns for the safety of the daughter. There is no record of any follow up when the mother missed her next two appointments.

Due to frequent moves, there was significant instability in the child's life during the following two years. School records indicate that during Kindergarten and Grade 1, the child attended three different schools in three different towns.

During a parent-teacher interview when the child was in Kindergarten, the mother described her child as happy and shy. School records indicate that the child underwent an informal evaluation by a speech-language pathologist. Her language skills "*were found to be delayed*" and she was noted as having difficulty following verbal direction.

Mid-way through Grade 1, the child and her mother moved back to the grandparents' home on-reserve. The child now attended the public school that served the children and youth from the child's First Nation community and surrounding communities. She would attend this school for the remainder of her life.

During her Grade 1 year, when the child was six-years-old, the teacher referred her to a school district psychologist and a speech-language pathologist due to difficulties she was having in the classroom. Psycho-educational testing in November 2002 found the child's intellectual functioning to be consistent with "*mild intellectual deficiency*" with her test performance placing her in the first percentile, meaning that her scores were equal to or higher than only one per cent of students in her age group. With intellectual functioning this low, the child met the criteria for inclusion in the B.C. Ministry of Education's special education category of Mild Intellectual Disability.⁷

⁷ B.C. Ministry of Education, *Special Education Services: A Manual of Policies, Procedures and Guidelines*, September 2002.

The psycho-educational assessment also found deficits in her language-acquisition skills and word knowledge. Overall, her verbal skills were found to be consistent with “*moderate intellectual deficiency*,” while her overall adaptive behaviour skill was found to be as expected from a four-year, seven-month-old child. Deficits in social understanding were also noted and the assessment revealed that she tended to deal with negative feelings and distress on her own rather than approaching others for help, and that she was also easily led by others. The main learning goal for the child was to “*work on language development*” and long-term guidance by a school counsellor was recommended.

Despite her academic struggles in meeting Grade 1 expectations for reading, writing, math and oral language, she was promoted to Grade 2.⁸ As a result of the psycho-educational assessment, an Individual Education Plan (IEP)⁹ was developed for the child, but the plan was not developed and implemented until the child was in Grade 2. She was also placed in an English Skills Development Program (ESD).¹⁰

On May 30, 2003, the mother was taken to the Emergency Room at the hospital in town after being referred by a community nurse. Hospital records noted: “*Voices sometimes tell her to harm herself or others.*” She reported hearing voices for the past two years and that she had seen a traditional healer one year earlier without any improvement.

The Emergency Room physician suspected that the mother suffered from paranoid schizophrenia, although a full assessment was not conducted at this time. A nurse sent an urgent fax to the mother’s physician advising him of the diagnosis, stating: “*need medication orders A.S.A.P.*” There is no indication in records that either the ER physician or nurse asked whether the patient was a parent.

The mother was prescribed an antipsychotic oral medication and discharged from the hospital. The discharge summary noted that she left the hospital with her parents and daughter with “*plans to set up an appointment with family doctor.*” When the mother saw her physician two days later, she told him about having suicidal thoughts and that she had one child. He concluded that a “*referral to psychiatrist would be helpful.*” However, no referral was made at this point.

On June 18, 2003, a community nurse working with the family on-reserve wrote a letter to the mother’s family doctor advising him that: “*She tells me she is still hearing voices that scare her and tell her to kill herself and harm her five-year-old daughter.*” There is no record of the nurse or the family doctor notifying the ministry of these concerns.

⁸ BC Ministry of Education policy is based on research suggesting that retaining students is associated with a number of negative outcomes, and the recommended approach is to promote with intervention.

⁹ An Individual Education Plan is mandated by the Ministry of Education ministerial order 638/95 to provide individualized plans to students identified with special needs and who require: more than minor adaptations to educational material or instructional or assessment methods; the expected learning outcomes to be modified; and require more than 15 hours of remedial help to meet the modified expected learning outcomes from someone other than the classroom teacher. Changes to policy have occurred over time. For the current ministerial order see: <http://www.bced.gov.bc.ca/legislation/schoollaw/e/m638-95.pdf>

¹⁰ English Skills Development is a Ministry of Education program that provides language development support to First Nations students and other students who come from an environment in which English is not the first language.

The nurse also advised the doctor that the mother was not taking her prescribed medications because “*they give her the shakes.*” The nurse offered to administer injectable medications if prescribed.

During her next visit with her physician on June 19, the mother was reportedly willing to continue with oral medication on a longer term basis. There is no documentation to indicate that a referral to a psychiatrist was made by the physician even at this point.

Just prior to her next appointment with her regular physician, the mother saw a different physician at a doctor’s clinic on-reserve on July 22, 2003.

This physician made a referral to an outreach psychiatrist who traveled regularly to the town. The physician wrote on the referral: “*Please see for schizophrenia, she presented with auditory hallucinations sometimes deprecating comments, often they tell her to hurt herself or her daughter.*” This referral identified the mother’s regular physician to the outreach psychiatrist.

The mother’s medical records indicate that the normal intake process for seeing an outreach psychiatrist was bypassed to expedite her treatment.

On July 29, 2003, the mother saw her regular physician. He recorded that she was “*generally ok*” and tolerating her medications which she only occasionally forgot to take. The physician also reported that she was still hearing voices periodically.

On July 30, 2003, the same community nurse provided the outreach psychiatrist with a detailed written account of the mother’s illness and lack of compliance with medication, stating that the mother “*did not express any suicidal ideation but voices were giving her commands to hurt her daughter and her mother.*” The nurse also advised that she would see the mother once or twice a week as the mother remained noncompliant with her medication. The mother had been informed that she would be required to take medication indefinitely, which she was having difficulty accepting.

In August 2003, the same community nurse drove the mother to town for her first appointment with the outreach psychiatrist.

The psychiatrist noted the mother’s persistent psychiatric symptoms since the birth of her daughter and diagnosed the mother with psychosis not otherwise specified (NOS). Schizophrenia was “*suspected.*” Because the mother was not taking her oral medications, the psychiatrist prescribed her an injectable medication that could be administered every two weeks.

During this visit, the mother told the psychiatrist she would never harm her daughter. However, the psychiatrist wrote in his consultation report that the voices in the mother’s auditory hallucinations “*would sometimes swear at her or say, referring to her daughter ‘snap her head.’*” The psychiatrist did not report to the ministry the potential risk posed to the child.

According to medical records, the mother met with the outreach psychiatrist approximately every four months, from August 2003 until January 2008. His records

indicate that the mother's symptoms, including her suicidal ideation and thoughts of harming her daughter, remained in remission from August 2003 until February 2006 when her injectable medication was switched back to oral medication. The Representative's investigators note that the outreach psychiatrist's consultation reports were not always provided to the mother's physician, but rather to the referring physician in another clinic.

An assessment by the outreach psychiatrist on Nov. 1, 2005 confirmed that the mother's condition was "*chronic paranoid schizophrenia*" but that it was "*in partial remission with residual symptoms.*"

During this time, the girl continued to struggle academically but she was promoted through Grades 2 and 3. In Grade 3, she was still unable to read Grade 1-level books without teacher support. Despite the academic challenges, her report cards noted that she demonstrated a positive attitude and made good efforts while she continued in the ESD and modified programs.

The follow up from the referral for a speech and language assessment in Grade 1 did not take place until the child was in Grade 3. The result of this testing determined that the child had a "*severe receptive and expressive language delay and developmental articulation errors*" and that her language skills were "*at a level of a typical 4 to 5 year old child.*" At the time the child was tested she was eight-years-old.

An IEP was again developed and placed the child on a modified program for language arts and math. According to the IEP, the focus that year was to improve her reading, writing and math skills in addition to improving her receptive and expressive language skills. She also continued in the ESD program.

Despite her academic challenges, the child was promoted to Grade 4. While the child continued in the ESD program, it appears no subsequent IEPs were developed as none were found in the child's education records.

On Jan. 19, 2006, the mother told a community nurse that she wanted to have a baby. The nurse sent a note to the outreach psychiatrist with a copy to the mother's regular physician advising of the mother's plans and seeking guidance regarding her medication.

On Feb. 13, 2006, the mother was prescribed oral antipsychotic medication by the outreach psychiatrist. The psychiatrist noted in his consultation that the mother had been taking her injectable medication on a voluntary basis and "*is competent to make treatment decisions.*" This medication adjustment was required to restore the mother's menstrual cycle, which had been compromised by the injectable medication she had been taking for the past three years.

The outreach psychiatrist sent notifications of the mother's medication change and plan to become pregnant to the band Health Centre and the physician who had referred the mother to him. There is no indication that the mother's regular physician was advised.

Within two weeks of being back on oral medication, the mother saw a community nurse and reported that she was hearing voices “*telling her to harm her daughter, but no one else.*” On Feb. 23, 2006, the community nurse wrote to the outreach psychiatrist about these concerns, requesting that the mother again be prescribed injectable medication. She wrote: “*I am very concerned about her 9 year old daughter.*” The risk to the child was not reported to the ministry.

The outreach psychiatrist did not see the mother again until April 18, 2006, when she told him that she had broken up with her boyfriend and was no longer planning to get pregnant. The mother denied having suicidal thoughts and command hallucinations and asked to remain on oral medication.

The outreach psychiatrist renewed the mother’s previous prescription for oral antipsychotic medication, “*As she claims she is compliant to treatment and there is no new re-emerging psychotic symptoms by self-report.*” The outreach psychiatrist also wrote that he did not need to see the mother for the next five months.

The mother remained on oral medications in the ensuing months. There were no further reports of symptoms of her psychosis to those involved in her medical care until the fall of 2006.

The next time the mother saw the outreach psychiatrist, on Sept. 19, 2006, she brought her daughter along. The psychiatrist’s report indicated that the mother and daughter interacted appropriately. He observed that the mother’s psychosis was well controlled and in a residual state with only occasional auditory hallucinations. She was continued on oral antipsychotic medication.

The mother told the psychiatrist that she was still trying to get pregnant. It appears that this time the outreach psychiatrist’s consultation report was sent to the mother’s regular physician with a copy sent to the band Health Centre.

Late the following night, the mother called the town hospital’s Crisis Response Unit (CRU).¹¹ She was in tears and alone with her now 10-year-old daughter. The grandparents had gone away for nine days. The mother told hospital staff that the voices were laughing/talking to her that night and preventing her from sleeping. The nurse noted that the mother was “*unsure if having another child is the right decision.*” The nurse encouraged the mother to make another appointment with the psychiatrist to review her medications.

Hospital CRU records state that a community nurse called on Sept. 21, 2006 and expressed concern that the mother’s mental health had deteriorated since the “*injection meds*” were discontinued in January 2006.

¹¹ Located within the hospital, the Crisis Response Unit operated 24 hours a day, seven days a week with a nurse and care aid for a limited number of beds. It provided services to people experiencing a crisis. The level of service was midway between outpatient therapy and a psychiatric hospital.

Two days later, two community nurses discussed concerns that the mother's mental health was deteriorating and that she was being left alone to care for her young daughter. The community nurse then advised a hospital CRU nurse that she would follow up with the mother "*if possible.*"

The Representative's investigators found no documented reports about the mother's mental health from community nurses during the next nine months.

In November 2006, during his consultation with the mother, the outreach psychiatrist noted that she remained opposed to injectable medication and was adamant she still wanted to have another child. He continued her prescription for oral medications.

Over the next few months, the mother had multiple contacts with various health care professionals including the outreach psychiatrist, her regular physician, a nurse in her own community, and hospital staff. These contacts were about miscellaneous health concerns and unrelated to the mother's mental health. There was no indication that her intentions to become pregnant were discussed.

On June 25, 2007, the outreach psychiatrist concluded that the mother's psychotic symptoms were in almost complete remission. He noted that he no longer needed to be involved in her care, but that he could reassess her in six months if necessary.

Within two months, the mother's parents reported concerns to a community nurse that she was yelling at them, not sleeping due to bad dreams, and crying frequently. The nurse made a referral for the mother to see the outreach psychiatrist, and provided a detailed account of the grandparents' concerns about their daughter's thoughts and behaviours.

The psychiatrist saw the mother two days later, on Aug. 3, 2007, and concluded that she was not taking her medication and that her symptoms had returned. The psychiatrist adjusted her oral medication and scheduled a reassessment for the following month. There was no indication in the mother's consultation record that her desire to have a baby was discussed.

A month later, on Sept. 3, 2007, the mother was brought by ambulance to the hospital in the nearby town with "*abdominal swelling.*" She was found to be in premature labour. An attending doctor observed that she had a history of schizophrenia. He described the pregnancy as "*high risk.*"

The mother was immediately transferred to a licensed psychiatric facility with obstetrical services in an urban centre 300 kilometres away. She was seen by an obstetrician, who observed that she had active schizophrenia. He noted that she had received no prenatal care. At this time, she stated she did not know she was pregnant. Within hours, she gave birth to her second daughter.

She was examined by a psychiatrist at the psychiatric facility the following day. He found that her psychotic symptoms appeared to be quite intrusive and wrote: "*I think Social Services needs to be involved to ensure that the baby's basic care needs are being met and that support services which she needs for her and her family are accordingly arranged.*"

This psychiatrist provided his consultation report to the mother's family physician. He noted her history of psychiatric disorder and reported "*that she was not too compliant with the medications and would take it occasionally ... every second or every third day. As to why she would not take the medication, she reports she was afraid that the medication may affect the fetus.*"

On Sept. 5, 2007, a hospital social worker assisted with the mother's discharge to the care of her sister prior to moving back in with her parents on-reserve. The infant was discharged a week later. A community nurse was notified to follow up.

There are no records to indicate that the ministry was contacted for follow up with the mother and baby's discharge from hospital despite the psychiatrist's documented concerns.

A week after the mother was discharged, a community nurse wrote to the mother's physician stating: "*My concern is that if [the mother] is still psychotic when the baby returns home, her safety could be an issue.*"

The mother saw her physician on Sept. 14, 2006. He did not address the nurse's concern with the mother, only encouraged her to return to injectable medication. There is no record of any contact with the ministry by the community nurse or family physician.

The outreach psychiatrist saw the grandfather and mother on Oct. 9, 2007. The psychiatrist recorded: "*I have a sense that she is not forthcoming and I get little information about how she functions at home from her father.*" The mother remained strongly opposed to injectable medication. Oral medication was initially continued.

Six weeks later, the grandfather advised the outreach psychiatrist that his daughter was non-compliant with her oral medication and continued to be psychotic. In response to his concerns, the psychiatrist gave the grandfather a prescription for injectable medication and advised him to have a community nurse administer the medication. There are no records to indicate that the mother was administered the injectable medication.

In the early morning hours of Dec. 29, 2007, the mother called the RCMP reporting that the children's grandmother was choking the eldest daughter and was a "*devil worshipper.*" The RCMP attended and found the children sleeping and safe with their grandparents. The mother was taken to a neighbour's house for the night and the grandparents were advised by the RCMP officer to call a community nurse for mental health support.

Later that same day, the mother was transported by ambulance to the town hospital. Hospital records noted that she was "*noncompliant with medication, increasingly agitated, paranoid ideas of people trying to hurt her, suicidal threats and according to family members trying to abuse her 10-year-old daughter and three-month-old [child].*"

RCMP records show that they were called to the hospital Emergency ward twice as medical staff felt that they needed assistance in subduing the mother. However, in each instance, hospital staff were able to control her without assistance.

The attending physician certified the mother under the *Mental Health Act (MH Act)*. (See Appendix E.) Her long history of non-compliance with medication, threats to her children and paranoid ideas were noted.

The mother was transported on Dec. 31, 2007 to the designated psychiatric facility. A second psychiatric assessment resulted in a recertification under the *MH Act*. The mother's resistance to taking medication was noted and she was diagnosed with psychosis NOS. Schizophrenia was "*suspected*." The child's grandparents were not available for consultation as they were away for the New Year. There is no record of the ministry being advised of the risk to the mother's children or her certifications under the *MH Act*.

The mother was discharged on Jan. 4, 2008 and returned to live with her parents and children. Her oral anti-psychotic medication was discontinued and she was returned to injectable medication. The discharge summary noted that an appointment was made for her with the outreach psychiatrist and that her family physician would be notified of her discharge. The discharge summary was distributed to the mother's family physician and band Health Centre.

The mother saw the outreach psychiatrist on Jan. 22, 2008 and requested that she be returned to oral medication as she found the injections too painful and unpleasant. Although the psychiatrist noted no symptoms of psychosis, he declined her request due to a lack of collateral information. He asked her to bring a relative in to provide this information on her next visit. This was the last time she attended an appointment with the outreach psychiatrist for nearly three years.

On Aug. 25, 2008, a community nurse informed the hospital CRU that the mother had pulled a knife on her 10-year-old daughter: "*This lady's parents are very concerned again about her behaviour and have worries about the grandchildren's safety,*" the nurse wrote in the referral. "*On Aug. 21, her 12 year old daughter says [the mother] pulled a knife on her but didn't attack. [The mother's] 11-month-old baby acts afraid to be left alone with her.*"

An appointment was made for the mother to see the outreach psychiatrist the following month. This incident and the risk to the children were not reported to the ministry.

The mother had missed her prior appointment with the outreach psychiatrist in June and would miss the subsequent appointment on Aug. 26. This was not reported to her regular physician but instead to the physician who had originally referred the mother to the psychiatrist in 2003. There was no indication that the community nurses were advised of this.

On the weekend of Oct. 24, 2008, the mother took her two children to town. She had advised the grandparents that she would be staying with her sister. When the grandmother discovered that she had not been truthful about where she was taking the children, she phoned the RCMP.

The RCMP located the children in a hotel room and returned them to the grandparents. The Representative's investigators could find no records to indicate that RCMP notified the ministry about this incident.

Second Contact with the Ministry

More than nine years after the first protection report involving the girl, a second report was made to the ministry on Oct. 27, 2008.

While administering a flu shot to the girl, a community nurse noticed scratches on her arm. The girl, now 12-years-old, reported that her mother had inflicted the injuries. The grandmother had noticed the injuries when the RCMP returned the girl the previous weekend. The nurse advised the grandparents to report the incident to RCMP, which they did at the local detachment.

After interviewing the girl, the officer reported the concerns to the ministry's After Hours program and requested follow up. Critical information gathered from the officer included:

- a nurse saw the scratch marks and saw a need for RCMP intervention;
- the child retracted her statement in front of the RCMP officer and stated that she had wanted to get her mother in trouble as they were not getting along;
- the grandparents confirmed that the two were not getting along;
- custody and access were identified as possible issues;
- the mother and her daughters lived with the grandparents on-reserve, but the mother was reportedly at a hotel in town with her boyfriend;
- the primary caregivers seemed to be the grandparents; and
- the RCMP officer believed that the child was in need of counselling.

The community nurse talked with the girl's grandfather about connecting the girl with a school counsellor, to which he agreed. Following this, the nurse contacted the school secretary, who advised that the girl was already seeing a school counsellor but agreed to inform the counsellor that she had harmed herself.

The following day, the girl got into an altercation with another student at school. It is not clear what the altercation was about or what consequences were given to the other student, but the girl who is the focus of this report was suspended for three days.

After receiving the After Hours' memo about the injuries to the girl's arm, a ministry social worker consulted with her team leader. The team leader advised the social worker to contact the band to discuss the concerns, call the grandparents to offer support and close the Request for Family Services intake if they refused.

A meeting took place on Oct. 30, 2008 at a local Aboriginal Agency. The social worker met with the band manager, who advised that the mother had another child, but was not capable of looking after her children on her own. The grandparents were the primary caregivers. The band manager also referred to the mother as having mental health challenges. She stated that she would have the grandparents phone or visit the social worker.

A week later, the social worker phoned the girl's grandmother to discuss support services in the form of a school-based counsellor as well as another counsellor who worked in the community. The grandmother declined the offer. During this discussion, the social worker learned that the grandparents had raised the children since birth.

Almost two weeks later, another ministry social worker spoke with the band manager in an effort to make arrangements to see the family. The social worker was advised that the ministry was not allowed on-reserve. She tried unsuccessfully to explain to the band manager that a discussion of available services with the grandparents would be more effective if it was done in-person.

That same day, it appears the social worker again offered supports to the grandmother over the phone, but she again declined the offer. Following this, the social worker wrote her a letter advising the grandmother that the file would be closed as of Nov. 18, 2008.

The Representative's investigators could find no indication that the community nurse, ministry protection workers or the school counsellor ever connected to discuss the girl's self-harming behaviours or to strategize on how best to work with the grandparents. Safety concerns regarding the children were not addressed. Neither the girl nor her baby sister was seen by social workers.

On Nov. 24, 2008, the girl was again suspended from school for two days for being “disrespectful” to another student. On Dec. 9, 2008, the school principal learned that some students had stolen a school key. He contacted the RCMP to request that an officer attend the school to speak with the students involved about the seriousness of the matter and the implications of theft. When the officer spoke with two students, they alleged that they were given the key by the girl who is the focus of this report. The officer also spoke with the girl about the concerns. The principal did not pursue the matter further.

Three days later, the girl was suspended for the third time that fall. In this instance, she was suspended for 10 days for the wilful destruction of property.

Her interim (September to November) Grade 7 report card stated the girl “*has great difficulty functioning in the classroom. I have been working with her one on one in social studies, math and sometimes English. When she is focussed, she is quite capable of completing the work presented to her. We need a more consistent effort.*”

The Girl Calls Police

On the evening of July 11, 2009, the girl, now 13-years-old, called RCMP for help, reporting that her mother had hit her with a TV remote, pulled her hair and thrown a chair down the stairs. Two RCMP officers attended the home to find the girl on the front steps holding her baby sister, now 22-months-old.

The girl explained that she and her mother had argued and her mother had locked both children out of the house. The grandparents were in town for the evening. The girl told the officers that incidents such as this occurred when her grandparents were not home. The girl also stated that her mother was not drinking but was being bothered by “*spirits.*”

The mother told RCMP officers that she and her daughter got into an argument because her daughter refused to listen to her. She denied throwing the TV remote and pulling her daughter's hair. With agreement from the mother, the RCMP made arrangements to have the children stay with neighbours for the night.

The neighbours advised RCMP that occurrences such as this one were frequent and occurred only when the grandparents were out of the house. The neighbours also told the officers that the mother had mental health problems.

After the children were taken to the neighbours' home, the RCMP officers transported the mother to a nursing station in her own community for assessment. The attending nurse advised the officers that the mother had been diagnosed with paranoid schizophrenia. After some discussion between the nurse and officers, it was decided that the mother should be taken to the town hospital to be assessed by a physician.

That night, the investigating officers reported the incident to the ministry's After Hours and requested follow up. An officer advised the ministry that the mother had a history of mental health issues and had been taken to the town hospital for an assessment. A third intake was opened by the ministry in the mother's family service file.

At the hospital Emergency Room, the attending nurse conducted an initial assessment which included gathering information from the grandfather. A report by the hospital's CRU noted: *"Collateral info from [the mother's father] that client was cutting up her clothes and her children's clothes and that she had 'hit' her daughter. Collateral information from [the client's] mother via telephone states same and that, 'family stays up all night to watch her so she doesn't hit the kids... [the client's] father...expressed concern that client was refusing any treatment and seemed to be getting 'worse and worse'."*

The grandmother also stated in the CRU report that the mother was hearing voices and behaving oddly including *"putting jam all over the floor, cutting up her own and the children's clothing, running out of the house and failing to come back, even in the night."* The grandmother also reported that the mother had squeezed toothpaste all over the bathroom sink, toilet, and tub, had cut up and burnt money and did not purchase groceries or disposable diapers for her children.

The mother denied any mental illness. The grandmother said she did not want the mother to return home until she received some treatment.

That same day, July 12, 2009, the mother was reassessed by a nurse at the CRU. The doctors arranged to transport the mother to the designated psychiatric facility for a full psychiatric assessment. However, the mother walked away from the hospital the following day.

A request to apprehend her under the *MH Act* was made to the RCMP by a CRU nurse. This request was declined by the RCMP as the mother was not certified under the *MH Act*. Both the CRU nursing staff and a community nurse worked together to try to locate the mother and have her returned to the hospital.

On July 14, 2009, a ministry child protection worker assigned to the intake resulting from the girl's call to RCMP three days earlier coded it for "Investigation." He phoned the community's band manager to discuss the concerns. The band manager advised the social worker that the mother had schizophrenia and that the grandparents were aware that they could not leave the mother alone with the children. The band manager agreed

to monitor the situation until the worker was able to make a trip to the community, which was just over an hour's drive from town.

On July 15, 2009, the mother was finally located. The grandfather visited the RCMP detachment to report that his daughter had returned home from the hospital but was still without any medication. The officer agreed to transport the mother back to the town hospital.

At the hospital, the attending physician assessed the mother but did not find her certifiable under the *MH Act*. The mother remained voluntarily at the hospital CRU, where she was administered injectable medication.

On July 19, 2009, the mother was given a pass to go on an outing but did not return to the CRU. This time, the hospital notified the family and RCMP that the mother had left and contacted her physician who advised that “*client can return if she wants to otherwise she can make her own decision ...*”

An appointment was made for the mother to see the outreach psychiatrist eight days later. It does not appear that the mother's physician was aware that the mother had not seen the outreach psychiatrist since January 2008. The Representative's investigators could find no record of the mother either being notified of the appointment with the outreach psychiatrist or attending it.

On July 31, 2009, the mother hitchhiked with her two children from the reserve to the town hospital, some 100 kilometres away. The children had again been left alone with their mother while the grandparents went on a four-day camping trip. The mother made the trip to the hospital under the mistaken belief that she was pregnant.

The mother was seen by the same physician who two weeks earlier had found her not to be certifiable. This time he noted: “*If children involved then danger to kids – required to certify and involve social services.*” The physician further noted that the mother “*is covertly psychotic. She is delusional with disassociated thought. This presents a severe impairment to her functioning and her ability to care for her children. In my opinion she requires treatment at a designated facility as she presents a risk to others and herself. She refuses to be admitted voluntarily.*”

A hospital nurse reported the concerns to the ministry's After Hours. Information from the nurse, which was documented on the After Hours system, stated that: “*[The mother] presented at hospital with her 12- and two-year-old daughters. After being assessed [doctors] have decided to certify [the mother] and she will be transported to [the psychiatric facility] for ongoing assessment.*”

The on-call social worker responded to the nurse's report and placed the children with their aunt as the grandparents were camping and could not be located. When the grandparents returned the next day, they picked up their grandchildren and returned home. The actions and interventions of the on-call social worker were documented on the After Hours system and an action alert was sent to the social worker assigned to the July 12 intake and his team leader for follow up.

The same day, July 31, 2009, the attending physician determined that the mother was psychotic and certified her under the *MH Act*.

The mother was examined by a second physician, who did not find her certifiable or at risk of leaving against medical advice. This physician treated the mother for severe anemia.

On Aug. 2, 2009, a third physician assessed the mother and re-certified her under the *MH Act*. He requested that she be transported to the designated psychiatric facility where she had previously been treated. On this same day, the mother left the hospital. She returned to the reserve to live with her parents and children without support.

This third doctor, who was primarily responsible for the mother's care, wrote a discharge summary stating: "*On August 2, 2009, her anemia was cleared up. She did not have any psychosis ... She, at that stage, decided that she would like to leave and, basically was discharged, to follow up with [a physician] the following week.*" There was no clear explanation about how the mother could be recertified under the *MH Act* in preparation for transport to a designated mental health facility and yet be allowed to walk away from the hospital without follow up on the same day.

No new ministry intake was opened in response to the hospital's report to the ministry's After Hours and the information did not subsequently appear in documentation regarding the open protection investigation report of July 12, 2009. There was no indication that the report to After Hours was acknowledged by the social worker or team leader.

On Aug. 11, 2009, the ministry social worker assigned to the July 12 intake attended the child's community to follow up on the concerns, but the family was not home. The social worker took the opportunity to meet with the investigating RCMP officer to confirm details of their report.

Although not reflected in ministry records, RCMP records show that, on Aug. 25, 2009, the investigating RCMP officer contacted the ministry, whose staff advised they were aware of the mother's mental health issues, were working to reintegrate her back with her children and had involved the community's chief in the process. The officer subsequently concluded his investigation assured that the ministry was involved.

Two ministry social workers met with the family on Sept. 10, 2009. A band family support worker accompanied the social workers to the family's home. The mother, her parents and youngest daughter were home. The girl was at school. The social workers were again advised of the mother's schizophrenia and non-compliance with her medication.

During this visit, the grandparents reported that they did not often leave the children alone with their mother and that, when they did, it was only for short periods of time. The mother admitted to throwing the TV remote at her daughter, but not to throwing a chair. She reported becoming frustrated when her daughter did not listen to her. The mother also admitted that she had not been taking her medication.

A safety plan was discussed with the family, which amounted to a verbal agreement that the grandparents would not leave the mother alone with the children. The mother and grandparents gave the social worker permission to speak to the girl at school.

There is no indication in ministry files that the details of the mother's recent hospitalizations were explored with the family or that contact with health care staff or the mother's physician had been made to ascertain the mother's mental status and compliance with medication.

The social worker's only interview of the girl did not take place until Nov. 30, 2009, more than four months after she had called the RCMP for help. The girl was noted as being small for her age, slim and dressed appropriately in jeans and a long-sleeved shirt. During this discussion, the girl stated that her mother did not take her medication because she did not trust doctors. The girl indicated that, despite this, things were good at home. In his investigation report, the social worker noted:

"[The girl was] frustrated with her mother sometimes, maybe embarrassed ... [She] states that she would do the same thing again should her mother become unstable or violent. She would take her little sister and go to the neighbours' again and call the police ... [The girl] appears to have 'street savvy' in understanding her mom's conditions and how to respond. Last time her and her mom had an argument was on Nov 20, 2009 ..."

The following day, the social worker consulted with his team leader to discuss the intake concerns. The team leader was informed that the mother was refusing to take her medication for schizophrenia and that the grandparents were aware that they could not leave the mother alone with her children. The team leader was also informed that the band was aware of the situation and would monitor the home. It was determined that the intake concerns had been addressed and that the children were not in need of protection.

The investigation concluded with a finding of "*no evidence of physical harm or likelihood.*" In summarizing the report, the worker noted that "*although allegations were substantiated, investigation determined that grandparents are the primary caregivers and understand they cannot leave their daughter unsupervised with her children.*" Records reflect that the band would monitor the home. The intake and family service file were both closed.

The Girl Calls Police Again

Less than three weeks later, on Dec. 18, 2009, the girl again contacted RCMP, following another violent outburst by her mother who was throwing things at her and around the house. The children had again been left with their mother while the grandparents went to town.

When the RCMP officers arrived, the house was dirty and it was evident that items had been thrown around the house. The girl told the officers that she and her sister were scared of being hurt by their mother if they were left alone with her. The officers recorded that the children had not eaten that day. The girl disclosed two prior incidents – one which involved her mother hitting her on the back in August 2009 and another in which her mother threw her to the ground by her ponytail on Nov. 20, 2009.

The RCMP officer reported the incident and the two newly alleged incidents to the ministry's After Hours and requested assistance with the children. Carrying out the

immediate safety plan, to which the mother had agreed, the on-call social worker transported the children to the home of their aunt, who lived in town. The aunt was instructed to keep the children until the ministry was able to investigate and assess the situation.

The social worker who had previously dealt with the family was on holidays and a new social worker was assigned. The intake was coded for investigation. The new worker called a meeting with the grandparents and aunt at the ministry office on Dec. 22, 2009. Both children were present.

During this discussion, the grandparents stated that their daughter was not taking her medications and would act out when she became frustrated. The grandparents were exhausted by the stress of managing their daughter's mental illness and needed a break from the unrelenting pressure. They understood that their daughter needed ongoing treatment, including proper medication, but were at a loss as to how to make this happen.

The outcome of this meeting was that the aunt agreed to provide respite care to the children, so that the grandparents could have periodic breaks. All parties agreed that, twice a month, the aunt would be funded by the grandparents and ministry to look after the children. According to family members, this respite was only provided for one month.

Custody was also discussed. While the grandparents were the primary caregivers to the children, they did not have legal guardianship. The grandparents agreed to seek guardianship in the new year. The protection worker indicated that the ministry would be in a better position to fund supports for the grandparents if this step was taken.

On Jan. 12, 2010, an “*immediate safety assessment*” was completed by the social worker. The worker's assessment found that, because the mother had schizophrenia and refused to take her medications, her “*mental/emotional/physical health status seriously affected her ability to supervise, protect or care*” for her children. However, this social worker concluded that there were “*no findings to substantiate [the Dec. 18] report.*” This conclusion was reached despite the RCMP report to the ministry After Hours the previous month. The investigation was concluded with a finding that there was “*no evidence of neglect by parent with physical harm.*” It was determined that the intake could be closed but the family service file, under the mother's name, would remain open for services.

By the next day, the intake was closed and signed off by both the worker and his team leader. Aside from the team leader's signature closing the intake, there is no record of the team leader being consulted on the actions taken during the investigation.

Due to an oversight, however, the intake was not closed on the ministry's information management system. Clerical staff requested the protection worker to check the information on the system so the intake could be closed. However, the intake remained open on the system in error for several months.

Clerical staff subsequently requested the protection worker who had previously worked with the family on the July 12, 2009 intake to close the Dec. 18 intake. However, by this time, he was away on a two-month sick leave.

By the time the protection worker returned to work on April 19, 2010, the intake still had not been closed on the ministry system. More than a week later, he consulted with his team leader, who advised him that she believed the mother, grandparents and children were all living in the home. She instructed the worker to follow up with the grandparents to confirm the safety plan – that the children were not being left alone with the mother. She also directed the worker to gather collateral information from the band office and the RCMP. She advised him to close the intake and the family service file if the safety plan was still in place and the community was supporting the family.

Follow up with the family would not take place for nearly two months. On the intake, the worker noted that “*overdue workload issues*” and commitments to other families prevented him from following up with the family.

The girl was now 13-years-old and in Grade 8. Wrestling had become one of her passions and outlets and she had achieved some success in the sport. In January and February of 2010, she had placed among the top four competitors at three different wrestling tournaments throughout the province.

On April 19, 2010, the girl was suspended indefinitely from school for assaulting another student with a pencil. The incident and suspension were reviewed by school district representatives at a hearing on April 28, 2010. The grandparents and band family support worker were present. The hearing resulted in the girl’s indefinite suspension being lifted, allowing her to return to school, but with a number of conditions applied.

These conditions, set out by the school district, included: developing a plan with the school principal on how to respond to feelings of frustration with other students, working with a school counsellor to develop positive assertive behaviour skills and anger management, joining the band’s Boys & Girls Club for after-school activities, and connecting with community counselling at the town’s Friendship Centre.

On June 8, 2010, the request for support services was initiated by the school principal to connect the child with a school counsellor and the previously noted supports. It is not clear if this request was implemented as school was closed for summer holidays later that month.

Grandparents Apply to Child Out of the Parental Home Program

While the previous intake was still open and unresolved, a fifth intake on the family was initiated by the ministry After Hours on April 28, 2010. This intake was opened in response to the grandparents’ application to the Child Out of the Parental Home (COPH) program,¹² which they hoped would provide some funds to assist in the care of their grandchildren.

¹² The COPH program was introduced on Jan. 1, 2010 by Indian and Northern Affairs Canada (now known as Aboriginal Affairs and Northern Development Canada) and provides income assistance to children placed with a relative living on-reserve. It replaced the Guardian Financial Assistance program and introduced a screening component, which is conducted by the ministry’s After Hours to check that there are no apparent safety issues related to the proposed caregivers.

After Hours conducted a prior-contact check to see what history the ministry had with the family and requested criminal record checks on all the adults in the home to assess the degree of risk to the children.

On this same date, the screening results determined that there was evidence of risk to the children due to the mother having a prior conviction for assault causing bodily harm, which was a relevant offence for rejecting COPS applications. The decision was also informed by the mother's history with the ministry, specifically because the mother had *"schizophrenia, does not take her medication regularly and is violent with her children."*

The grandparents' fatigue with the home situation when the mother was present was again noted. The screener documented being unsure whether the grandparents were able to protect the children. The screener noted the most recent violent incident had taken place when the grandparents were not home.

As a result of the findings, the grandparents' application for COPS funding was denied by After Hours, which also requested confirmation of the custody status of the children.

On April 29, 2010, the team leader advised the child protection worker to visit the grandparents' home and assess the risk to the children. The worker was instructed to explore the possibility of the mother moving out of the home *"otherwise it will be difficult to manage risk with [the mother] in the home."*

During a phone call on May 13, 2010, the protection worker advised the band family support worker that the COPS application had been rejected due to the potential risk to the children as long as the mother remained in the home. The family support worker agreed to inform the grandparents and explore alternative living arrangements for the mother. The homes of the children's two aunts were considered as options.

Information was recorded on the previous intake's record, concerning the second incident in which the child called RCMP for help on Dec. 18, 2009, and which was still considered an active and unresolved child protection investigation. That information included:

- On June 18, 2010, the protection worker attended the reserve. He met with the band family support worker, who said that she had been checking in with the family on a bi-weekly basis. The mother was living with her children in the grandparents' home. The social worker documented that the family support worker reported that the family was doing well.
- The protection worker also met with the family that day. The mother was home, but did not want to speak to the social worker so she waited outside. She was still refusing to take her medication. The grandparents said they had attempted to have the mother hospitalized but she could not be detained because she was a voluntary patient. The social worker discussed the concerns with the grandparents and confirmed the ministry's decision to deny the COPS application as long as the mother remained in the home. The social worker was informed that the mother had not seen her doctor in more than a year.
- A collateral check with the RCMP on June 22 revealed that they had received no new reports about the child and her family.

Two days later, the child protection investigation was concluded and signed off by the social worker and his team leader. The ministry again found that the children were not in need of protection, stating that there was “*no evidence of risk or physical harm or likelihood*” and “*no evidence of neglect by parent with physical harm.*” The summary noted: “*RCMP has also been notified that [the mother] is not to be alone with her children. The [First Nation] band will also monitor the family and support them anyway they can.*” The family service file remained open to facilitate support services, which included the grandparents’ CPH application that had been declined on April 28, 2010 but remained open to assess concerns about the family and address them.

According to the ministry’s intake record¹³ for the CPH application, during the spring and summer of 2010:

- The social worker talked to the family support worker at the band office on May 13. The mother was still in the home and still non-compliant with her medication for schizophrenia. The grandparents were having a difficult time financially with their CPH application being denied.
- On June 13, the grandparents phoned the social worker, who confirmed the decision that the CPH application could not be approved as long as the mother remained in the home and was non-compliant with the medication.
- The social worker talked with the family support worker on July 7. The mother had an incident the previous night. It was reported the mother’s behaviours escalated to the point requiring RCMP intervention and hospitalization in town for an assessment.
- On July 8, the grandparents phoned the social worker to advise that the mother had calmed down and returned home from the hospital on her own free will. Physicians could no longer detain her.
- On July 9, the grandparents phoned the social worker again – this time to advise their daughter had been committed to a licensed psychiatric facility. A meeting was arranged for the social worker to assess the grandparents’ home on July 12.
- On July 12, the social worker visited both the family support worker at the band office and the grandparents in their home. The mother was still in a licensed psychiatric facility. The intake report notes: “*when [the mother] returns family has a plan that may work for [the mother] and her children.*” The plan was for the mother to live with her sister, who would soon be relocating to a new town.
- On July 29, the family support worker phoned the social worker on behalf of the family to advise of the plan developed. The plan was for the mother to live with her sister once she was released from the psychiatric facility. The grandparents stated they wanted their daughter to stay out of the home until she “*stabilizes or stays on her meds to manage her schizophrenic symptoms*” while they raised their granddaughters. The grandparents were to advise the family support worker if the mother returned home. The family support worker stated that band, grandparents and mother approved of this plan.

¹³ The timelines documented in ministry records with respect to the mother’s hospitalizations do not align with dates recorded in RCMP and hospital records. Since RCMP officers and medical personnel were directly involved with the mother during her hospitalizations and treatment, their records are taken to be more accurate with respect to describing these events.

- After this telephone call, the social worker consulted with an acting team leader about the plan. The grandparents and family support worker stated that the mother was in support of this plan. During this discussion it was revealed that the grandfather had “two unsecure rifles in the stair closet” that had previously been confiscated by RCMP officers. The RCMP were holding them until the grandfather purchased an approved locking cabinet.

The grandparents’ CPH application was approved as the worker and his supervisor determined there was no longer any evidence of risk in the home. The ministry After Hours program was informed of the assessment and the family’s plan. After Hours faxed the family support worker the documentation, stating that the grandparents’ application had been approved.

In contrast to ministry records, RCMP and hospital records show that on July 13, 2010, the mother’s behaviour escalated and both the RCMP and a community nurse were called to the grandparents’ home. The mother’s concerning behaviours included statements that she would kill herself and her daughter. When RCMP arrived, the children were not home, but instead at their aunt’s home in town. With the assistance of a community nurse, arrangements were made for RCMP to escort the mother and paramedics to the town hospital, where she could be assessed. The ministry was not notified of the mother’s statements.

After examining the mother, doctors declined to certify her under the *MH Act* and she returned home to her children and the grandparents.

Following a meeting between the community nurse and the grandparents on July 14, 2010, the nurse faxed a letter to the hospital Emergency Room physician stating that the mother:

“has become more bizarre with behaviours that are threatening to the parents and also their children (ages two and 14). Yesterday the children were left with the patient as the Grandparents needed a break and the children ultimately locked themselves in a bedroom to try to be as safe as possible. Very afraid of their mother. Patient isolates herself in her room – also afraid to go out in the local community. Only eats rice, has not eaten protein or fruits and vegetables for months. Has lost a lot of weight in the last year. Has obsessive/compulsive behaviour ... washes herself for hours – takes hour long baths. Sleeps during the day and is awake all night. Uses a scissor, cuts up clothing, towels, breaks dishes, screams and talks to herself (day and night). Parents are afraid she will harm them so they are also sleep deprived and anxious, while trying to look after the grandchildren. No help from the Child Protection Community, although they have spoken with various staff. Patient has verbally said, ‘I am being told to kill my daughter’, having auditory and visual hallucinations ... The aged parents and grandchildren are at risk and there is no mental health worker in the community. The parents are no longer able to have this person live with them – they have managed basically with no help for the last 15-20 years, but have come to the end of their coping abilities.”

The community nurse believed that the mother needed to be committed to a psychiatric unit for a comprehensive assessment as she was a danger to herself and others. When the Representative's investigators interviewed this nurse, she stated that the children witnessed their mother's violent outbursts at least five times a year and the family went through multiple sets of dishes over the years due to the mother breaking them during her outbursts.

While in hospital, the mother denied experiencing hallucinations. She also denied the information that had been faxed by the community nurse. Despite the collateral information provided, the attending physician did not find her certifiable under the *MH Act*. The mother was allowed to leave the hospital to return to her children and the grandparents, who were very upset that she had been released. The ministry was not advised of the mother's return to her parents and children.

The community nurse, Emergency Room nurse and a mental health worker worked collaboratively with the grandparents, RCMP and CRU staff to have the mother re-admitted to the town hospital.

As a result of these efforts, on July 16, 2010, the RCMP were again contacted to bring the mother to the hospital Emergency Room for evaluation. The mother was located at the grandparents' home, where the grandmother told an RCMP officer that the mother was threatening to kill herself and her two children. The officer transported the mother to the town hospital, where she was certified under the *MH Act* the following day. The hospital record indicates that a social worker confirmed prior incidents of RCMP responding to the home. There are no corresponding ministry records to verify any contact between the hospital and a ministry social worker.

Following certification under the *MH Act*, the mother was transferred by ambulance to the designated psychiatric facility where her certification and diagnosis of paranoid schizophrenia were confirmed. A consultation report written by the physician who confirmed the certification noted the concerns identified in the previously noted faxed letter written by the community nurse and made the following observations:

"... [The mother] has a previous diagnosis of psychosis NOS, has been off medication for the past 2 or 3 years and has been progressively deteriorating in the community over that period of time. She now presents with slowed thoughts, responding to internal stimuli, echolalia, laughing at nothing, hearing voices to kill her daughter, making threats to harm herself ... Family has been attempting to cope with this for many years, they are becoming progressively more frightened ..."

During her treatment, the mother was prescribed an antipsychotic injectable medication. The hospital psychiatrist requested that a referral be made to the health authority's Mental Health and Addictions program to have a case manager assigned. This referral was made to ensure the mother's compliance with medication upon her discharge on a leave authorization.¹⁴

¹⁴ A leave authorization means that the patient is still involuntarily admitted and is no longer staying in hospital but at another mental health facility in the community. This may be a "pass" to spend a weekend with family or live in the community with specific supports.

On July 20, 2010, a social worker with the psychiatric facility noted that a meeting with the ministry would be set up through the community nurse the following day to discuss guardianship of the children and whether the mother could return to the grandparents' home. There is no indication in ministry records to confirm the community nurse had contact with ministry staff.

On July 24, 2010, the mother walked away from the designated psychiatric facility despite being certified and detained under the *MH Act*. A warrant under the *MH Act* was issued and she was apprehended within 24 hours and returned to the psychiatric hospital.

A discharge plan, developed by the mother's care team, was to have the mother admitted to a psychiatric residential care facility in the town near her community. The mother's care team, which consisted of the psychiatrist and social worker from the psychiatric facility, and the newly assigned mental health worker, felt this was the best plan to support and stabilize the mother before releasing her back into the community.

The Representative's investigators could find no indication in medical records or ministry records that the specifics of the mother's hospitalization, assessments and certification were ever brought to the attention of, or requested by, the ministry.

Information gathered by the ministry social worker about the mother's status was obtained solely from the grandparents and band family support worker. The one exception was a call to the local RCMP detachment in June 2010 to inquire if there were any recent reports concerning the family.

The Representative's investigators learned in an interview with the grandparents that the ministry's requirement that the mother not live in their home was very painful for them. The family felt that they were forced to choose between their daughter and their grandchildren. Despite the challenges, they wanted their grandchildren to have a connection to their mother. The Representative's investigators also learned that the band family support worker shared the grandparents' sentiment that the children should be connected to their mother.

On July 30, 2010, the mother was moved from the designated psychiatric facility to the residential care facility under a leave authorization. She was re-referred to the outreach psychiatrist and a new family doctor. She had not seen a family physician in more than a year and had not seen the outreach psychiatrist since January 2008.

On Aug. 16, 2010, the mother met her mental health worker for the first time. In her progress notes, the mental health worker wrote that the mother "*showed very little insight into her illness.*" She also added: "*Writer doesn't believe that this client would be able to live on her own, her children will be taken from her parents if she returns home. The parents do not want her at home as they are unable to care for her and her children.*"

On Sept. 8, 2010, while still at the residential psychiatric facility, the mother was assessed by the outreach psychiatrist. The psychiatrist noted that her reasons for admission were her worsening schizophrenia and auditory hallucinations "*taking the form of a command to kill her children.*" He observed that, since her return to injectable medication, the

mother “*reported no command hallucinations to harm people, she does however hear voices telling her to break dishes and do other things, but she can resist them.*”

The psychiatrist wrote: “*The leave authorization did not stipulate where the mother needed to live ... Once the family ensures that the children are safe and not residing with her, it might be possible to live closer to her family.*” The outreach psychiatrist provided his consultation to the mother’s new family doctor.

The mother met with the family doctor on Sept. 28, 2010 and, contrary to the initial plan that she would live with her sister in town, she advised him that she was moving back to the reserve with her daughters. The family doctor recorded no concerns with this plan.

Two days later, on Sept. 30, 2010, the mother remained certified under the *MH Act* but was discharged and placed on a leave authorization from the residential psychiatric facility to live with her parents and her children on-reserve. The nurse at the residential facility provided written notification of the discharge to the mother’s doctor, pharmacy, mental health worker and Ministry of Employment and Income Assistance (MEIA) trustee. The mental health worker was to finalize the mother’s follow-up care. MCFD was never notified of the mother’s return to the family home.

On Dec. 9, 2010, the mental health worker accompanied the mother to her appointment with the outreach psychiatrist. During this visit, the psychiatrist noted that the mother “*has been doing very well on her injectable antipsychotic and her schizophrenia is in remission.*” He noted that she was periodically consuming excessive amounts of alcohol. The psychiatrist later told the Representative’s investigators that this would not have affected her antipsychotic medication but would have had a sedating effect.

The psychiatrist also noted during this visit that the mother would remain certified under the *MH Act* and was not suitable for voluntary treatment due to poor insight, alcohol use and high risk of deterioration. He scheduled her next appointment for six months in the future.

The grandparents, meanwhile, were continuing to have difficulty coping with their situation both financially and personally. In January 2011, the mother moved to her sister’s home in another town, although she would return to her parents’ home from time to time. The responsibility for supporting the mother was transferred to a mental health worker in the town where the mother now lived.

The Girl is Admitted to Hospital for Self-Harm

In February 2011, while on a school bus that was returning from a wrestling tournament in town, the girl cut her wrists. The bus driver took her to the hospital Emergency Room, where she was seen by a physician. The attending physician noted previous scarring and the girl’s new cuts required 20 stitches. He wrote his final diagnosis as “*Self mutilation Large Laceration.*” The physician requested a consult with a CRU nurse.¹⁵

¹⁵ The hospital did not have an adolescent Crisis Response Unit and relied on the adult CRU nurses for emergency assessments of individuals including youth in crisis.

Patient records for the assessment taken by the CRU nurse noted that the girl denied any plan or intention to take her own life. During this assessment, she said that it was difficult for her “*to talk to adults about things as they scare her.*” The girl said she was in conflict with her peers, including a romantic conflict with a boy she liked.

A ministry social worker who happened to be at the hospital at the time assisted the nurse during his assessment of the girl. The social worker advised the girl of a Child and Youth Mental Health (CYMH) clinician who could talk to her about alternatives to cutting. After the girl agreed to see the clinician, the social worker made a referral to the ministry’s CYMH program.

The grandparents were also present during the assessment after being notified of the incident. The girl agreed to a safety plan, which consisted simply of her promising not to harm herself again. She was then discharged to the care of her grandparents, who were advised by the social worker that another ministry worker would follow up with the family.

A “notepad” of the incident was created and entered on the ministry’s information management system for follow up. A notepad is a temporary record created to capture a report made to the ministry regarding a family’s need for services and the ministry’s response to the report. Once the information is entered on the system as a notepad, it is then forwarded for follow up to the appropriate supervisor and the social worker on the file.

If the notepad is not acted upon within 30 days, it is automatically deleted. This is what social workers refer to as a notepad “*falling off the system.*” If notepads are not printed, critical information regarding a family is lost and it is likely the family’s needs will go unaddressed in the face of other pressing intakes and investigations involving other families.

The information on the notepad included notes from the social worker who happened to be at the hospital. This worker completed a ministry prior contact check on the family, included this information on the notepad and advised another social worker and her team leader for follow up. The intake was coded as “*Offer Support Services.*” A hardcopy of the notepad was printed off, but it took nearly six weeks before the ministry protection team responded to this incident.

The grandparents attended a screening meeting with the CYMH clinician two days after the incident, but they did not bring their granddaughter with them even though ministry records indicated that the grandparents had agreed to do so. At the request of the grandparents, the CYMH clinician telephoned the Aboriginal Wellness clinician at a local Aboriginal Agency to make an urgent request for an appointment for the family. Included with the referral form to the Aboriginal clinician was the hospital record pertaining to the physician’s treatment of the child’s cuts and the nurse’s assessment.

On Feb. 18, 2011, the grandparents drove the girl and her sister to town to meet with the Aboriginal Wellness clinician. Following the completion of the consent for treatment, confidentiality and consent for release of information forms, the girl quietly told the clinician that she would talk more if her grandparents left the room.

During this one-on-one discussion, the girl said that she was having problems with her boyfriend, who she said was in a gang. According to clinician's notes, these problems upset the girl and caused her to cut herself with scissors. She also reported being bullied by a girl on the wrestling team, adding that her one friend would not stick up for her and the wrestling coach would not intervene. The girl stated that she was a loner.

The girl willingly showed the clinician the cuts she had inflicted on her arm just three days prior. She stated that she would not harm herself again because, according to the clinician's note, she was "*bored with it.*" The clinician's notes also mention that the girl's mother was unable to care for her and her little sister due to "*health problems,*" but there was no elaboration on those health problems.

When the clinician asked for a release of confidentiality to talk to others, the girl agreed only that her best friend with whom "*she talks to about everything in her life*" could be contacted. This friend was never contacted.

The session ended without a suicide risk assessment being conducted and with a loose agreement that subsequent sessions would occur when the grandparents could bring her to town, approximately every two weeks.

The Aboriginal Wellness clinician told the Representative's investigators that a comprehensive assessment would have begun when the girl attended her next appointment.

However, the family did not keep the next appointment scheduled for March 4, 2011, even though the clinician had called the day before to confirm. When the clinician followed up on the missed appointment, the grandmother advised that the girl had been playing in the school gym.

A subsequent appointment was scheduled for April 15, 2011, almost six weeks later. The Aboriginal Wellness clinician reported that the long delay was due to scheduling conflicts and spring break for students. Ultimately, the initial Feb. 18, 2011 session was the only one the girl had with the clinician.

On March 22, 2011, the grandmother contacted the ministry office to request respite services. Records state that the grandmother was "*caring for two grandchildren as their mother is struggling with schizophrenia.*" A social worker was directed to check the ministry's information management system for the family's history in order to assist the grandmother's request. However, there is no indication that this request was followed up by ministry staff.

At this time and in the year prior, the local ministry office was experiencing significant staffing challenges. Two staff members had been suspended and were eventually terminated. A significant amount of staff time had also been lost as a result of a number of staff going on various types of leave. There was no backfill for any of these absences.

In 2010, three social workers on the team had transferred, retired or resigned from their positions. Finding experienced staff has been a long-standing challenge in this area.

The ministry's child protection team responsible for serving the girl's community is tasked to serve multiple First Nations communities over a large geographic region extending hundreds of kilometres outside of town. The team was designed to have seven child protection workers and one team leader. From January to June 2011, this team was reduced to three protection workers – one of whom had less than one year at full child protection delegation and two new hires. At this time, the team leader had less than a year in the supervisory position.

In addition to instability at the front-line level, there was also instability at the management level. Prior to January 2011, the area had been managed by three Community Services Managers (CSM). After January, the management structure was reduced to one CSM who had only recently taken on the role. This new CSM was challenged with formidable staffing issues, re-organization and the recruitment and training of new staff.

With three child protection workers remaining, managing workload was a significant issue. The only fully delegated protection worker, who had less than one year at full delegation, was tasked with orienting one of the newly hired workers to the protection work and communities served. Child protection cases were managed through a triage process in which only the most concerning cases got the attention required. During this time, there were 63 child protection intakes outstanding in the team's catchment area.

Because the remaining delegated social worker had a caseload covering a large geographic area, and the workload was backlogged, her availability to support the new social worker was limited.

On March 29, 2011, one of the newly hired social workers, who had not been fully delegated to do child protection work, found a printed copy of the notepad regarding the child's Feb. 15, 2011 cutting incident. This partially delegated worker followed up on the incident and learned of the child being referred to the Aboriginal Wellness clinician.

The next day, this worker and the fully delegated social worker she was shadowing attended the band office in the girl's community to follow up on the incident. However, they were turned away as the two band family support workers were unavailable to assist due to a federal government audit that was underway. Local protocol did not permit ministry social workers to conduct work on-reserve without a band representative's presence or agreement to attend with band representation. In urgent child protection matters, the RCMP would be called upon to assist.

On April 4, 2011, the partially delegated worker followed up with the Aboriginal Wellness clinician, who advised of challenges in meeting with the family due to the family living on-reserve and the clinician having no budget to travel to the child's community.

On April 6, 2011, the partially delegated worker discussed her concerns with an experienced social worker who had been brought in temporarily to assist the relatively inexperienced staff. The partially delegated worker was instructed to re-enter the information back on the ministry's information management system and follow up with the family to see if any supports were needed.

Girl Alleges Sexual Assault by a Peer

The following day, on April 7, 2011, after an incident in which the girl punched a female peer at school, she disclosed to her teacher that she had been sexually assaulted by an older boy. She stated that she had been forced to perform oral sex on the boy on four separate occasions between October 2010 and April 2011.

The teacher gathered as much information from the girl as she could about the alleged sexual assaults and advised her that she would be required to notify social services in order to prevent this from happening again. The teacher also told the girl that, as a result of punching her classmate, she was suspended from school for two days.

The teacher had been acting as the school administrator that day and was in her first year of teaching in a community that was new to her. After consultation with the school principal, she reported the girl's disclosure to the ministry.

The partially delegated social worker gathered the information from the teacher and created a new intake. During this discussion, the teacher reported that *"the child seemed okay emotionally after the disclosure and indicated that this could be because [the child] is possibly FAS [fetal alcohol spectrum disorder (FASD)]."* The intake also stated that the grandparents were resistant to outside help due to the fear that their grandchildren would be taken away. The worker was also advised that a school counsellor was involved with the girl and working with her on anger issues.

After consulting with a senior social worker, the partially delegated worker was instructed to report the incident to the RCMP, follow their lead, and to contact the family to offer the girl support and referral to counselling or Victim Services. During this consultation, concern about the safety of the alleged perpetrator's younger sister (who had been punched by the girl who is the focus of this report) was expressed. The social worker advised the school principal that no one else should talk to the girl about the assault including the principal, teacher and counsellor, until the girl and alleged assaulter had been interviewed by the RCMP.

The following day, the partially delegated worker reported the incident to the RCMP. An officer who had been posted to the detachment three months earlier was assigned to investigate the sexual assault allegations.

The girl and her family were not informed of or prepared for the RCMP investigation that would follow. It appears that there was no discussion about having a support person for the girl during her interview with RCMP and there was no contact made with Victim Services. The partially delegated worker did, however, express concern for the alleged perpetrator's younger sister and the potential risk to which she might be exposed.

The RCMP officer first interviewed the girl's teacher, who discussed the girl's disclosure and struggles with her peers. During the interview, the teacher told the officer about the girl's difficulty with expressing herself. The teacher stated: *"I had to give her various options of ways to word things because I know she struggles with vocabulary to express herself. She is a student with FASD."* (The Representative's investigators found no evidence that the girl had FASD.)

On April 9, 2011, the young male RCMP officer attended the grandparents' home to request that the girl be brought into the RCMP detachment. There he took a video and audio statement from the girl. Her family did not learn what this interview was about until they were informed by the Representative's investigators.

The interview of the girl took place in a padded room located between two prison cells in the RCMP detachment. The room was primarily used for interviewing offenders and could be described as an intimidating environment. The officer conducted the interview alone with the girl, in his full uniform with his sidearm visible.

When the officer questioned the girl about whether the incidents were forced or consensual, and repeatedly emphasized that she tell the truth, she broke down crying and stated that she had not been forced. At the end of the interview, when the officer asked a final time about whether the incidents were forced or not, the girl replied, "*I wanted to, but it got all wrong ... it wasn't supposed to happen.*" The officer then concluded the interview.

The officer later consulted with his sergeant. They concluded that there was not enough evidence to support a charge. The officer told the Representative's investigators: "*I wasn't saying it didn't happen; but I think there wasn't enough evidence to support a charge.*"

On April 13, 2011, the partially delegated worker, her co-worker and the band family support worker attended the grandparents' home in an effort to interview the girl about her disclosure. The girl's mother answered the door and advised that her parents were not home.

The ministry workers left a business card with the mother, apparently unaware that she was not to be living in the grandparents' home or left alone with her children as a condition of the CPH funding. This lack of awareness is puzzling, as that information was included in the family's service file and therefore readily accessible to the social workers.

The mother was still certified under the *MH Act* and, according to health records, eight days overdue on taking her injectable medication. On April 14, 2011, a community nurse located the mother and administered the medication.

On April 15, 2011, the girl and her grandparents missed her scheduled appointment with the Aboriginal Wellness clinician, despite the clinician confirming the appointment with the grandparents three days earlier. The clinician was not made aware, by either the grandparents or the social worker, of the girl's recent allegation of sexual assault.

On April 26, 2011, the investigating RCMP officer requested the social worker to discuss the sexual assault disclosure with the girl and explore the truthfulness of her allegations.

The following day, the social worker returned a call to the school principal, who expressed concern that the girl was spiralling downhill, had been cutting her hands and had run away from school that day. The girl's grandfather had located her, but she would not return home with him.

On April 28, 2011, the RCMP officer interviewed the girl's cousin, to whom she had referred during her interview with the officer. The school principal and another officer were present. During this interview, the investigating officer asked the girl's cousin if she had "*disclosed to him that she was forced to give anyone, especially [the alleged perpetrator], oral sex.*" The child's cousin replied that he knew nothing about it.

The investigating officer closed the file stating: "*File is concluded due to the fact the alleged victim made a false allegation and she stated she wasn't forced to perform oral sex and there are no witnesses.*"

Following this, there was no further action taken by the RCMP in investigating the child's sexual assault allegations. The alleged perpetrator was never interviewed. The concern expressed by the social worker about the safety of the alleged perpetrator's sister was not investigated by either the ministry or the RCMP. Further, neither the girl's school counsellor nor the Aboriginal Wellness clinician was made aware of her disclosure.

On May 6, 2011, the partially delegated social worker met with the Aboriginal school counsellor, who had been working with the girl on a weekly basis since November 2010. According to ministry records, "*[the counsellor] is very worried that if [the child] felt suicidal ... [she] could complete suicide. [The child] needs mental health assessment.*" The counsellor told the social worker that she wanted to work with the family on the struggles the girl was coping with. The school counsellor said the same thing to the school principal. However, she was prevented from doing so by school administration due to her other ongoing responsibilities at the school.

Because of the girl's limited vocabulary, the counsellor, like the girl's teacher, had tried to communicate with her in different ways. According to the counsellor, the girl did not trust people, particularly because she felt no one listened to her. The counsellor learned that the girl was afraid when her grandparents left the home as "*people would try to do things to her.*" The girl would not elaborate and said she had confided in another adult, who did not believe her.

In response to the girl's cutting incident, a community member began working with the grandparents. This counsellor lived down the road from the grandparents' home – less than a five-minute walk. This community member told the Representative's investigators that she was instructed by the chief to work with the grandparents, but not with the girl because she did not have the qualifications to deal with suicidal behaviours. She also stated that while she was comfortable working with adults, she was not comfortable working with children.

On May 9, 2011, the partially delegated social worker followed up with the Aboriginal Wellness clinician, who reported that the girl had not attended any appointments beyond her initial visit even when the appointments were confirmed with the grandparents.

This discussion appears to be the last documented action taken in relation to the girl by either the partially delegated worker or the Aboriginal Wellness clinician before the girl's death. There is no indication that the two discussed the girl's potential for suicide or her urgent need for a mental health assessment as requested by the school counsellor.

During this period, the girl was having difficulties in relationships with two boys. One was a romantic relationship and the other was a close friend. Her peer group at school was described as a "*tough*" one and she was struggling to find her place.

Unknown to the family, the girl had posted messages on her social networking site about being upset over her former boyfriend and adding that she should die for her own good. The children's aunt disclosed to the Representative's investigators that the girl and her younger sister had spent the night at her house on May 21, 2011. According to the aunt, the girl broke down after logging off her social networking website. She sat at the kitchen table crying and asked her aunt what was wrong with her mom. The aunt felt that the child never fully understood her mother's condition.

On May 22, 2011, the girl was left to babysit her younger sister while her grandparents went to town. A community member saw the girl around 6 p.m. that evening. Her head was down. The community member stopped to check on her.

According to the community member, the girl disclosed being sad about everything, and that people, including her grandparents, thought she was crazy, that she was hurt, and that things had happened to her. When the girl was questioned about what had happened, she only repeated that things had happened to her.

Suspecting abuse of some kind, the community member told the girl that she had been sexually abused at a young age by an uncle and that her family refused to believe her. The girl began crying in response to the story. The community member encouraged her to tell someone if this was happening to her. The girl disclosed that she had repeatedly tried to tell someone, including her grandparents, but that nothing would change.

While not disclosing the details of what was happening to her, the girl told the community member that she wished it would just go away. The girl asked what the community member did to "*fix it*" in her own situation. The community member replied that she had struggled for years but eventually went to counselling, which helped her to heal. The girl was offered assistance in talking to her grandparents about what was going on, but they were not home.

The community member then offered to have the girl and her younger sister to her home for dinner until the grandparents returned but the girl declined, stating that she had to go home and prepare dinner for her younger sister. After a few more words, they parted ways.

Later that evening, the girl dropped her 3½-year-old sister at her great-aunt's home, about 50 metres from and within sight of the grandparents' home.

At about 11 p.m., the grandparents returned from town. When they parked their truck, they noticed a light on in the basement. They then heard music coming from a cell phone in the front yard. The family dog was barking uncontrollably.

When the grandfather went outside, he saw his granddaughter hanging from a tree in the yard. The grandmother called 911. The grandfather reported that the girl's body was still warm and he could hear her breathing. He was instructed to cut the rope and begin performing CPR.

When RCMP and paramedics arrived on the scene, they continued CPR but the girl was unresponsive. She was pronounced dead on the way to the hospital.

After the Child's Death

RCMP provided the grandparents with contact information for Victim Services. Officers were instructed by their sergeant to *“take statements where possible and speak to other persons who may have information to determine the death was not suspicious and help determine why the deceased took her own life.”*

In the course of their investigation, an anonymous witness reported to the RCMP that the girl had been sexually abused by a man who had recently passed away.

When RCMP looked into the girl's social networking website, they found posts about her being depressed and suicidal. The girl's last post was made the day she died. In the post she stated that she was sad about the passing of an elderly man.

In the girl's room, RCMP officers found a prescription dated May 21, 2011 for Amoxicillin to treat her tooth infection. The officer also found a dental assessment for more than \$1,000 worth of orthodontic work including surgery that was required and a pamphlet outlining payment plans.

The RCMP investigation did not determine who was the last person to see the girl alive. In the end, the RCMP concluded that there was no crime committed as the girl died by suicide.

In cooperation with the RCMP, the coroner's investigation began during the early hours of May 23, 2011. By mid-morning, the coroner had decided not to pursue either a toxicology screen or an autopsy.

During the investigations, the coroner considered the girl's history of self-harm, peer pressure, bullying and her sexual assault allegation. The coroner worked on the investigation for the remainder of the week before turning it over to the regional coroner's office because he was retiring at the end of that week.

The coroner's investigation remained dormant for more than a year. It was completed on June 29, 2012. The final coroner's report concluded that the girl's death was a suicide and made no recommendations.

On May 24, 2011, the partially delegated social worker was advised of the girl's death. She met with her team leader and regional manager to discuss a community plan in the wake of the tragedy.

On May 25, a healing circle was organized in the girl's community. Many professionals and adults attended as well as several of the girl's friends. Healing circles were also organized at the local schools that day.

On this date, the Director of Child Welfare was notified of the girl's suicide. In this notification, the plan of action by the social workers was to connect with the family to suggest a referral to CYMH services for the girl's younger sister. However, the Representative's investigators could find no evidence that such a referral was made.

On June 9, 2011, the partially delegated worker documented a discussion with a family member that the younger sister had witnessed her sister's suicide.

An email on June 28, 2011 from the regional practice analyst confirmed the ministry's decision to not proceed with a case review that would look more in-depth into the circumstances surrounding the girl's death. Such reviews are considered when a child and his or her family were receiving services from the ministry in the year prior to the incident. The ministry determined that the girl's death did not meet the criteria for a case review for the following reasons:

- *"It was not a sudden infant death*
- *It was a death by suicide but did not have ongoing active CYMH involvement (only two appointments were kept)*
- *There is no offender in this case, such as a parent or any alternative caregiver*
- *Youth was not in a custody centre or full time Youth Justice program*
- *There does not appear to be any policy or practice that led to this outcome."*

In this same email, the lack of available funds for the LAA's Aboriginal Wellness clinicians to travel to the communities they served was noted as an outstanding systemic issue.

On May 8, 2012, almost a full year after the girl's death, the mother's mental health worker made a referral to Aboriginal Wellness services for the younger sister, writing *"sister committed suicide last year, lives with mother who has schizophrenia."* The referral was made to the same Aboriginal Wellness clinician who had met with the girl on Feb. 18, 2011. The clinician declined the referral as she understood there was no apparent mental health concern.

Analysis

Overall Finding: *This girl was at significant risk of emotional and physical harm throughout her life because of her mother's volatile behaviour and mental illness. But, in effect, there was no functioning child welfare system to ensure the safety and protection to which this girl was entitled. There was also effectively no system of mental health services and supports for her, despite the significant trauma and behaviour problems she experienced over the years. Her complex special needs added to her burden of trauma, and she did not have the benefit of a full assessment or interventions to meet her developmental and educational needs. Had appropriate supports and services been made available to this girl and her family, it is very probable that she would have been more resilient in the face of her life circumstances.*

The ministry did not meet its obligation to protect this girl from physical and emotional harm. The ministry and numerous other service providers effectively left the responsibility of protecting the girl and her younger sister to the grandparents, who felt that they were being forced to choose between their grandchildren and their daughter.

The girl endured hardships well beyond what any child should have to experience. Near the end of her life, it was clear she felt unsafe. With her cries for help unanswered, she lost hope that circumstances would change. Two weeks before her 15th birthday, she took her own life.

The girl's developmental delays directly affected her ability to learn, communicate and understand. The reasons for these delays were never investigated, nor did she receive CYSN services. She was raised in an unpredictable environment and with a mother whose mental illness could create chaos and physical threats in the home. The girl struggled to understand her mother's mental illness and had to protect herself and her younger sister from their mother's erratic and sometimes violent behaviours.

In addition, the girl encountered even more troubling and unsafe experiences, particularly during the last three years of her life. She was bullied by peers, had relationship conflicts, was teased about her mother's condition and was exposed to lateral violence¹⁶ and abuse outside the family home. In addition to her disclosure that she had been sexually assaulted by one of her peers, there are strong indicators that she was being sexually abused by an adult. As one school staff member stated: "*The fear in that young girl was incredible. She was just very afraid to say too much. She didn't give me names.*"

The grandparents, with whom the girl spent most of her life, had a deep mistrust of the ministry and were very resistant to services that could have supported her. This mistrust was rooted in the traumatic experience of having some of their own children taken away to attend residential school decades earlier.

¹⁶ According to Wesley-Esquimaux & Smolewsky, lateral violence is one of the pathological expressions of historical trauma in relation to a long history of colonization and internalized oppression and is prevalent in many First Nations communities. It can take the form of gossiping, shaming, humiliating, bullying and socially excluding others.

The experiences of the girl and her family were by no means unique in their small community. Other families and individuals were affected by sexual abuse, pervasive poverty, violence, intimidation, feelings of hopelessness, lack of opportunities, mental health challenges and a strong mistrust of outsiders. Inter-generational impacts of the residential school system were pervasive.

The location of the community made service delivery and communication even more challenging. Despite this, the medical professionals involved with the mother were well aware of the chaos that the mother's mental illness created in the family home. The voices she heard telling her to harm her eldest daughter were well documented and so were the family's struggles in coping with her condition.

Despite these clear risk factors, doctors and nurses who had ongoing contact with the mother and her family consistently failed to report child safety issues to the ministry.

One community nurse interviewed by the Representative's investigators attributed her failure to report to past experiences with the ministry, during which she believed the response had been inadequate. She also cited the risk of retaliation from other members of the community, something she had personally witnessed when others had come forward to report abuse.

From 2008 to 2011, the ministry office in the nearest town was in a constant state of disarray. The child protection team mandated to provide services under the *CFCS Act* struggled with delivering services due to near debilitating fluctuations in staffing levels, a "*dysfunctional work environment*," staff burn-out, the under-resourcing of services intended to be provided over a large geographic service area, and staff absences due to stress, illness and disciplinary action.

From October 2008 to May 2011, there were six intakes regarding the girl who is the focus of this report and her family. Ministry intervention did not address the girl's need for protection from physical and emotional harm. Ineffective safety planning continuously placed the onus to protect the child on the grandparents despite the ministry's legal obligation to protect when there were s. 13 concerns.

Compounding the inadequate response was the failure to accurately characterize child protection reports. Two of the intakes should have been fully investigated, but instead the ministry coded the intakes as a "Request for Support Services," which led to a less rigorous response and effectively left the child without help.

When reports were investigated, the ministry neglected to gather collateral information from medical professionals involved with the mother. This critical information was relevant to understanding family functioning and the impacts the mother's mental illness had on the girl and her younger sister's safety and well-being.

When the girl was referred to CYMH services as a result of her self-harming behaviours, she did not receive the suicide risk assessment she so desperately needed. The girl's Aboriginal Wellness clinician worked part-time for a LAA that served her community in addition to 14 other surrounding First Nations communities spread over a vast geographic service area. A lack of financial and human resources limited the agency in providing adequate services.

It was the girl's school counsellor who could clearly see her downward spiral and recognized the very real risk of suicide, but the counsellor's clear and urgent observations failed to galvanize the ministry and others into taking immediate and effective action.

As the life of this girl and her family has shown, access to the appropriate and necessary supports and services was a challenge and the focus was not on the child. This situation is not unique. First Nations people in Canada frequently face significant barriers to appropriate services due to inconsistent availability of the services, financial barriers, non-financial barriers to presentation of need (e.g. linguistic barriers), and equitable quality of care.¹⁷

Child Protection Services

Finding: Ministry social workers repeatedly failed to provide adequate child protection services in line with the ministry's own practice standards and left the girl in situations where she experienced long-term emotional and physical abuse. Inadequate assessments of risk, compounded by an over-reliance on the grandparents to provide protection for the girl and her younger sister, resulted in ministry staff failing to meet their primary responsibility – protecting the child from harm.

Investigations to assess the risks posed to this girl's physical and emotional well-being were not sufficiently comprehensive and did not occur within the timeframes prescribed in policy. During the last three years of the girl's life, Comprehensive Risk Assessments and risk-reduction plans were never completed because poorly conducted investigations concluded that the girl was not in need of protection despite clear evidence of physical and emotional harm.

Ministry social workers failed to recognize the potential risks to the girl in October 2008 when they opened their second intake for the child after receiving a report from an RCMP officer about cuts on her arm. The girl was 12-years-old at the time. Initially, she reported to her grandparents and a community nurse that her mother had inflicted the injuries. But when questioned by an officer, the girl retracted her statements, stating instead that the cuts were self-inflicted and that she was trying to get her mother in trouble because they had not been getting along.

The social worker who created the intake coded it as a "Request for Family Support Services." An RCMP officer reported child safety concerns. It is unclear why this did not prompt the social worker to code the intake as an "Investigation," which would have resulted in a more urgent and thorough assessment of the girl's circumstances.

The initial report by the RCMP officer identified a number of risk factors which required follow up. It was clear from the report that the girl was in conflict with her mother and that there was considerable instability in the home. In addition, there was no clarity around who had custody of the girl, the involvement of the mother's boyfriend and the status of the biological father. These concerns should have prompted a more rigorous assessment.

¹⁷ Bowen, S. (2000). Access to health services for underserved populations in Canada. In certain circumstances: Issues in equity and responsiveness in access to health care in Canada. A collection of papers and reports prepared for Health Canada. Ottawa, ON: Health Canada.

Had the intake been properly coded as an “Investigation,” the social worker would have been required to apply the Risk Assessment Model¹⁸ to assess the priority level for intervention and act promptly based on the results of that assessment.

Additional information was gathered when the social worker contacted a band worker to discuss the concerns, but the social worker failed to fully explore the family’s circumstances. The band manager made reference to the mother’s mental health challenges, but the social worker did not seek clarification. A more thorough discussion about the mother’s mental health challenges may have brought to light the specific nature of the mental health concern, what treatment, if any, the mother was receiving, and a better understanding of what impact it was having on the girl and her family.

The social worker also learned from the band manager that the mother had a younger daughter and that the grandparents were the primary caregivers as the mother was unable to adequately care for her children. The social worker did not explore the mother’s capacity to parent or how the grandparents were coping with raising two grandchildren while living with a daughter who had a significant mental illness.

Another and potentially more serious consequence of not coding the response as an investigation was that, although s. 96(1) enables a social worker to request information from a public body when it “*is necessary to enable the director to exercise his or her powers or perform his or her duties or functions under this Act,*” this section would not normally be used in non-protection cases.

Medical records would have contained information about the mother’s certification under the *MH Act* only 10 months earlier, which involved circumstances of her children witnessing their mother’s bizarre and threatening behaviours. Had social workers contacted the community nurse, they would also have learned that the mother had threatened the girl with a knife three months earlier.

In this case, it was an RCMP officer who had interviewed the girl, but ministry protection workers did not. While it is entirely appropriate for the ministry to consult with the RCMP concerning their interview, and while the case was more complicated because the girl had recanted her allegations of abuse, the ministry was still required to form its own independent judgement, particularly given the different standards applied in criminal and child protection investigations. In addition to investigating the allegations, the girl would have required considerable support from the ministry regardless of whether or not her allegations proceeded to charges.

In these circumstances, the girl should have been interviewed directly by the ministry. While doing so was undoubtedly hindered by the band’s refusal to allow the ministry on the reserve at the time, the ministry could have seen the girl at school. The social worker’s discussion with the RCMP about the girl also failed to elicit the information that the girl and her younger sister had been returned to their grandparents’ home by RCMP officers the previous weekend after the mother took them to a hotel where the mother’s boyfriend was staying.

¹⁸ The Risk Assessment Model for Child Protection in BC

When the social worker made contact with the grandmother nine days after the initial report was made, the grandmother declined the offer to connect the girl to a counsellor. The grandparents' reluctance to engage in services should have elevated concerns about the girl. Instead, the social worker and supervisor closed the intake a month later.

The third report to the ministry was made in the early hours of July 12, 2009, once again by an RCMP officer. The children were locked out of the house after the mother had a violent outburst and threw a TV remote control at the girl. The children were taken to a neighbour's for the evening as the grandparents were not home. The officer reported that the mother had mental health issues and she was taken to the town hospital for an assessment. This time, the ministry intake was correctly coded as an "Investigation."

When an investigation is determined to be the most appropriate action to address concerns regarding physical harm or likelihood of harm by a parent, ministry standards require completion of the investigation within 30 days. In this case, the investigation was drawn out over a five-month period, during which interventions and actions were minimal and inadequate to address the needs of the girl and her younger sister.

Two days after this report was made, the assigned social worker phoned the band manager, who advised that the mother had schizophrenia and the grandparents were "*aware they must not leave [the mother] alone with her children ...*" It was agreed that the band would "*monitor*" the home until the ministry could meet with the family. The meeting with the family did not take place until Sept. 10, 2009, two months after the initial report.

The discussion with the band manager provided the first clear indication to the ministry that the grandparents were struggling with managing their daughter's behaviour and monitoring her interactions with her children. While the band manager agreed to monitor the family's situation, how this would actually occur was not planned.

A subsequent report was made to the ministry's After Hours two weeks later. A hospital nurse reported that the mother had hitchhiked to the town hospital with her children and was subsequently certified and detained under the *MH Act*. The actions and interventions of the on-call social worker were documented on the ministry's After Hours system and an action alert was sent to the social worker assigned to the July 12 intake and his supervisor for follow up.

This is the only documented contact between the health care system and the ministry with respect to the risk the mother's mental illness posed to the safety of her children.

While the immediate safety of the children was addressed by the on-call social worker, there was no investigation or follow up to this incident by the responsible ministry worker and his supervisor.

In response to this incident, a new intake should have been opened. If legislation and standards had been followed, this would have led to an investigation since the children's safety had been placed at risk, the mother had been detained under the *MH Act* and the grandparents could not be located.

Reliance on the band to monitor the home also clearly proved inadequate. When the Representative's investigators interviewed a band family support worker and inquired about her ability to work with families and monitor homes, she responded:

"There's not really a whole lot of time for the families that are dealing with the [ministry]. We probably deal with them maybe once or twice a month ..."

The ability of the band's two family support workers to adequately monitor the home was limited because their primary responsibility was administering income assistance to clients and responding to the reporting requirements of the federal government.

Despite the mother's recent certification under the *MH Act*, the social worker did not meet with the family until two months after the July 12 report was made. The outcome of this meeting did not improve the circumstances for the girl and her younger sister.

During this meeting with the family on Sept. 10, 2009, for which the girl was not present, the mother admitted to throwing the remote control at her daughter, becoming frustrated when her daughter would not listen to her, and not taking her medications.

In response to this, the resulting safety plan was simply a verbal agreement from the grandparents that the mother was not to be left alone with the children.

The girl was not interviewed until 4½ months later. The social worker assessed her as being "*street savvy*" about her mother's illness and how to respond to the mother's violent outbursts. The girl stated she would call the RCMP and take herself and her sister to the neighbours if she felt threatened again. That the girl demonstrated apparent "*street savvy*" in how to respond to her mother's outbursts should have been an indication to the social worker that she had been faced with these threats in the past. This should have prompted a more assertive approach by the social worker to address the girl's safety.

The issue of the emotional impacts on the girl of growing up with a parent with largely untreated mental illness remained unconsidered. Had the social worker looked into her behaviour at school, significant psycho-educational markers would have been apparent, including the girl's developmental delays and multiple suspensions for aggressive behaviours.

Following a consultation with the team leader, the responsibility for protecting the children was left with the grandparents, who did not understand their daughter's mental illness or the long-term effects this was having on the children.

Ministry standards regarding informal kinship care arrangements were not followed. Ministry workers never made efforts to involve the mother in discussions regarding long-term plans for her children, including custody arrangements. Ministry workers shifted child protection responsibilities onto the grandparents with no assessment of their skills or capacity to parent or protect.

While it was not technically an "out-of-care living arrangement" since the mother was living in the home, it was clear that she was not able to properly care for her children and that the grandparents required support to ensure the living arrangement was a safe environment for the child and her younger sister.

CFS Standard 8: Informal Kinship Care states: If a parent is unable to care for a child, give priority to supporting a safe alternative living arrangement with a relative or person who is known to the child or who has a cultural or traditional responsibility to the child, which:

- *encourages the parent's involvement in decision making and planning to the greatest extent possible*
- *supports the care provider in caring for the child, and in supporting the child in maintaining his or her relationships with siblings and family, and*
- *continues until the child returns home or an alternative living arrangement is made that achieves continuity of lifelong relationships.*

The standard goes on to state:

Assisting a parent in selecting a care provider

When an out-of-care living arrangement is proposed for a child, assist the parent in selecting a person who can safely care for the child. This includes helping the parent to:

- *gather relevant information to determine the ability of a proposed care provider to safely care for the child*
- *identify the potential strengths and weaknesses of a proposed care provider, and*
- *identify any supports required to ensure the success of the living arrangement.*

CFS Standard 16, Conducting a Child Protection Investigation, states that social workers are to “*obtain and consider relevant background information about the child and his or her family.*” While collateral information was obtained from the RCMP officer, the school secretary, family and band workers, critical information regarding the mother’s mental illness and the behaviours associated with it was never obtained from health care professionals.

When the Representative’s investigators asked the supervisor if it was common practice to gather collateral information from health care professionals when there is evidence that a parent’s mental illness is impacting the safety of the children, the supervisor stated: “... *I don’t think that is common practice.*”

By this point, health care professionals had a long-standing history of working with the mother. Had contact been made, the ministry would have been better positioned to make a thorough assessment of the level of risk within the family.

Limited contact with collateral sources of information was previously identified as a key issue in the Representative’s report *Isolated and Invisible* (June 2011):

“The assessment of risk of harm to the child was flawed as it did not include contact with important collateral sources, with the exception of contact initiated by the school. These collateral sources could have provided valuable information about this family’s circumstances ... If collateral contacts had occurred with relevant medical professionals it would have become immediately evident that [the child and her mother] had numerous health issues with no plans in place to manage an increasingly fragile situation.”

That report urged the ministry to “*develop and implement policy and guidelines with respect to checking with collateral sources of information when conducting child protection investigations.*” The intent behind this recommendation was to ensure that front-line workers gathered information from an array of non-professionals and professionals involved with a child and his or her family to gain a better understanding of family functioning and establish a more robust assessment of risk.

The regional manager was interviewed by the Representative’s investigators and asked about the basic expectation of social workers to gather collateral information on a family in a situation similar to the one that confronted this family:

“I guess it depends on what the situation is presenting ... if we were trying to assess if the parent could parent, then I assume that we would talk to somebody ... who was providing services to her ... if there was a mental health provider or maybe her physician ... [but] we probably wouldn’t have connected the dots. We should, but I don’t think we would have.”

It is apparent that the failure to obtain adequate collateral information was a systemic issue. An assessment of risk during an investigation cannot be fully established without all relevant information. Inadequate collateral checks repeatedly placed the girl at risk throughout the ministry’s involvement.

On Dec. 15, 2009, the ministry completed its investigation concluding that there was “*no evidence of physical harm or likelihood.*” Inexplicably, though, it also stated in the summary that the allegations were substantiated and the mother was at the time non-compliant with her medication. It is difficult to understand how the child protection concerns could be considered resolved in light of these factors.

Three days after the last investigation was signed off and considered resolved, the girl – at this point 13-years-old – again phoned RCMP because of a violent outburst by her mother.

When RCMP officers attended the home on Dec. 18, 2009, they found evidence of a fight in the home. The mother had thrown things around the house and had thrown a glass at the girl. The girl told the RCMP officers that she was scared to stay with her mother and that if the officers left she was scared that her mother was going to hurt her and her younger sister. The girl also disclosed two additional incidents of assault.

When the RCMP officer reported the incident to the ministry, it should have been obvious by this point that the safety plan, which put the onus for protecting the children on the grandparents, was not working.

This third intake was correctly coded as a child protection investigation with a priority level of “Dangerous.” Despite this, the investigation was poorly conducted and was dragged out for months.

The Dec. 22 meeting between the social worker and the family took place prematurely. It should not have occurred until the social worker had conducted his investigation, including

interviewing the children and gathering relevant collateral information from the RCMP and the mother's medical team. Had he gathered this information, he would have been better informed to discuss the appropriate supports and intervention needed. Although the girl was present for this meeting, the social worker did not take the opportunity to attempt to interview her.

Following this meeting, no further action was taken until almost two weeks after the new year, at which point the social worker's "*immediate safety assessment*" was completed. It did not accurately reflect all of the information provided to him, including only the mother's diagnosis of schizophrenia and her refusal to take her medications. It did not account for the girl's traumatic experience during the most recent incident. Nor did it account for the two new incidents of assault the girl had disclosed to the RCMP officer.

The investigation, in which the circumstances had initially been deemed "Dangerous," resulted in an informal agreement on respite care for the children as the appropriate response to the child safety concerns. Factors that would draw the grandparents out of the home (e.g. appointments, shopping, other commitments) leaving the children and their mother alone together were not considered.

During this investigation, neither of the two children received a medical exam, which is prescribed practice when investigating child abuse. The younger sister was just over two-years-old. Standard 16 states: "*Further to the minimum requirements for conducting an investigation as described in this standard, arrange for a medical examination of the child as required according to the child's circumstances (e.g. when the child may have been physically harmed or sexually abused).*"

While the investigation was initially concluded and signed off by the team leader within 30 days as required by standards, the social worker concluded with a finding of "No Evidence of Neglect by Parent with Physical Harm." That finding failed to address the emotional impact of the mother's outburst on the girl, or the risk of future physical harm given the mother's behaviour. The family service file was kept open to offer support services only in the form of respite, which was provided for one month.

This child protection worker was terminated with cause in the summer of 2010. A second child protection worker on the same team was also terminated with cause.

For technical reasons, the intake regarding the Dec. 15, 2009 incident was not closed on the ministry information system and, as a result, remained open, in error, for several months. The intake was later assigned for follow up to the social worker who had worked with the family on the previous intake of July 12, 2009.

On April 28, 2010, the fifth intake was opened by the ministry's After Hours to process the grandparents' application for CPH funding. The application was declined due to the risk posed to the children with the mother living in the home. Consultation with the team leader resulted in direction for the social worker to assess the risk and discuss with the family the possibility of the mother moving out of the grandparents' home.

By this point, there were two intakes open – one to process the Copenhag application and one from the Dec. 15, 2009 investigation, which had remained open on the ministry's information management system. The social worker was now responding to the concerns of both intakes.

The period between April 28, 2010 and July 30, 2010 was a critical one. The ministry's After Hours had clearly identified the risk to the children as long as the mother remained in the home and was non-compliant with her medication, yet the local ministry office failed to act.

Throughout this period, the social worker was repeatedly advised that the mother was still in the home and not taking her medications. The risk posed to the children and need for further intervention should have been obvious.

On June 18, 2010, the social worker visited the family and learned that the mother had been hospitalized but that she could not be detained as she had been admitted voluntarily. She remained non-compliant with her medications.

The Dec. 15, 2009 investigation was concluded on June 24, 2010. The ministry's findings were "No Evidence of Physical Harm or Likelihood" and "No Evidence of Neglect by Parent with Physical Harm." The girl was found not to be in need of protection. In the closing summary, the social worker noted: "*Children can never be left alone with their mother for even short periods of time as she refuses her meds.*" The ministry relied on the band to monitor the home and notified the RCMP that the mother was not to be alone with the children. This plan showed no understanding of the reality of the situation and the lack of capacity available on the reserve to effectively supervise such a high-risk scenario.

On May 13, 2010, the social worker learned the mother continued to be non-compliant with her medications. Although this information should have prompted the social worker to intervene to mitigate the risk posed to the children, no action was taken.

In early July, the social worker learned that the mother had been at the centre of an incident the previous night. Her behaviours had escalated to the point of requiring RCMP intervention and resulted in hospitalization for an assessment of her mental health. As the mother was not certified under the *MH Act*, she returned home the following day.

By her second day back in the grandparents' home, the mother's mental health had again deteriorated to the point where she was certified under the *MH Act* and taken to a designated psychiatric facility. Reference to this in the social worker's intake report is scant and did not accurately capture the medical and RCMP intervention that occurred to have the mother certified.

The plan for the mother's release was for her to move in with her sister and continue treatment. This would remove the barrier to Copenhag funding, which was her continued presence in the grandparents' home. With that plan in place, the Copenhag application was finally approved and the intake closed at the end of July 2010.

However, the plan never came to fruition. The mother never resided with her sister and, by the end of September 2010, she was back in the home with her parents and children. Although residents of the reserve were aware of her presence, the ministry was never notified and had no contact with the family again until the girl cut her wrist in February 2011.

In February 2011, when the girl was taken to the hospital Emergency unit, a social worker responsible for a different geographic area happened to be there and was notified by hospital staff. This worker responded immediately and referred the girl to a CYMH clinician, who then referred the family to an Aboriginal Wellness clinician at the request of the grandparents.

In addition to the referral to CYMH services, the ministry social worker at the hospital advised the supervisor of the responsible team and its only fully delegated social worker about the girl's recent self-harming incident. A notepad of the incident was loaded on the ministry's information system for follow up by the social worker and her supervisor.

The notepad created in response to the girl's self-harming incident was printed, but it was nearly six weeks before further action was taken. According to *CFS Standard 16*, intakes should be concluded within 30 days. However, with the child protection team down to one fully delegated protection worker and two partially delegated and inexperienced protection workers – all of them overwhelmed by the workload and travel time required to follow up on incidents – this timeline was not met.

Near the end of March 2011, more than a month after the girl cut herself, the partially delegated worker came across the printed-out notepad. After consultation with her supervisor, the worker was instructed to reload the intake on the ministry's information system and follow up on the incident.

Another standard not met was the requirement of the social workers to “*immediately inform the designated director*” when there is a critical injury to a child. The ministry's *CFS Standard 25* requires that deaths, critical injuries and serious incidents of a child who is receiving services or had received services under the *CFCS Act* in the 12 months prior to the incident be reported immediately to a designated director. This standard “*provides opportunities to objectively review [the incident], receive feedback and learn from these incidents. It also provides opportunities for the designated director to support individuals, including staff, who are affected by these events.*” This is part of a quality assurance process and an opportunity for learning that can lead to improvements in the child serving system.

The ministry is required to submit these reports to the Representative for review as set out in s. 11(1) of the *RCY Act* for the purpose of ensuring public accountability and transparency about government services to vulnerable children and youth. No report was submitted to the Representative. Neither was a report submitted when the child alleged being sexually assaulted in April 2011.

When the Representative's investigators inquired about the notepad "*falling off the system*," the social worker replied: "*Unfortunately, I think that happened quite frequently in the ministry office ... there was an intake that was found in the last year that was back from 2006. [The printout] was in somebody's drawer that had left years and years previous. So it's not good but things happen like that, unfortunately.*"

When the two social workers visited the girl's community on March 30, 2011, they were unable to meet with her. When the social workers reported to the band office to seek support in attending the child's home, they were denied assistance because the band family support workers were busy with a federal government audit.

By April 2011, the partially delegated social worker was still attempting to resolve concerns regarding the girl's Feb. 15, 2011 cutting incident. The social worker had followed up with both clinicians and learned from the Aboriginal Wellness clinician that the girl had attended one appointment, on Feb. 18, 2011, and that a subsequent appointment had been missed. This failure to attend scheduled appointments should have elevated the social worker's level of concern.

Both the social worker and the CYMH clinician had open files concerning the girl and both were unable to fully engage her or her grandparents. The social worker stated that she asked the Aboriginal Wellness clinician to travel out to the community to visit the girl, but the clinician advised that it wasn't possible to do such outreach due to a restricted travel budget and challenges with scheduling appointments.

A more collaborative approach was needed, one aimed at identifying risk factors and strategizing on a joint plan to help the girl, mitigate the risks and explore natural supports in the community.

One of the obvious sources of potentially valuable information was the girl's school counsellor, who had developed a trusting relationship with her. A call to the girl's school could have informed social workers about the counsellor's involvement, and the counsellor could have been asked to assist the Aboriginal Wellness clinician and social worker in connecting with the girl to follow up with the concerns identified. Unfortunately, this opportunity was not explored by either the partially delegated social worker or the Aboriginal Wellness clinician.

According to the partially delegated social worker, the ministry's inadequate response to the girl's cutting incident was because there was no real case management going on for the first six weeks after the intake was opened on Feb. 15, 2011. While the intake was initially to be assigned to the only fully delegated social worker, she was unable to respond due to other pressing responsibilities. When the partially delegated worker began taking action on the file, another new protection report concerning the child was received. Subsequent ministry actions and interventions were documented on this new intake.

A seventh and final report to the ministry, made April 7, 2011, was received when the girl alleged she was the victim of a number of sexual assaults at the hands of a male schoolmate.

Direction on how social workers are to respond to child protection reports is provided by the ministry's *CFS Standard 12: Assessing a Child Protection Report and Determining the Most Appropriate Response*, which states:

“Assess every report received about a child’s need for protection, and determine the most appropriate response within five calendar days of receiving the report.

Appropriate responses include:

- *taking no further action*
- *referring the family to informal and formal support services*
- *providing a family development response*
- *if the child is a youth, providing a youth service response; or*
- *conducting a child protection investigation.”*

The report was coded a “Request for Family Support Services.” Similar to a previous intake, the coding did not reflect the severity of the circumstances. The information included in the report noted the following:

- A male classmate forced the child to perform oral sex on him on four occasions throughout the school year;
- The child had punched the younger sister of the alleged perpetrator after being shoulder-checked by the sister;
- The girl was suspended from school for punching the sister;
- The girl disclosed the assault to her on-again/off-again boyfriend;
- The girl possibly had FASD; and
- The school counsellor had been working with the girl on anger issues.

The only appropriate response to this information would have been to conduct a full child protection investigation, particularly because the nature of the concern was sexual abuse of a child and the possibility existed that the younger sister of the alleged perpetrator was also at risk.

The concern about the younger sister was raised by a senior social worker, who had been seconded to support the area's depleted child protection team. When the partially delegated social worker later followed up on these concerns, she concluded that the younger sister was safe in the home. Her assumption was based solely on a phone conversation she had with the band manager, who stated that the girl's safety was not at risk as there were “*always people around.*” The social worker further stated that the RCMP officer's conclusion that the evidence was insufficient to support charges of sexual assault ultimately reinforced her decision to take no further action.

The consultant advised the partially delegated worker: “*Depending on grandparents’ response to [the child’s] disclosure, offer support and refer to counselling/Victim Services.*”

There was no discussion about ensuring that the girl or her grandparents were prepared for the involvement of RCMP. The girl was not aware that RCMP would investigate her allegations and that she would provide a statement about the alleged sexual assaults at the local detachment without any support. The grandparents told the Representative's investigators that they were never informed that the child had disclosed being sexually assaulted by a schoolmate. How could the grandparents be expected to support and protect their grandchild if they were not made aware of the potential risks to her safety?

The day the report was made, the partially delegated social worker phoned the school principal. During this discussion, the social worker advised the principal that no one – including the girl's school counsellor, the principal or the teacher she disclosed to – should speak to the child about the assaults until after the RCMP had a chance to interview her. This direction further isolated the girl from emotional support in the wake of these traumatic allegations.

The following day, the social worker reported the incident to the RCMP. The social worker noted in her report that the RCMP did not request assistance with the pending interview of the girl. The protection report also noted the possibility that the girl could have been affected by FASD. There were no steps taken to assess this possibility. This was unfortunate because this condition may significantly impact children developmentally and intellectually, increasing their vulnerability and decreasing their coping abilities. The need to explore a child's developmental level before an interview with that child occurs is set out in the ministry's *CFS Standard 16*. This information could have been obtained from the teacher, the principal or the school counsellor.

The girl went through the RCMP interview with no support person present and her intellectual limitations unrecognized. The investigating officer did not believe her disclosure was sufficient to support a criminal charge.

After the interview, the officer asked the social worker to further explore with the girl the truthfulness of her statement. The social worker made two attempts – by phone and in-person – to connect with the family to set up a meeting with the girl, but these efforts were unsuccessful.

On April 27, 2011, when the social worker and principal discussed the child's situation, the social worker learned that the child had gone missing from school that day and the principal was very concerned about the child. The child was "*spiralling downhill*" and was engaging in "*mild cutting*." This information, in the context of the family's history with the ministry, should have prompted immediate intervention and potentially a full child protection investigation. This did not occur, and the child was left unsupported, isolated and in a high-risk situation.

On May 6, 2011, one month after the sexual assault report was made to the ministry, the social worker met with the school counsellor. The counsellor again reported being very worried about the girl and that "*if [the child] felt suicidal that [she] could complete suicide*." The counsellor believed that the girl needed a mental health assessment and she volunteered to work with the family.

This information should have triggered an immediate intervention. The Aboriginal Wellness clinician should have been contacted to arrange an immediate suicide risk assessment. This could have occurred by bringing the girl into town or having the clinician make an emergency trip out to the community. But, despite the clear risk reported by the school counsellor, her warnings failed to provoke any response.

When interviewed by the Representative's investigators, the Aboriginal Wellness clinician stated that she was never made aware of the counsellor's concerns and request for an assessment. The clinician was also unaware of the involvement of the school counsellor or the new ministry intake for sexual assault.

Child and Youth Mental Health Services

Finding: *The girl's urgent need for assessment and intervention was not met. She had limited access to mental health services, and was cursorily served by an over-taxed Aboriginal Wellness clinician who lacked clinical supports and access to current policy. This clinician was not working in a team and was not collaborating with social workers on immediate safety concerns. Despite clear warnings from school staff, there was no mental health response to the girl's "downward spiral."*

This girl had a history of self-harm – including the Feb. 15, 2011 incident when her self-inflicted cuts required 20 stitches – and she presented with multiple risk factors for suicidal behaviour. However, her needs were not addressed by the scant CYMH services she received. She did not receive a proper assessment and there was no immediate safety plan or treatment plan to address her needs. Further, there was no meaningful engagement with the girl and her family.

In response to the girl's Feb. 15, 2011 cutting incident, she was assessed by a CRU nurse at the hospital. A social worker was present and sent an urgent referral for CYMH services. The grandparents attended a screening meeting with a CYMH clinician, who referred the girl to the LAA at the request of the grandparents. By Feb. 18, the girl had an initial session with an Aboriginal Wellness clinician. Given the seriousness of the information presented at this point, a full suicide risk assessment should have been conducted. Instead, her situation was deemed non-urgent and the degree of activity, as well as the communication and collaboration, completely waned after Feb. 18, 2011. Like the initial response, intervention beyond this point did not meet the presenting needs. An assertive response was required.

Important indicators for risk of suicide were provided to the CYMH clinicians in the referral package from the hospital during those first 72 hours of the child cutting her own wrist. The girl's presentation also indicated other potential risk factors.

Leading up to the Aboriginal Wellness clinician's initial session with the girl, the clinician had access to the information on the referral form, which included the hospital records for the Feb. 15 incident. This documentation noted:

- Scars from historical cuts were observed and documented by a nurse;
- The girl required 20 stitches for the self-inflicted cuts;

- The girl denied being suicidal and did not want to talk about why she cut herself;
- She avoided eye contact with the nurse;
- The nurse documented that: “[Client] finds it hard to talk to adults about things because they scare her;”
- Conflicts with other people;
- Bullying was occurring at school;
- The girl had an argument with a boy she liked but did not trust; and
- Depression was raised as a possibility.

During the first session, there was sufficient information provided to the clinician to warrant a considerable degree of concern and to prompt her to ask more probing questions to further evaluate the girl’s mental state. Instead, the session focused on the formalities of completing confidentiality, release of information and consent for treatment forms.

Discussions about the struggles the girl was experiencing were cursory. The clinician told the Representative’s investigators that the purpose of that initial meeting “*was to basically open her file based on [the CYMH clinician’s] information and the hospital’s information saying she should be referred for a one-on-one. So, at that first meeting we all do all the consent forms, so we do the consent for treatment form and kind of explain it and find out if they have any questions about what to expect.*”

However cursory the discussion was, critical information was still revealed to the clinician during this session. According to the clinician’s notes, the girl quietly told the clinician that she “*would talk more if her grandparents left the room.*”

During this discussion, the girl talked about problems with her boyfriend, which “*made her*” cut herself with scissors. She also disclosed being bullied and told the clinician that her mother was unable to care for her and her little sister due to “*health problems.*” There was no discussion about what the girl believed her mother’s health problems were and the other issues she raised did not appear to be of significant concern to the clinician.

The session ended without a suicide risk assessment or an assessment of the girl’s mental health.

Had a thorough assessment been initiated during this first session, the urgency of the girl’s need for intervention would have been apparent. As the girl had not been assessed by a child and youth psychiatrist, the need for the clinician to conduct a suicide risk assessment was even greater.

A thorough assessment would have considered all the possible risk factors, the severity of each, and the protective factors to counteract the risks. This information could then have informed the development of an immediate safety plan and the coordination of an appropriate response to the girl’s needs with the commitment of service partners. This type of intervention is what is prescribed in the *CYMH Clinical Policy Manual*.

Policy B-17: *Suicide Risk Intervention* states:

“CYMH clinicians must make all reasonable efforts to prevent suicide in children and youth and must screen and monitor for suicidality with new clients referred to CYMH and with ongoing CYMH clients as clinically appropriate. Whenever a clinician assesses that there is a potential suicide risk, a standard process based on the best available evidence and outlined in Preventing Youth Suicide: A Guide for Practitioners, October 2010 is followed. This process includes a specialized suicide risk assessment and, depending on the level of risk, outreach and emergency response as necessary (see policy B-5), service coordination among all involved service providers, and evidence-based therapeutic interventions tailored to acute or chronic suicidality as applicable. In high risk cases the clinician will seek clinical supervision and/or consultation during this process.”

Further, *CYMH Standard 5 – Service Delivery: Mental Health Assessments* states that, “screened clients receive a comprehensive mental health assessment before treatment and support services are commenced ...”

Despite the contractual requirement for the LAA to follow ministry CYMH standards and policies, when requested by the Representative’s investigators to produce them the LAA provided only some of those policies. Notably absent was the policy on suicide risk intervention. The LAA reported that it was not advised of new or revised ministry CYMH policies and standards and it made no efforts to seek these new documents. The LAA had no access to the ministry policy website and no director of mental health or similar professional to consult with on cases.

Despite the lack of access to ministry policies and standards, the Aboriginal Wellness clinician would have been expected to apply a standard of reasonableness in assessing the girl’s situation and her potential for suicide. She had 20 years experience as a mental health clinician working with people from the same First Nation to which the child belonged. She would have gained valuable insight during that period into the struggles and challenges faced by the First Nation’s youth.

Had a proper assessment taken place, numerous issues would have been canvassed: relationships with family members, peers, and community members; academic functioning; recent events at home, in the community or at school; fears and anxieties or evidence of major mental illness in the girl; previous assessments, including psycho-educational assessments; family history of mental illness; and a discussion about what protective factors there were in the girl’s environment.

When the clinician asked the girl for permission to speak to others in order to obtain information, the child agreed only that her best friend with whom “*she talks to about everything in her life*” could be contacted. This friend was never contacted.

If the clinician had pursued her inquiries, she may have also uncovered other risk factors. She may have learned the girl was often intimidated by adults, something observed by the hospital nurse, and about the bullying the girl was experiencing at school. As well, a

more thorough discussion could have provided insight into how the girl felt about her mother being unable to care for her and her beliefs about her mother's "*health problems*."

A proper assessment would also have taken into consideration the girl's protective factors, including her willingness to talk to the clinician, her connection to her little sister, the love from her grandparents and the trusted friend that she mentioned to the nurse and the clinician.

Risk and protective factors are those identified in the ministry's October 2010 *Preventing Youth Suicide: A Guide for Practitioners* (see Appendix F). This guiding document, which was available at the time the clinician was involved with the girl notes that, "*Suicide and suicidal behaviours (including suicide attempts, plans and thoughts) among adolescents are influenced by multiple, interacting risk and protective factors that encompass biological, psychological, familial, interpersonal, social and political dimensions.*"

It should have been apparent, even with the clinician's cursory discussion with the girl, that the risk factors were significant and outweighed the protective factors in her life. The clinician's immediate concern was to determine whether the risk was high. Having formed the judgment that it was not, the clinician determined that the issues could be addressed at future appointments. Unfortunately, several appointments were missed and no outreach followed.

The Aboriginal Wellness clinician identified a number of factors that she felt limited her ability to follow up with the girl. The clinician was one of two clinicians who worked part time for the LAA. At the time, this clinician was also working part-time for another First Nations community. The clinician confirmed that the volume of work was too great to handle in the time she had. In addition, there was a lack of funding for travel between the widely separated communities.

Given these limitations, and the poor engagement of the girl and her grandparents, special efforts were called for and they were not made. When the girl did not attend her appointment on April 15, 2011, which had been set five weeks previously, there was no follow up from the clinician's office. By this point, school staff perceived that the girl's mental health was deteriorating significantly. No efforts were made by the clinician to contact the school, which was described as a major source of referrals for mental health services. The school held crucial information about the child's cognitive challenges, her declining mental health and the involvement of a counsellor.

A request for an urgent mental health assessment was made to the social worker by the child's school counsellor on May 6, 2011, but this was not acted upon. Although the Aboriginal Wellness clinician had an active file for the child and the social worker was aware of this, the clinician was not told about the urgent request for the assessment.

The lack of collaboration and communication among service providers set the stage for a very tragic outcome. The Aboriginal Wellness clinician had no awareness of the school counsellor's involvement or of the active file the social worker had, and was not even informed of the girl's death. The clinician learned of the suicide when she visited the girl's school for other matters.

With respect to clinical practice and oversight, the ministry's *Child and Youth Mental Health Standards 3 Clinical Supervision, Consultation and Continuous Professional Development* states:

“The CYMH program assumes responsibility for providing high quality culturally appropriate services by providing clinical supervision and consultation and by promoting professional development of clinicians in new competencies and evidence-based practices ... The provision of clinical supervision, consultation and continuous professional development is essential because of: 1) The complexity of the presenting concerns; 2) The close interpersonal delivery of services; 3) The variety of professions and the breadth of knowledge in the mental health field; 4) The constant evolution of this knowledge. Consequently, clinical supervision needs to address the therapeutic process and ethical issues in the relationship between clinician and client/family, as well as the use of specific therapeutic modalities and the need for continuous clinician professional development.”

Since its inception, the LAA's Aboriginal Wellness Program has been without a clinical supervisor to oversee and guide clinical practice. Instead, the two part-time clinicians were left to their own devices and expected to know their limits in terms of clinical judgements and self-care in the face of the pressing needs of the children and youth they served.

One clinician noted that:

“Within non-Aboriginal CYMH, there is a structure that allows for internal Clinical Supervision. The Team Leaders are the Clinical Supervisors for their teams. These Team Leaders also oversee the intake process, consult and support their team as they deal with client crises, and generally support and manage their teams.

“Because the Aboriginal CYMH¹⁹ teams are not provided with Team Leaders, they do not receive this internal structure, support, or supervision.”

Limited clinical guidance is provided by a consultant, who provides case consultations to the clinicians on an as-needed basis. However, the funds the LAA has to contract with the consultant are limited. Currently, case consultations are conducted in-person, three hours each month. In the past, case consultations took place by conference call. While case consultations are valuable and the current consultant is highly regarded, consultations occur at the discretion of the clinician and do not occur for every child. MCFD created this arrangement and appears to have given no consideration as to where such an arrangement would allow for a functioning clinical mental health service to high-risk children.

In 2011, when there was a different consultant in place, there was no case consultation regarding this girl. With the lack of clinical oversight, important steps regarding assessment and intervention for children at risk of suicide may be missed, overlooked or not even considered.

¹⁹ This clinician was referring to the Aboriginal Wellness Program.

This LAA's Aboriginal Wellness Program has been drastically under-resourced since its inception. It was developed without proper consideration for what was required to meet CYMH policies and standards or contractual requirements. The LAA's contract with the ministry does not include resources for clinical supervision despite requirements for the agency to ensure its Aboriginal Wellness Program includes supervision:

"Clinical Supervision will be the responsibility of the contractor. The agency will ensure that the Clinical Supervisor has relevant cultural and clinical qualifications to provide clinical supervision that are equivalent or greater to that of the Aboriginal Development clinician.

"The agency/clinician will receive MCFD Aboriginal Child and Youth Mental Health Services Regional Clinical Consultation in collaboration with local clinical/cultural supervision. (This cultural and clinical supervision may be accomplished through more than one person)."

Despite the provisions allowing for the Aboriginal Wellness clinicians to have access to ministry regional clinical consultation and supervision, in practice this has not occurred.

In addition to the lack of clinical supervision, the program has no administrative staff to help coordinate its efforts and assist with information management. Instead, the program has been primarily run by two part-time clinicians totalling 1.5 full-time equivalents. The team was recently expanded to include a Wellness Coordinator, but this individual was hired after the death of the girl and funding for the position has come at the expense of another program area.

The two part-time Aboriginal Wellness clinicians provide services to children and youth from 15 First Nations spread across a large geographic area. The Wellness Coordinator does not provide direct services in the form of assessments and counselling sessions, but assists in coordinating services for clients.

Unlike the LAA's Aboriginal Wellness Program, the ministry's CYMH program is supported with infrastructure and multiple invaluable resources. As one LAA staff noted:

"Agencies are given one or two (or 1.5) clinicians and expected to cover an extensive geographical area, coordinate and implement their own intake process, manage their own referrals and case management system, conduct individual therapy sessions, maintain appropriate client files, travel to the communities they serve, facilitate groups and workshops, participate in clinical supervision sessions, and perform all related administrative duties. [The LAA] as an agency does not believe that these are reasonable or realistic expectations."

While a positive working relationship between the two teams has been reported, it is clear that the Aboriginal Wellness Program is starkly under-resourced compared to its ministry counterpart.

In addition to having access to clinical supervisors and administrative staff, ministry CYMH workers also have access to a library of material posted to the ministry's intranet

site, which includes standards, policies, news and updates and links to references on best practices, which guide all CYMH workers' practice. Further, having an electronic case management system facilitates the ministry clinicians' ability to collect, track and monitor client information with ease. The LAA has no electronic case management system, but instead relies on a paper filing system. Entries can easily be lost or destroyed and no service history is available.

In 2011, the Aboriginal Wellness clinician responsible for supporting the girl was the part-time clinician primarily responsible for one-on-one counselling sessions in town, while the other part-time clinician was primarily responsible for community capacity-building initiatives in the form of workshops held in various communities. There was no travel budget for clinicians to hold one-on-one counselling in communities. A key issue with the large geographic service area was that the time spent commuting great distances between communities further eroded the limited capacity of the clinicians to provide service.

MCFD Staffing Issues

Finding: *In the ministry office responsible for responding to this child, there were chronic staff shortages, and a chaotic and dangerous work environment with inexperienced staff who lacked appropriate supervision and mentorship. There was inadequate intervention over a prolonged period to deal with what amounted to a human resources crisis, that no doubt contributed to this girl being left without the help she needed. There was no MCFD emergency response to working conditions or situations that were impossible to manage and that left child safety in jeopardy across the service delivery area.*

During the last three years of the girl's life, ministry staffing levels in the office responsible for serving her were not maintained at a sufficient level to allow ministry child protection standards and policy to be met. Chronically low and fluctuating staffing levels were a significant issue between October 2008 and May 2011 when service providers had the greatest involvement with the girl who is the focus of this report and her family.

The Representative's investigators documented serious staffing issues involving lost time due to stress leave, dysfunction in the working environment, staff terminations and the failure to maintain an adequate number of qualified staff to properly investigate and respond to child protection reports.

Compounding the situation were significant safety concerns. One protection worker told the Representatives investigators, "... as far as being intimidated I think myself, because I've been in situations where I've had a hunting knife pulled on me, I've had a gun pointed at me out there. My colleague that I worked with... was actually threatened to – to get shot one time when we were out there... it's like any isolated community... it has its challenges and... I don't think that – that it's for everybody."

Another protection worker told the Representative's investigators, "We have workers who are fearful of going out there. I, at times, have been completely fearful of being out there."

Service provision is further hampered because the community and surrounding area have no cell coverage. This also can put social worker's safety at risk as they often travel alone

and have no back-up. A third social worker expressed frustration in trying to maintain a safety plan, from a corner store pay phone, often with the ministry's After Hours who may not be familiar with the situation or geography. The protection worker stated, *"But you know, things change so quickly when you're out there. You go knock on one door and they're, 'Well they're over there at their aunties.' So you drive over at their aunties. Well you don't have time to – and it is hard to go, 'Can I borrow your phone? Then I'll tell you why I'm knocking on your door.'"*

As one regional manager noted, the critical issues impacting service delivery were:

"... insufficient staffing allocations ... a large geographical area requiring outreach, conflict between the two floors, the serious staff situation resulting in two [team] employees dismissed ... and many staff reporting experiencing significant trauma as a result of their experiences ... and significant damage to relationships and trust between Aboriginal communities and MCFD, making it quite a challenge for the workers that were left ..."

Between October 2008 and May 2011, there were at least three staff members on significant leave every year due to illness or disciplinary action. The office environment at the time was described as *"toxic."* The team leader, promoted to the position in the fall of October 2008, said she left her job in the spring of 2010 due to stress and exhaustion. Her departure came just prior to the termination with cause of two suspended employees in the summer of the same year.

The first half of 2010 was a revolving door of acting leaders for the team responsible for serving the area that included the girl's community. A year-and-a-half after one social worker was hired in the spring of 2009, she went on a lengthy stress leave. Like others who worked in the office, she was a recent graduate and not fully delegated. Nevertheless, she had been conducting child protection work for more than a year before she completed her delegation training.

As team members went on leave in the office, this new worker was left to manage their caseloads on top of her own. She could no longer manage and cope with the stress of a relentless and ever increasing workload – at one point, she was the only remaining member of her team.

Managing large numbers of cases, many of which were complex, combined with the dysfunctional environment in the office and lack of support, took a toll on the worker's well-being. She described it to the Representative's investigators:

"As people were taking leaves, I was taking on more files and doing the best that I could. [After the first supervisor left] ... it just was kind of a revolving door of different acting team leaders ... in March [2010] I basically show up at work one day and I had no team and I still wasn't delegated as a worker ... I was basically doing delegated work as an undelegated social worker for many months ... there was no plan in place to deal with the fact that, you know, you had one undelegated social worker covering the [entire First Nation] ... there's been a lot of [regional managers] too ... I was covering my own caseload, I was covering vacant caseloads, and just sort of whatever was coming in ..."

Regional MCFD Office: Allocated vs. Actual Fully Delegated Child Protection Workers*



2008: 3.94 fully delegated Child Protection Workers



2009: 3.56 fully delegated Child Protection Workers



2010: 2.34 fully delegated Child Protection Workers



2011 (Jan. 1 to May 31): 1.2 fully delegated Child Protection Workers²⁰

* For each of these years, this Regional MCFD Office was supposed to be allocated seven fully delegated child protection workers. This graphic shows the number of fully delegated workers actually in place for each year.

²⁰ When social workers are first hired for child protection services, they receive two weeks of post-hire training and a partial delegation of authority to carry out restricted responsibilities under the *CFCS Act*. Their responsibilities in child protection investigations are limited. While he or she may take on a caseload, a new social worker is heavily reliant on a fully delegated social worker and supervisor for guidance until they can demonstrate the competencies required for full delegation. The time frame for obtaining full delegation varies widely, depending on the competency of each individual social worker.

By January 2011, the office – previously managed by three regional managers – had been reduced to one regional manager to improve consistency in oversight. This manager recognized the crisis and took immediate action to alleviate the staffing and workload issues. In February 2011, caseloads were eased with the transfer of 45 child service and family service files to another ministry team. Permission to hire two social workers over and above the normal staffing complement was granted by senior management. Two experienced social workers were brought in from other offices for short periods of time to assist in guiding junior staff.

Despite the regional manager's efforts, staffing and workload issues persisted. Even with the transfer of 45 files, 63 intakes were still being managed by the team, which consisted of three relatively inexperienced staff who were supervised by a team leader with less than one year of supervisory experience. The only fully delegated worker had less than one year of experience at full delegation, another worker had less than one year experience at partial delegation and a recent graduate was hired in January 2011. Eventually, the permission to over-hire was withdrawn.

The regional manager also left her position due to stress. As one social worker commented in an interview with the Representative's investigators in the spring of 2013, "... [*The regional manager*] really tried to change things and kind of level the playing field ... [*but*] I don't see that it's worked ..."

Clearly the staffing and workload issues persist and this causes the Representative great concern. The safety and well-being of the children and families served by this ministry office will remain at risk until this situation is rectified. The girl who is the focus of this report did not receive a standard of service required by law or policy. She was neglected and her right to safety was not meaningful or adequate to protect her from physical and emotional abuse or neglect. In large part, this was because MCFD failed to manage a crisis in working conditions in the local office.

Further, the Representative emphasizes that Appendix 4 of the component agreement between the Government of B.C. and the B.C. Government and Service Employees' Union (BCGEU) representing social workers sets out a process to address workload issues. Specifically it requires supervisors and management of the ministry and union representatives to address workload issues identified by social workers when they are unable to fulfil their statutory obligations (see Appendix I) because of the demands of the job.

As well, the Representative further emphasizes the need to ensure the safety of social workers as set out in Article 22 of the Master Agreement between the Government of B.C. and the BCGEU.²¹ That social workers' safety is at potential risk when carrying out their statutory obligations is of grave concern to the Representative. As such, the Representative implores the ministry and the BCGEU to work together to address these issues in collaboration with front line staff. Children's safety is tied to worker safety.

²¹ Article 22 can be found in the Master Agreement: http://www.bcgau.ca/sites/default/files/16th_Master_Agr_Mar_12.pdf

Failures by Health Care Professionals to Report a Child in Need of Protection

Finding: Health care professionals who were involved with the family, including physicians, repeatedly failed in their duty to report child protection concerns to the ministry, as required by s.14 of the CFCS Act, when a child is in need of protection as set out in s. 13. The failure to recognize the risk to the girl posed by the mother's mental illness is inexplicable, particularly in circumstances such as these where the mother was repeatedly experiencing auditory hallucinations directing her to harm her children. Failure to report is an offence in the CFCS Act that should be enforced. Children's lives depend on it and no prosecutions for this offence have occurred in many years.

The CFCS Act states when protection is needed:

- 13 (1) A child needs protection in the following circumstances:
- (a) if the child has been, or is likely to be, physically harmed by the child's parent;
 - (b) if the child has been, or is likely to be, sexually abused or exploited by the child's parent;
 - (c) if the child has been, or is likely to be, physically harmed, sexually abused or sexually exploited by another person and if the child's parent is unwilling or unable to protect the child;
 - (d) if the child has been, or is likely to be, physically harmed because of neglect by the child's parent;
 - (e) if the child is emotionally harmed by the parent's conduct;
 - (f) if the child is deprived of necessary health care;
 - (g) if the child's development is likely to be seriously impaired by a treatable condition and the child's parent refuses to provide or consent to treatment;
 - (h) if the child's parent is unable or unwilling to care for the child and has not made adequate provision for the child's care;
 - (i) if the child is or has been absent from home in circumstances that endanger the child's safety or well-being;
 - (j) if the child's parent is dead and adequate provision has not been made for the child's care;
 - (k) if the child has been abandoned and adequate provision has not been made for the child's care;
 - (l) if the child is in the care of a director or another person by agreement and the child's parent is unwilling or unable to resume care when the agreement is no longer in force.
- (1.1) For the purpose of subsection (1) (b) and (c) but without limiting the meaning of "sexually abused" or "sexually exploited", a child has been or is likely to be sexually abused or sexually exploited if the child has been, or is likely to be,
- (a) encouraged or helped to engage in prostitution, or
 - (b) coerced or inveigled into engaging in prostitution.
- (2) For the purpose of subsection (1) (e), a child is emotionally harmed if the child demonstrates severe
- (a) anxiety,
 - (b) depression,
 - (c) withdrawal, or
 - (d) self-destructive or aggressive behaviour.

In cases where a medical professional (or any other member of the public) has reason to believe that a child needs protection, s.14 of the *CFCS Act* is in effect:

14 (1) A person who has reason to believe that a child needs protection under section 13 must promptly report the matter to a director or a person designated by a director.

That section imposes a duty on everyone, including health professionals, to report to the ministry when they have reason to believe a child needs protection. While it is not this Office's role to assess the conduct of private medical professionals, the Representative does have the authority in the course of a report to make recommendations to any public body, director or person she considers appropriate.

Therefore, the Representative emphasizes the independent duty of all citizens, including medical professionals, to report to the ministry if they believe a child needs protection. This duty applies even if someone else has made a criminal report.

"A person who has reason to believe that a child needs protection" includes anybody who has a belief that a child may or could be at risk of physical or emotional harm. Everyone in B.C. has a legal duty to report child safety concerns to a social worker authorized under the *CFCS Act* to intervene and ensure a child is protected from harm.

This legal requirement for physicians to report child protection concerns has been emphasized in both protocol and standards of the College of Physicians and Surgeons of British Columbia.^{22 23}

From the time this girl was five-years-old, the mother was assessed and treated for her mental illness by at least 15 physicians and psychiatrists practising in two different hospitals. She was admitted to hospital on seven occasions. At least 16 community and hospital nurses were involved in her care, including three band nurses, numerous local nurse practitioners and community nurses as well as at least three nursing staff from a residential psychiatric facility.

In each case, documents confirm that the health care professionals were aware of the mother's risk of harm to her children and the chaos in the family home. The mother's severe psychotic symptoms included command hallucinations to harm the girl and these very real risks to the girl's safety were overlooked by medical professionals. None of these risks were reported to the ministry with the exception of one instance when the mother hitchhiked to a neighbouring town with her two children on July 31, 2009 and was subsequently certified under the *MH Act*.

On that occasion, when the mother was released from hospital, there was no consideration by medical professionals to supporting the grandparents and the children in coping with the challenges presented by the mother's mental illness. As well, while the nurse reported

²² Protocol for Communication Between Staff of Ministry for Children and Families and Physicians – Appendix to Child Abuse Guidelines – College of Physicians and Surgeons of British Columbia

²³ College of Physicians and Surgeons of British Columbia Professional Standards and Guidelines

child safety concerns and the ministry responded to the immediate needs of the children, there was no ongoing communication or collaboration between health services and ministry staff.

The mother's health care records repeatedly documented concerns from doctors and nurses about the risk to the mother's children as a result of her non-compliance with medication and the resulting deterioration of her mental health. She delivered the girl's sibling in a psychiatric facility and went home with the infant without a report to MCFD, despite being disturbed by voices telling her to kill her other child.

According to medical records reviewed by the Representative's investigators, the mother first saw a physician for suicidal thoughts in 2001. When the mother failed to attend her appointments with her physician, there was no follow up despite knowledge that she had a five-year-old daughter. From this point on, and particularly from the death of her brother three months later, the mother's psychotic symptoms increased. In effect, the girl was invisible to health care professionals as they treated her mother's symptoms with medication that she would not willingly take.

Her psychiatric diagnoses were "*Psychosis [Not Otherwise Specified] and suspected schizophrenia [symptoms of social withdrawal decrease of functioning and hallucinations].*" The psychiatrist noted that the mother "*endorses the presence of auditory hallucinations in the form of voices telling her to either hurt herself or her daughter ... The voices would at times swear at her or say, referring to her daughter, 'snap her head'.*"

Throughout this time, the mother was treated by the psychiatrist, a community health nurse, her family physician and various hospital staff when she was admitted to the Emergency Room for psychotic episodes. While there was a brief period of time when the mother's psychosis appeared controlled, all of the health care professionals were aware of the mother's lack of compliance with medication and of the potential for the mother's bizarre and threatening behaviours to return.

Many medical professionals documented the mother's behaviours and risks to her daughters without notifying the ministry, despite the obvious threat. A community nurse reported that the girl was witnessing significant violent outbursts by her mother an average of five times a year based on her observations.

No one adequately considered the emotional toll that having a mother who was displaying such bizarre and threatening symptoms would have on the girl or her younger sister. No supports were offered to either the girl's mother or to the grandparents, who were struggling to cope with the mother's behaviours.

The girl was often left to cope with her mother's behaviours and, as indicated on the night prior to taking her own life, she would never understand them.

Even when the mother's mental health deteriorated to the point requiring her to be certified and detained under the *MH Act*, concerns about the children's safety were never shared with the ministry.

A health care professional might take the view that because certification involves detaining the patient in custody, there is no immediate prospect of harm and thus a report to the ministry is unnecessary. In the Representative's view, however, the duty requires a professional to take a longer view and consider the patient's condition and the potential risks to a child if a person with a chronic psychotic illness later decompensates, particularly when the decompensation manifests itself in thoughts of harming a child.

Case Management by Health Care Professionals

Finding: *Medical practice was clearly focused on the mother's mental illness and not on her role as a mother or on the long-term impacts it would have on her children or parents.*

It is concerning that while the mother was first diagnosed with psychosis in August 2003, it was not until her certification under the *MH Act* in July 2010 that a community mental health worker was assigned.

When a parent has a mental illness, an ideal model of care would see the parent's family doctor and psychiatrist ensure that the parent is supported not only with the treatment of his or her mental illness, but also in their role as a parent. In this case, the delay in referring the mother to a mental health worker was contrary to the interests of the patient and her family, including her children.

The mother was either released or allowed to leave voluntarily from psychiatric care on six separate occasions between December 2007 and September 2010 without supports provided to the family to cope with her often threatening psychotic symptoms.

With respect to safety, the regional health authority's Mental Health and Addictions policy refers to a "caution alert" that may be placed on a patient's file when they potentially pose a danger to self, staff, the patient's family, friends or other members of the community. This appears primarily focused on staff safety. There was no reference to the s.14 *CFCS Act* duty to report to the ministry a child's need for protection. There was no indication in the mother's medical records that a "caution alert" was recorded respecting the mother's risk to her parents and children.

Notably absent from policy and client forms and checklists are indicators that a client has children and acknowledgement of the emotional and physical harm that children may be exposed to when living with a parent with a severe mental illness. Certainly in the case of the girl's mother, medical records make no reference to this.

Also significantly absent are formal inter-agency processes and procedures for health care professionals and ministry social workers to work together in supporting families. This has been a significant issue in B.C., one that has been well researched and documented. Mental health services and child welfare services must be integrated – this is essential to a holistic approach to supporting a parent with a mental illness.²⁴

²⁴ AK Blanch, J. Nicholson & J. Purcell, 'Parents With Severe Mental Illness and Their Children: The need for human services integration', *The Journal of Mental Health Administration*, vol. 21, no. 4, 1994, pp. 388-96

According to the World Psychiatry Association:

“The UN Convention on the Rights of the Child ... states that nations should provide preventative health care and guidance for parents. Current practice in adult psychiatry falls far short of this requirement. The status or even existence of children is often not noted. Psychiatrists must be aware that many patients are parents, and that their children are at increased risk of psychological problems. Clinicians must adapt the standard psychiatric history to include questions about parenting, marriage and family life. These must be included in mainstream training for mental health professionals.”²⁵

The term “invisible children” has been used to describe children in these situations, when health services to a parent are individually focused and do not account for the parental role. Programs such as *The Invisible Children’s Project*,²⁶ which focussed on providing family-centered services to parents with mental illness, demonstrated improvement across multiple outcomes.

In February 2006, the mother was placed back on oral medication in support of her desire to become pregnant. The outreach psychiatrist notified the mother’s family physician of her plan to become pregnant and the switch to oral medication.

While the mother communicated some ambivalence about her decision to have another child to a hospital Emergency nurse in a moment of crisis, the wisdom of her decision does not appear to have been explored by either her psychiatrist or family physician.

The mother saw her family physician and psychiatrist on a number of occasions over the following year. However, her pregnancy remained undetected and unsupported until her presentation at the hospital with “*abdominal swelling*.” At this time, she was immediately transferred to a designated psychiatric hospital to give birth to her second child.

It is inconceivable that such a planned, high-risk pregnancy would not be monitored or the ministry notified. It is even more inconceivable that the birth of the child to a mother with a serious mental illness, including command hallucinations to kill her first child and a reluctance to take her medication, went unreported to the ministry by all of the health care professionals involved in her care and release from hospital.

Within days of the birth of the younger sister, a community nurse wrote to the mother’s family physician stating “*my concern is that if [the mother] is still psychotic when the baby returns home, her safety could be an issue*” and requested the mother be put back on injectable medication because she had a history of non-compliance.

Communications between the family physician and outreach psychiatrist document the mother’s deteriorating mental health throughout the fall of 2007. When the

²⁵ Brockington, I., Chandra, P., Dubowitz, H., Junes, D., Moussa, S., Nakku, J., Ferre, I., *World Psychiatry Association WPA Guidance on the Protection and Promotion of Mental Health in Children of Persons with Severe Mental Disorders*.

²⁶ The Invisible Children’s Project: A Family Centered Intervention for Parents with Mental Illness, Mental Health Association in Orange County, N.Y.

mother was first certified under the *MH Act*, it was a result of her violent outburst on Dec. 29, 2007. Physicians involved documented their concerns noting that the mother was, “*noncompliant with medication, increasingly agitated, paranoid ideas of people trying to hurt her, suicidal threats and according to family members trying to abuse her 10-year-old daughter and three-month old [child.]*”

She was released back to her children and parents four days later. Within eight months, she threatened her eldest daughter with a knife and stopped seeing both her physician and outreach psychiatrist without any follow up. Neither of these two events was reported to the ministry.

The mother stopped taking her medications and her behaviours resulted in responses by RCMP and reports to the ministry. There was no case management provided by either her family physician or psychiatrist and the family was left to cope with the return of the often-threatening symptoms of her psychosis.

The leave authorizations for the mother to return to live with her parents and children following her certification under the *MH Act* in July 2010 are particularly concerning. While there was a hospital social worker involved with the mother’s case planning at the designated psychiatric facility, no efforts were made to contact the ministry despite clear indications that the mother posed a risk to her children. Instead, the hospital social worker relied on the hearsay of the band home care nurse that the ministry was involved in planning for the family.

On Aug. 16, 2010, the mental health worker recorded that she “*doesn’t believe that this client [the mother] would be able to live on her own, her children will be taken from her parents if she returns home.*” On Sept. 8, the outreach psychiatrist wrote: “*The leave authorization did not stipulate where the mother needed to live. Once the family ensures that the children are safe and not residing with her, it might be possible to live closer to her family,*” and forwarded these concerns to the mother’s new family doctor.

When the mother met with the family doctor three weeks later and announced that she was returning to live with her parents and children, her plan was not challenged. The mother was granted leave to return to live with her unsupported parents two days later. All of the agencies involved with the mother were notified of her release except the ministry.

It is not surprising that, after another three months, the grandparents could no longer cope and the mother moved, for the most part to live with a sister in another town.

Child's Special Needs

Finding: The girl's developmental delays went largely unaddressed outside of school and unrecognized. The cause of her intellectual impairment was never determined or explored. She did not get the services and supports that could have assisted her in achieving better life outcomes and possibly protected her from abuse. This lack of support directly affected her ability to communicate with the professionals she encountered, including police investigating her allegations of sexual assault.

The girl's special needs first became apparent as a result of a school psycho-educational assessment, which resulted in a test score that was no higher than one per cent of students in her age group. Her abilities to function socially and understand her surroundings were significantly impaired. Further testing three years later confirmed the persistence of her developmental disabilities. No complete assessment of her health development was conducted or even suggested.

It was clear that the girl was unable to deal with her social and academic challenges. Her ability to cope deteriorated to the point of aggressive behaviours which resulted in a series of suspensions from school.

Special resources within the school were provided to assist her with her academic challenges and eventually she was meeting with a school counsellor to help manage her anger. However, individual education plans to accommodate her special needs beyond Grade 3 were never put in place. This was in breach of the Ministry of Education Ministerial Order 638/95, which stipulates that school boards must ensure that a child with special needs have such a plan in place. As well, the child was never re-assessed by the school district to further determine her level of development over time.

Outside of the school system, no supports or assistance were put in place by service providers to further assess and treat the girl's special needs. No consideration was given by the ministry to provide CYSN services, the provision of which would have been problematic given her residence on-reserve some distance from town. Yet she should have received a comprehensive assessment and adequate investigation of the cause of her intellectual impairment. Teachers would later tell others the child had fetal alcohol spectrum disorder. This, too, was completely unfounded as she had never been assessed.

These unmet special needs were especially problematic when the girl reported being sexually abused by a classmate. In the subsequent interview with the RCMP officer, she struggled to make sense of complex concepts (such as consent) in providing her statement. Her inability to clearly articulate her version of events, particularly in a stressful setting without any supports, meant that crucial evidence was missed or misinterpreted.

Despite the challenges in providing services, social workers, mental health clinicians and other service providers must use every opportunity they have to identify the special needs of a child. Once those needs are identified, service providers are better positioned to more effectively support children and youth. As this report has illustrated, several critical opportunities were missed in identifying the special needs of this girl. She should have had proper assessments and these should have informed supports at home, in the

community and at school. She was at the age when she should have been transitioning to Community Living BC. Yet she had no proper assessment or service.

Barriers to Service for this First Nations Child

Finding: Adequate services were not available to this First Nations girl living in her reserve community and, across the spectrum, this created a situation of risk and reduced her resiliency in the face of enormous personal, family and health vulnerabilities. If she was not First Nations, living on-reserve, it is very likely she would not have been left as isolated, invisible and unsupported.

This child grew up in a First Nations community that was more than a one-hour drive from town, where most of the social services were located. The distance from town and the cost of travel proved challenging for both community members in need of services and for service providers attempting to respond to the needs of children and families.

In addition to the distance issue, there were many other barriers to getting help from the ministry and mental health services. Many band members are resistant to outside service providers because of a lack of trust based on historical conflicts with mainstream society.

Another significant barrier to engaging clients is the lack of culturally relevant services, including service provision that respects the primary language spoken by the First Nations community. Access to services is further compromised because the few supports that are in the community are so stretched.

Currently, the two band family support workers represent critical connections between children and families on-reserve and services providers in town. Both of these workers have deep roots in the community, are well respected and are fluent in their traditional language.

The family support workers divide their time between family support work, administering income assistance funds and adhering to the reporting requirements of the federal government. For the portion of their time spent on family services, they are funded through a contract with the LAA responsible for their community. The contract is small, amounting to \$27,870 annually, which is split between two band workers tasked to do family support work.

However, the primary responsibility of the family support workers is not family support work at all, but rather administering and accounting for federal income assistance funds for community members. The family support work has been placed on top of their regular duties which, according to both family support workers and ministry staff, has not been conducive to working with and supporting children and families in the community. According to one of the family support workers:

“... income assistance is probably the biggest [part of our job] ... we have approximately 200 [clients] on income assistance on the reserve ... And reports take a huge chunk of our time. We don't get to spend much time with our clients ... probably [on] average we see them for 15 minutes a month ... I'd say probably at least four days a week [are spent on reports for the federal government].”

The Representative's investigators observed that both family support workers were overworked, underfunded and not fully trained to meet the demands of child and family services, including child protection services and court matters. During an interview with the chief, he stated that the two workers have accumulated 400 hours of overtime, which the community does not have the funds to pay out, and that they cannot be compensated with time-off without compromising the demands of the workload because there is no one to backfill their position.

The family support contract identifies the family support workers as being the contacts for ministry social workers during intake and investigation activities. They help explain the process of investigation and social worker involvement to the families. Additionally, they support the family as social workers receive and investigate child abuse and neglect reports. The practical difficulty this posed for the ministry, however, was the band's requirement that these workers would accompany any ministry social workers as they conducted their inquiries on-reserve. If the band workers weren't available, ministry staff were effectively stymied. Said one social worker:

"When we weren't allowed on reserve it was difficult ... we had our office on lockdown a couple of times because families there had come in and threatened a particular social worker on our team that they were gonna kill them for getting their son jailed and that sort of thing ... One time when we were headed out the [former] chief said, 'If you come there will be guns' and so we just didn't [attend the reserve]."

The issue of access may explain why ministry social workers sought the assistance of the family support workers to monitor the grandparents' home in 2009, despite the clear absence of real capacity to do this effectively. It may also explain why, while the ministry expected the family support workers to advise them if the mother returned to live with her children after the CPH application was approved, the workers didn't follow through.

The community does have nurses to provide health care services directly in the community. While these health care professionals communicated very well with other health care professionals, there was an urgent need for communication to extend beyond their colleagues in order to report protection concerns about the girl who is the focus of this report. Further, there was a need to share not only their health care expertise, but also their intimate knowledge of the area and residents with ministry social workers and CYMH clinicians.

For this community and others like it, there is a strong need for at least one full-time worker dedicated to facilitating child and family services, including CYMH, adult mental health, drug and alcohol counselling and Victim Services. With the lack of services provided directly in the community, this role becomes more critical since this individual, ideally a widely respected community member, can act as a conduit for community members in need of support. This individual can also play a key role in explaining the necessities of child protection services and de-stigmatizing mental illnesses and accessing mental health supports.

The chief remarked on the struggle to bring in qualified professionals. In an interview with the Representative's investigators, he stated that: "... it is a huge struggle to get somebody with just two years college [training] to come to our community and work."

In addition to this, band leadership has been tasked with the formidable challenge of dealing with a historical financial crisis. The community has been in a deficit situation for several years and it has taken the community years to make any significant progress in paying down the debt.

Funding services on-reserve is the responsibility of AANDC, a department of the federal government. However, AANDC appears to not be a part of the dialogue with the community with respect to child and family services.

Poor and ineffective service provision to First Nations children and youth living on-reserve has been well documented. These First Nations children and youth do not have access to the same level of services available to other children and youth who live off-reserve. This is particularly true for First Nations children and youth who require mental health supports and special needs services. CYMH and CYSN services, which are provincially funded services, are not provided uniformly throughout the province and most First Nations communities do not have direct access to these much-needed services.

While AANDC funds child welfare services on-reserve, these funds are inadequate and do not allow for the effective provision of mental health and special needs services. This view is shared by the Office of the Auditor General of Canada, which stated in its June 2011 Status Report:

"It is clear that living conditions are poorer on First Nations reserves than elsewhere in Canada. Analysis by Indian and Northern Affairs Canada (INAC) supports this view. The Department has developed a Community Well-Being Index based on a United Nations measure used to determine the relative living conditions of developing and developed countries. INAC uses its index to assess the relative progress in living conditions on reserves. In 2010, INAC reported that the index showed little or no progress in the well-being of First Nations communities between 2001 and 2006. Instead, the average well-being of those communities continued to rank significantly below that of other Canadian communities. Conditions on too many reserves are poor and have not improved significantly."

The report goes on to note:

"Notwithstanding all the actions taken and efforts made, we found that INAC, the Canada Mortgage and Housing Corporation, and Health Canada have not made satisfactory progress in implementing several of our recommendations. The recommendations relate to some of the most important issues of concern to First Nations, including education, housing, child and family services, and administrative reporting requirements. The three federal organizations have made repeated commitments to action. Nevertheless, we found that those commitments and subsequent actions have often not resulted in improvements. In some cases, conditions have worsened since our earlier audits ..."

For First Nations children and youth with complex needs and living on-reserve, the situation can become dire. Often children with complex needs have to move away from their home on-reserve in order to receive adequate care and support. The separation of family and the expense of travel can present either an insurmountable barrier or unreasonable burden to families in many cases.

For these children, the federal government and the province have supported and are implementing Jordan's Principle, which is a child-first approach. Jordan's Principle, which B.C. endorsed in 2008, ensures that First Nations children receive the health and social services they need in a timely manner even in the face of funding disputes between the federal and provincial governments. However, while Jordan's Principle addresses funding ambiguity on a case-by-case basis, it does not ensure the ongoing availability of support for the majority of First Nations children who require help with their mental health challenges and special needs while living on-reserve.

Inability for the ministry and the LAA to meet the needs of this girl reflects the concerns identified in the Representative's special report, *When Talked Trumped Service: A Decade of Lost Opportunity for Aboriginal Children and Youth in B.C.* In this report, the Representative illustrated how ill-guided spending of ministry funds has come at the expense of direct service delivery to children and youth:

"This process [of supporting Indigenous governance initiatives] had serious negative implications for the MCFD budget, as paying for these initiatives increasingly came out of direct service lines of MCFD operations so that all children and youth, including Aboriginal children and youth, who receive actual services paid the price and continue to do so. For example, there is no appropriate spectrum of residential services in B.C., something badly needed by many children including Aboriginal children, because significant money went to self-government planning projects. Meanwhile, the people on the front lines of the system – the overburdened child welfare workers, the grandparents and extended family members, the foster parents, the hospital staff and the school staff – have seen their budgets, services and opportunities shrink, arguably all to the detriment of the children and youth who needed help."

Jordan's Principle

Jordan's Principle was named for Jordan River Anderson (a child member of the Norway House Cree Nation in Manitoba) who died while governments disputed his home care expenses.

It is a child-first principle to resolving jurisdictional disputes within and between federal and provincial/territorial governments. It applies to all government services available to children, youth and their families. Examples of services covered by Jordan's Principle include but are not limited to: education, health, child care, recreation, and culture and language services.

The government of "first contact" must pay for Aboriginal children and family services and seek reimbursement at a later date. The principle applies specifically to First Nations status children who ordinarily reside on-reserve.

The Canadian House of Commons unanimously supported Jordan's Principle in 2007.

B.C. endorsed Jordan's Principle in 2008.

As this investigation has found, immediate and direct services to children and youth are badly needed. Without the adequate resourcing of front line work, B.C. will not have the ability to recognize and respond effectively to the safety, trauma and special needs of First Nations youth such as this girl.

Recommendations

Recommendation 1

That the Ministry of Children and Family Development in collaboration with its delegated Aboriginal Agencies, Aboriginal Affairs and Northern Development Canada and First Nations leaders immediately develop a plan to identify and remove barriers to the seamless provision of child welfare services to children and families living in First Nations communities, particularly those in remote or rural locations, so that no child is left in an unsafe situation because services are disrupted or refused or there is no clear accountability to meet legislative standards.

Detail:

This strategy will address:

- **Geography:** Where local ministry offices and DAAs identify a large geographic service area as a significant barrier to providing services in compliance with ministry standards and policies, the ministry, DAAs and CYMH contracted agencies will establish a strategy to create a presence in more remote area locations.
- **Child Safety Concerns:** The plan will include the requirement for protocols that clearly articulate the procedures to immediately address child safety issues when conflicts arise between stakeholders.
- **Stakeholder Relationships:** The ministry and DAAs, in collaboration with AANDC, will ensure that each First Nations community has a key contact, who is appointed by the First Nations community and who will be responsible for child and family support work with community members. Depending on the size and needs of the community, funding will allow for at least one full-time equivalent employee to assume responsibility for and be dedicated to family support work, which includes being the liaison for the ministry, DAAs, and CYMH and CYSN staff, and participating in child and family planning meetings.
- **Child and Youth Focus:** First Nations chiefs and leadership ensure that all child welfare activity keep their children and youth as the central focus to ensure children, youth and their families are receiving direct services and supports by qualified professionals in social work, mental health and special needs.

Strategy should be developed by Oct. 1, 2014 with implementation to begin by June 1, 2015.

Recommendation 2

2(a) That the Ministry of Children and Family Development, in consultation with its delegated Aboriginal Agencies, other CYMH contracted agencies, Aboriginal Affairs and Northern Development Canada and Health Canada, take immediate steps to provide effective CYMH services, with special attention to services provided to Aboriginal children and youth. Effective CYMH services will include:

- addressing gaps and barriers to service provision;
- improved provincial and regional leadership;
- a quality assurance framework that includes a comprehensive audit program;
- responsive and dependable services in rural and remote areas;
- tracking and monitoring services and measurable outcomes; and
- notification to the Provincial Director of Child Welfare, the Representative and the Public Guardian and Trustee of all children and youth who make a suicide attempt or engage in self-harming behaviours.

2(b) That the Ministry of Children and Family Development, delegated Aboriginal Agencies and contracted CYMH agencies take immediate steps to review CYMH services currently provided by delegated Aboriginal Agencies and contracted CYMH agencies to ensure there is effective clinical supervision and accountability.

Details:

- The ministry must ensure that contracted CYMH service providers have access to current, on-line CYMH policies, standards and information on CYMH best practices and practice memos.
- The ministry must ensure that staff of contracted CYMH service providers have training and access to the CARIS information management system to facilitate consistent information gathering, tracking and monitoring of clients.

Recommendation 2(a): The ministry will provide a progress report by Oct. 1, 2014 to the Representative of actions taken.

Recommendation 2(b): The ministry will implement this recommendation no later than July 31, 2014.

Recommendation 3

That the Ministry of Children and Family Development in consultation with its delegated Aboriginal Agencies, the Ministry of Education, and Aboriginal Affairs and Northern Development Canada ensure that special needs services are provided to First Nations children and youth living on-reserve on at least an equal basis with other children or in a manner that is effective and responsible to the needs of children and youth.

Details:

- Children, youth and their families will be supported through an integrated case management approach in cases where an assessment has revealed an intellectual disability for a vulnerable child or youth whose family has had ministry involvement.
- All children and youth who have a diagnosed intellectual disability will have an Individual Education Plan throughout a child or youth's schooling. IEPs will remain in place unless subsequent assessments (i.e. psycho-educational assessments, speech-language assessments, etc.) deem that such measures are no longer required.
- The reasons for disabilities that become apparent will be fully investigated so that teachers do not label or misdiagnose children in lieu of proper assessment and clinical service.
- AANDC develop a strategy in consultation with the ministry, delegated Aboriginal Agencies and Ministry of Education that will detail how it will fulfil its fiduciary responsibility to children and youth with special needs living on-reserve so that they have equitable access to the services which are available to other children and youth with special needs living in B.C.
- Ensure Jordan's Principle is understood and followed.
- School personnel, CYSN workers and, if involved, CYMH and social workers, will work as an integrated team to support the child on an ongoing basis.
- Where a child has been identified as having a special need as determined through assessments, the family will be supported to ensure that children and youth are accessing ongoing professional support through the ministry's CYSN program to ensure support to the child within and beyond the school setting.
- Support will include ongoing collaboration between CYSN workers and school personnel and may include further assessments, including mental health assessments to screen for impacts of trauma, therapy and respite services for families.
- If a child's parent has a mental illness, the integrated team will include the parent's mental health worker, if one is involved. The intent is to ensure the child and parent(s) are supported as a family unit.

The effective provision of CYSN services for First Nations children and youth living on reserve will be implemented no later than October 1, 2014.

Recommendation 4

That the Ministry of Health and Ministry of Children and Family Development improve service coordination and collaboration for families where there is a parent with a mental illness. As set out in a previous investigative report, *Honouring Kaitlynn, Max and Cordon – Make Their Voices Heard Now*, the Representative reaffirms the following recommendation:

That the Ministry of Health, in partnership with the Ministry of Children and Family Development, take immediate steps to ensure that all staff and professionals connected to their systems understand the risk factors relating to children of parents with a serious untreated mental illness, and ensure the safety and well-being of children by:

- a) Putting in place procedures for the identification at intake in the health care system or child-serving system of the parental role of people with a mental illness, including expectant parents;
- b) Developing and implementing policies and procedures to support workers to identify and reduce risk factors for children affected by parental mental illness and domestic violence;
- c) Ensuring appropriate information regarding referral to services for families affected by parental mental illness without abdicating the focus on child safety; and
- d) Developing and implementing policies for early detection of risk factors for families associated with mental illness (e.g., social isolation, frequent moves, emotional and financial instability and violent episodes).

Details:

Improvements should include:

- policies and standards for identifying and managing cases where serious parental mental illness or substance abuse may jeopardize the safety and well-being of children, ensuring that any new policies and standards include specific measures to address these issues in First Nations families and communities;
- policies and standards for identifying and managing cases where serious parental mental illness may jeopardize the safety and well-being of children, taking into account concurrent substance abuse;
- provision for an active outreach and monitoring program across the province, and identifying and monitoring for factors which may increase the risk;
- ensuring that children who have been traumatized are referred to and engaged with the child and youth mental health system;
- provision for a consultation service for social workers and other professionals involved with the child so that they can better understand the dynamics in the home;
- mechanisms to ensure effective links with child protection and child and youth mental health services at the local level;
- ensuring this report will be used to promote practical learning in the adult mental health system across the province and among policy staff in the ministry; and
- developing clear and current protocols between local health authorities and ministry offices.

Planning completed and implementation to begin by April 30, 2014.

Recommendation 5

- 5(a) That the College of Physicians and Surgeons of British Columbia and the College of Registered Nurses of British Columbia inform their members of the findings of this investigation with respect to reporting a child in need of protection, and remind their members of their statutory responsibility to report pursuant to s. 14 of the *Child, Family and Community Service Act*.
- 5(b) That the Attorney General of B.C. review the reasons for a lack of enforcement of the *CFCS Act* in the province and take steps to promote compliance, if necessary.

Details:

To be completed within 30 days of the release of this report.

Recommendation 6

As recommended in the Representative's report of 2008, *Amanda, Savannah, Rowen and Serena: From Loss to Learning*, the Ministry of Children and Family Development, as part of its current recruitment and retention strategy, undertake a comprehensive assessment of staffing, workload and safety challenges and develop a plan to address identified issues.

Details:

- An assessment of staffing levels to account for its impacts to service delivery and illustrate the challenges in meeting practice standards as a result of staff fluctuations.
- A rapid response team be available to cover service-delivery areas and MCFD offices in the areas of child safety, mental health and special needs, so that immediate steps can be taken to address emergencies and clear policies support how to trigger this response, with reporting to the Provincial Director of Child Welfare and the executive of MCFD.
- The assessment will include a review of the scope and scale of the workload of community service managers, and their roles and responsibilities. The intent of this recommendation is to ensure that CSMs are better informed of workload and staffing challenges on the front line.
- If staff turnover is determined to be a barrier to providing services in a manner consistent with legislation, standards and policies, the ministry must identify immediate corrective interventions, implementing innovative approaches to meet long term staffing needs.
- Regular and timely public reporting of staffing and training levels.
- The Representative emphasizes the need to ensure the safety of social workers as set out in Article 22 of the Master Agreement between the Government of B.C. and the BCGEU.

Assessment should be completed and shared with the Representative by June 1, 2014.

Plan should be developed and shared with the Representative by Sept. 1, 2014.

Plan should be implemented by April 1, 2015.

Conclusion

The Invisible Child

There were a great number of services and supports this girl did not receive during her short life, which likely contributed to her death.

One of the major reasons for this was the failure of the professionals involved in her life to recognize and assess the identified cognitive limitations and potentially negative consequences for a child growing up with a parent with an acute mental illness.

Research has shown that when a child experiences such an unpredictable daily life at an early age this can result in feelings of shame, self doubt, and confusion about reality and boundaries.²⁷ The child's coping strategies can be undermined. The child can experience developmental delays, have difficulty socializing, exploring and interacting with others and bonding to his or her parent.

Despite these adverse early-life events, when this girl entered Kindergarten, she was described as happy and shy. The significant difficulties she had with spoken language may have contributed to this shyness and isolation. Subsequent assessment indicated she had a "*mild intellectual deficiency*," some of which may have been the result of growing up in a family in severe distress.

The girl's continued educational testing would verify the persistence of "*severe receptive and expressive language delay*," which would also influence how she interpreted her subsequent experiences.

After her mother was diagnosed with schizophrenia in 2003, the girl was exposed to many of her bizarre and often threatening behaviours. Her home would become unpredictable and unsafe as she witnessed her mother struggle with voices telling her to hurt the girl and to kill herself. With little or no support from the mental health system, neither the girl nor her grandparents understood the mother's chronic mental illness, in particular the acute psychotic episodes the mother experienced. In this case, the mother was the only recognized patient with little or no appreciation for her role as both a parent and child.

This is one of the examples that illustrate how the members of this family and the girl in particular were invisible to the systems that could have helped her and offered services in a more appropriate manner.

This lack of awareness was coupled with a corresponding failure to appreciate the statutory duty on every British Columbian to report instances of actual or potential child endangerment. That multiple professionals repeatedly ignored this core

²⁷ Supporting Families with Parental Mental Illness. A Community Education and Development Workshop. 2002 MCFD and Ministry of Health.

responsibility is inexplicable in the circumstances. Reporting these clear physical and emotional threats to the ministry could have led to an earlier intervention, although the low level of functioning in the local ministry office meant that such an outcome was far from assured.

The child may have tried to provide care for her mother at different times when her illness worsened. This type of role reversal and premature responsibility can result in adverse longer-term consequences, including the loss of a sense of childhood and deep feelings of depression and anxiety. When the mother gave birth to a second daughter, the girl was also tasked with caring for, and sometimes protecting, the baby from their mother. At its most extreme, when the grandparents had left the home, the girl would barricade herself and her sister in their bedroom with a chair wedged against the door while their mother raged through the house. Neighbours told police the girl would have to deal with multiple instances of this kind of behaviour.

The lack of assistance or even recognition of the child's plight must have left her with feelings of deep despair, helplessness and hopelessness and little sense that her future held any positive possibilities.

It would be simplistic and inappropriate to attribute blame in this situation to family members for not providing the support needed to the child. The mother, although she received the most assistance from professionals, still did not receive the level of personal support and support as a parent that she would have received in an urban centre or a well-serviced rural setting. The grandparents were handicapped by their own previous life experiences and their fears for their daughter and grandchildren, including the fear that the ministry would take the girl and her younger sister away if they asked for help. They, like others in their generation, were reluctant to ask for help or did not feel confident that real help would be forthcoming.

The family lived in a closed community that was characterized by bullying and intimidation while being served by an under-resourced and under-trained support system. Mental illness was seen as a shameful secret, and that stigma created further barriers to seeking appropriate supports.

The girl, in particular, lived with secrecy and a sense of shame that affected her ability to trust or to gain any sense of influence and control in her environment. There would have been an additional sense of unresolved loss over the lack of a "normal" childhood, an appropriate parent-child relationship and the sense of a safe environment that is so important to the development of healthy and appropriate coping strategies. All of this placed her at a heightened risk for suicide.

With the confusion and chaos in her family life, this girl would have felt a particular desire to find other means to develop the sense of belonging that every child needs. This need to belong and be included made her vulnerable to exploitation by predatory individuals who were present in her community.

A counsellor who believed the girl had been sexually abused by an adult in the community saw her vulnerability clearly: “*The fear in that young girl was incredible.*” When she sought support after disclosing sexual encounters with an aggressive boy, her efforts to communicate what had happened to a person in authority were hampered by her own developmental challenges around speech and language. The silence in her life around unwanted sexual activity points to a deep problem around recognizing and supporting a response to abuse and early sexualization of First Nations girls. The absence of a social worker or even an adult who could have stood with her during the investigative process must have been a very difficult experience for her. Ultimately, the girl felt that she was not understood or believed and she expressed frustration that no one listened to her.

The frustration manifested itself in her self-harming behaviours and in physical conflicts with her classmates that led to multiple suspensions from school. Her social challenges and tendency to turn inward were well documented in school testing. It was in the school environment, however, that the risks she faced were most clearly perceived by an astute counsellor.

She found that she could release some of her feelings and anger when she joined the school wrestling team. She excelled at this, but her suspensions at school continued and she was still so stressed that she resorted to cutting her wrist with a pair of scissors while she was on a schoolbus heading back home after a tournament in another town. Twenty stitches would be needed to close that wound.

Research published two years prior to the girl’s suicide indicated that adolescents who were admitted to hospital for self-harm were almost twice as likely to make a suicide attempt if they had at least one biological parent with mental health problems. These risks increased for adolescents with previous suicide attempts and functional impairment.²⁸ That these factors failed to trigger the responsible individuals to take immediate action suggests deep underlying systemic challenges that require urgent attention.

Geography also played a role in how this child lived and died. Rural and remote locations pose significant challenges to service delivery, as do fragile relationships between bands and ministry staff that prevent workers from doing their job.

This tragic story will remain only that, unless it galvanizes professionals and communities to focus on directing financial and human resources to build better systems that truly serve children and always have them and their best interests at the centre of every decision.²⁹ This girl lived in a world that never reached out to make her life the best it could be – she received little or no service and, despite showing great resilience up to her 14th year, it all fell apart and she could no longer continue. She left a family to grieve for her and a story that can only be seen as tragic beyond words, especially because our system of safety and care was nowhere to be found.

²⁸ Cheryl A. King, David C.R. Kerr, Michael N. Passarelli, Cynthia Ewell Foster and Christopher R. Merchant. One Year Follow-up of Suicidal Adolescents; Parental History of Mental Health Problems and Time to Post-Hospitalization Attempt. August 2009, Published online at Springer Science and Business Media LLC 2009.

²⁹ Representative for Children and Youth, *When Talk Trumped Service: A Decade of Lost Opportunity for Aboriginal Children and Youth in B.C., Special Report.* (2013)

Glossary

Aboriginal: a broad term that, according to the *Constitution Act* of 1982, includes the Indian, Inuit and Métis people of Canada. However, the term “Aboriginal” is generally more broadly interpreted as including people who are registered status Indians, non-registered Indians, Inuit and Métis. Non-registered Indians are generally people who self-identify as having Aboriginal heritage, but who are not eligible to be registered under the *Indian Act*.

Child Family and Community Service Act (CFCS Act): the B.C. legislation governing child welfare services in the province. These services include child protection, children in care services and family support services.

Child and Youth Mental Health (CYMH) services: a range of mental health supports and services provided to children and youth under the age of 19. The range of services includes, intake, screening, referrals, assessment, planning, therapeutic treatment, case management and collaboration and clinical consultation. CYMH services are provided directly through the ministry or through contracted community based organizations, such as delegated Aboriginal Agencies.

Child Out of the Parental Home (COPH) program: introduced on Jan. 1, 2010 by Aboriginal Affairs and Northern Development Canada (formerly Indian and Northern Affairs Canada). It provides financial assistance to children placed with a relative living on-reserve. It replaced the federal Guardian Financial Assistance program and introduced a screening component, which is conducted by the ministry’s After Hours to check that there are no apparent safety concerns related to the proposed caregivers and other adults living in the home.

Child protection report: a report received about a child’s need for protection due to abuse or neglect. Every report received is assessed to determine the most appropriate response. Responses include taking no further action, referring the family to support services, providing a family development response, providing a youth response if the child is a youth or conducting a child protection investigation.

Comprehensive Risk Assessment (CRA): a process and document that describe the risk of harm to a child and the mitigating strengths of the family. Risk assessment includes a review of previous child protection reports regarding the family, identification of risk factors and the potential for future harm to the child. A CRA is completed whenever a child is found in need of protection.

Crisis Response Unit (CRU): a community facility with nurses that operates 24 hours a day, seven days a week. It provides voluntary services to people experiencing a crisis. The level of service is midway between outpatient therapy and psychiatric hospitals.

Delegated Aboriginal Agency (DAA): an Aboriginal agency that has negotiated a delegation agreement with the Provincial Director of Child Protection (the Director), who has given authority to the agency and its qualified social workers to undertake administration of all or parts of the *CFCS Act*.

Delegation: refers to the authority of the Director to delegate powers, duties and functions under the *CFCS Act* to qualified social workers. In addition to educational qualifications, delegation of authority is based on the individual to be delegated having achieved and demonstrated the necessary competence through competency-based training and supervised practices.

Designated Psychiatric Facility: a provincial mental health facility, psychiatric unit or observation unit where a person may be admitted under authority of the *Mental Health Act*.

Fetal Alcohol Spectrum Disorder (FASD): term used to describe the effects caused by drinking alcohol during pregnancy. These effects may include physical, mental, behavioural and/or learning disabilities with possible life-long implications. Some children with FASD have physical disabilities but many of the effects are not visible and may include problems with learning, memory, attention, problem solving, behaviour, vision and hearing. Someone who has FASD may not understand social situations and their behaviour is often interpreted as problematic, rather than as a symptom of an underlying condition.

English Skills Development (ESD): a Ministry of Education program that assists students in English language acquisition and skills development.

Family service file: the MCFD legal record of services provided to a family through the *CFCS Act* and *Adoption Act*.

First Nation(s): a term that became more common during the 1970s to replace the term “Indian.” While there is no legal definition for the term “First Nation(s),” it is meant to describe those persons who are registered as “Indians” under the Federal *Indian Act*.

Immediate Safety Assessment: an assessment completed during a child protection investigation that focuses on the child’s present situation and does not attempt to predict the occurrence of future harm to the child. It is conducted in consultation with a social worker’s supervisor.

Individual Education Plan (IEP): The IEP is mandated under the provincial *School Act* to provide individualized plans to students identified with special needs. These students are those assessed as requiring more than just minor adaptations to educational or physical supports or working on outcomes other than the prescribed curriculum, or working on regular outcomes with little or no adaptation but requiring 25 hours or more of remedial help from someone other than the classroom teacher.

Intake: the process by which child protection reports and requests for service are introduced into an office. These reports and requests for service are assessed and assigned to social workers for follow up.

Intelligence Quotient (IQ): a measure of intellectual capacity. IQ 70 has commonly been used as a cut-off point in talking about or defining intellectual disability. IQ results can be influenced by a person’s environment and a person may score lower due to stress in his or her environment.

Lateral violence: a dysfunctional and harmful behaviour in which aggression and hostility are directed towards colleagues, peers and community members. Lateral violence includes gossiping, shaming, humiliating, bullying and socially excluding others. This is seen as an intergenerational learned pattern and major social problem in Aboriginal communities. According to Wesley-Esquimaux & Smolewsky, lateral violence is one of the pathological expressions of historical trauma in relation to a long history of colonization and internalized oppression and is prevalent in many First Nations communities.

Leave authorization: from a designated facility refers to the release of an involuntary patient into the community under specific conditions. Short-term leaves are 14 days or less while extended leave is longer than 14 days.

Local Aboriginal Agency (LAA): an Aboriginal agency that has not negotiated a delegation agreement with the Provincial Director of Child Protection. An LAA may undertake contracted services for the ministry including Aboriginal Child and Youth Mental Health services, but it does not have the authority to undertake the administration of any part of the *CFCS Act*.

Protection investigation: A process of inquiring into the safety and welfare of a child under 19 years of age involving the review of information and interviews with the child, parents, teachers, daycare providers, public health nurses and extended family members. The authority to compel information from these sources is found in s. 96 of the *CFCS Act*.

Reviewable services: services or programs under the *CFCS Act* and *Youth Justice Act*, including mental health and addictions services to children. The Representative's authority to review or investigate is limited to a child or youth who has been critically injured or died and who had been receiving a reviewable service in the year prior to the child or youth's incident.

Schizophrenia: a mental disorder characterized by a breakdown of thought processes and impairment of emotional responses. Common symptoms are delusions including paranoia, auditory hallucinations, disorganized thinking and a loss of emotion, speech or motivation.

Section 96, *CFCS Act*: gives delegated ministry social workers the right to any information that is in the custody or control of a public body as defined in the *Freedom of Information and Protection of Privacy Act* and is necessary to enable the delegated social worker to exercise his or her powers or perform his or her duties or functions under the *CFCS Act*.

Social Worker (delegated): an employee of the ministry or delegated Aboriginal Agency who has been delegated all of the powers, duties or functions under the *CFCS Act* by the director, pursuant to s. 92 of the *CFCS Act*.

Suicide: Intentional, self-inflicted death.

Suicidal ideation: Self-reported thoughts of engaging in suicide-related behaviour.

Appendix A:

Representative for Children and Youth Act

Part 4 – Reviews and Investigations of Critical Injuries and Deaths

Reviews of critical injuries and deaths

- 11 (1) After a public body responsible for the provision of a reviewable service becomes aware of a critical injury or death of a child who was receiving, or whose family was receiving, the reviewable service at the time of, or in the year previous to, the critical injury or death, the public body must provide information respecting the critical injury or death to the representative for a review under subsection (3).
- (2) For the purposes of subsection (1), the public body may compile the information relating to one or more critical injuries or deaths and provide that information to the representative in time intervals agreed to between the public body and the representative.
- (3) The representative may conduct a review for the following purposes:
- (a) to determine whether to investigate a critical injury or death under section 12;
 - (b) to identify and analyze recurring circumstances or trends
 - (i) to improve the effectiveness and responsiveness of a reviewable service, or
 - (ii) to inform improvements to broader public policy initiatives.
- (4) If, after completion of a review under subsection (3), the representative decides not to conduct an investigation under section 12, the representative may disclose the results of the review to the public body, or the director, responsible for the provision of the reviewable service that is the subject of the review.

Investigations of critical injuries and deaths

- 12 (1) The representative may investigate the critical injury or death of a child if, after the completion of a review of the critical injury or death of the child under section 11, the representative determines that
- (a) a reviewable service, or the policies or practices of a public body or director, may have contributed to the critical injury or death, and
 - (b) the critical injury or death
 - (i) was, or may have been, due to one or more of the circumstances set out in section 13 (1) of the *Child, Family and Community Service Act*,
 - (ii) occurred, in the opinion of the representative, in unusual or suspicious circumstances, or
 - (iii) was, or may have been, self-inflicted or inflicted by another person.

- (2) The standing committee may refer to the representative for investigation the critical injury or death of a child.
- (3) After receiving a referral under subsection (2), the representative
 - (a) may investigate the critical injury or death of the child, and
 - (b) if the representative decides not to investigate, must provide to the standing committee a report of the reasons the representative did not investigate.
- (4) If the representative decides to investigate the critical injury or death of a child under this section, the representative must notify
 - (a) the public body, or the director, responsible for the provision of the reviewable service, or for the policies or practices, that may have contributed to the critical injury or death, and
 - (b) any other person the representative considers appropriate to notify in the circumstances.

Appendix B: Documents Reviewed for the Representative's Investigation

Ministry of Children and Family Development Records

- Mother's Family service file
- Grandmother's Family service file
- Child's Child service file
- Child's CYMH file
- Regional Critical Incident file
- Child's aunt's Family service file
- Child's reportable circumstance report
- Ministry staffing records
- Ministry practice audits (2007)

Local Aboriginal Agency Records

- Child's Aboriginal Wellness file
- Client Services Agreement with ministry
- CYMH component services schedule
- Contract with MCFD appendix – family support worker – preferred activities

RCMP Records

- Records from 4 communities respecting mother and child

Medical Records

- Child's medical records – 2 hospitals, medical clinic
- Mother's medical records – 3 hospitals, medical clinic
- Mother's Mental Health and Addiction file

Health Canada Records

- Child's clinical records

Ministry of Social Development Records

- Mother's file

BC Coroners Service Records

- Kimble report for child
- Kimble report for child's father
- Coroner's report for child
- Coroner's investigation notes for child

Ministry of Education Records

- Child's school records, Kindergarten to Grade 9

Legislation, Regulations, Standards and Policy

- *British Columbia Child, Family and Community Service Act* (1996) Victoria, B.C. Queens Printer
- *The Risk Assessment Model for Child Protection in BC* – MCFD
- *Mental Health Act* (1996) Victoria, B.C. Queens Printer
- *Child Abuse and Neglect Guidelines, Professional Standards and Guidelines*, College of Physicians and Surgeons of British Columbia
- *Child and Family Development Service Standards* – MCFD
- *Child and Youth Mental Health – Clinical Policy Manual*
- *Child and Youth Mental Health – Service Standards*
- LAA Aboriginal Wellness policy manual
- *LAA Administration and Operations Manual*
- All available protocols between MCFD, CYMH, contracted agency, health authority, band, RCMP, school
- *Mental Health and Addictions Policy Manual* – Ministry of Health
- *Preventing Youth Suicide: A Guide for Practitioners (October 2010)* – MCFD
- *BC Ministry of Education – Special Education Services: A Manual of Policies of Procedures and Guidelines (2013)*
- *RCMP "E" Division Operational Manual*
- *RCMP Headquarters Operational Manual*
- *The 16th Master Agreement Between the Government of the Province of British Columbia represented by the B.C. Public Service Agency and the B.C. Government and Service Employees Union (BCGEU) (November, 2012)*
- *The 16th Component Agreement Between the Government of the Province of British Columbia represented by the B.C. Public Service Agency and the B.C. Government and Service Employees Union (BCGEU) Social, Information and Health Component (November 2012)*

Appendix C: Interviews Conducted During the Representative's Investigation

- Family Members (6)
- MCFD child protection and management staff (9)
- MCFD CYMH staff (2)
- Local Aboriginal Agency staff (2)
- Regional health authority staff (7)
- Health Canada (1)
- School staff (4)
- Victim Services (1)
- RCMP staff (3)
- Band staff (5)
- Canadian Mental Health Association (1)
- Community mental health clinician (1)

Appendix D: Multidisciplinary Team

Under Part 4 of the *Representative for Children and Youth Act* (see Appendix A), the Representative is responsible for investigating critical injuries and deaths of children who have received reviewable services from MCFD within the 12 months before the injury or death. The Act provides for the appointment of a Multidisciplinary Team to assist in this function, and a Regulation outlines the terms of appointment of members of the Team.

The purpose of the Multidisciplinary Team is to support the Representative's investigations and review program, providing guidance, expertise and consultation in analyzing data resulting from investigation and reviews of injuries and deaths of children who fall within the mandate of the Office, and formulating recommendations for improvements to child-serving systems for the Representative to consider. The overall goal is prevention of injuries and deaths through the study of how and why children are injured or die and the impact of service delivery on the events leading up to the critical incident. Members meet at least quarterly.

The Multidisciplinary Team brings together expertise from the following areas and organizations:

- Ministry of Children and Family Development, Child Protection
- Policing
- BC Coroners Service
- BC Injury Research Prevention Unit
- Aboriginal community
- Pediatric medicine and child maltreatment/child protection specialization
- Nursing
- Education
- Pathology
- Special needs and developmental disabilities
- Public health

Multidisciplinary Team Members

Beverley Clifton Percival – Ms. Percival is from the Gitxsan Nation and is a negotiator with the Gitxsan Hereditary Chiefs' Office in Hazelton. She holds a degree in Anthropology and Sociology and is currently completing a Master of Arts degree at UNBC in First Nations Language and Territory. Ms. Percival has worked as a researcher, museum curator and instructor at the college and university level.

Dr. Jean Hlady – Dr. Hlady is a clinical professor in the Department of Pediatrics at the University of British Columbia's Faculty of Medicine. She is also a practising pediatrician at BC Children's Hospital and has been the Director of the Child Protection Service Unit for 21 years, providing comprehensive assessments of children in cases of suspected abuse or neglect. Dr. Hlady also served on the Multidisciplinary Team for the Children's Commission.

Sharron Lyons – With 32 years in the field of pediatric nursing, Ms. Lyons currently works as a Registered Nurse at the BC Children's Hospital, is past-president and current treasurer of the Emergency Nurses Group of BC and is an instructor in the provincial Pediatric Emergency Nursing program. Her professional focus has been the assessment and treatment of ill or injured children. She has also contributed to the development of effective child safety programs for organizations such as the BC Crime Prevention Association, the Youth Against Violence Line, the Block Parent Program of Canada and the BC Block Parent Society.

Dr. Ian Pike – Dr. Pike is the Director of the BC Injury Research and Prevention Unit and an Assistant Professor in the Department of Pediatrics in the Faculty of Medicine at the University of British Columbia. His work has been focused on the trends and prevention of unintentional and intentional injury among children and youth.

Dr. Dan Straathof – Dr. Straathof is a forensic pathologist and an expert in the identification, documentation and interpretation of disease and injury to the human body. He is a member of the medical staff at the Royal Columbian Hospital, consults for the BC Children's Hospital and assists the BC Coroners Service on an ongoing basis.

Sherri Bell – Ms. Bell is the Deputy Superintendent of Schools for School District 61 (Greater Victoria), and chairs Board subcommittees on Public Engagement, Professional Relations and Curriculum Implementation. She has more than two decades of experience working in education, including assignments as a District Principal, Director of Instruction and Associate Superintendent of Schools. She has a Bachelor of Education degree and a Masters of Administration and Curriculum Development.

Dr. Christine Hall – Dr. Hall is the Medical Director of Trauma Services for the Vancouver Island Health Authority and an Associate Professor at the University of Calgary and a Clinical Assistant Professor at the University of B.C. In addition to her training in emergency medicine, Dr. Hall has a Masters degree in clinical epidemiology.

Derren Lench – Chief Superintendent Derren Lench is currently the Deputy Criminal Operations Officer – Core Policing, working at “E” Division RCMP Headquarters in Surrey. He has several Provincial Programs that report to his position including Traffic Services, Critical Incident Program, Operational Communications Centers, Aboriginal Policing, Crime Prevention, West Coast Marine Section, Occupational Safety Officers and the Operations Secretariat. In his role, he works closely with RCMP District Commanders across the Province and liaises with the Province on key issues and priorities. C/Supt. Lench has 33 years of service with the RCMP. He is the Vice President of BC Association of Chiefs of Police, is the Pacific Region Vice-Chair of the National Joint Committee of Senior Justice Officials, and is on the Canadian Association of Chiefs of Police Victims of Crime Committee.

Cory Heavener – Ms. Heavener is Assistant Deputy Minister and Provincial Director of Child Welfare for the Ministry of Children and Family Development. She is the former Head of the Provincial Office of Domestic Violence. She was previously the Director of Critical Injury and Death Reviews and Investigations for the Representative for Children and Youth. Cory has a lengthy career in child welfare in British Columbia and began her career as a child protection social worker 25 years ago.

Pat Cullinane – Mr. Cullinane is the Deputy Chief Coroner of Operations for the BC Coroners Service. Prior to joining the Coroners Service in 2011, he was the Executive Director of Employment Standards for BC. Mr. Cullinane commenced his career as a child protection social worker and has been involved in both conducting and leading complex investigations in various ministries and programs since 1984.

Appendix E: The Mental Health System in B.C.

The *Mental Health Act (MHA)* provides the authority for the regional health authority to administer mental health services in B.C.

Most people in B.C. requiring treatment for mental health disorders are voluntarily admitted to hospital. However, many persons with serious mental disorders refuse psychiatric treatment. They may require involuntary admission to hospital, also called “certification” under the *MH Act*.

Without treatment, these people may continue to suffer and can cause significant disruption or harm to others. In 2003, there were approximately 8,000 involuntary admissions in the province.³⁰

Certification under the *MH Act* requires a hospital physician to complete one medical certificate (Form 4). If the criteria under the *MH Act* are met, the person can be legally detained for up to 48 hours in a hospital. During this time, the person may be transported to a hospital designated under the *MH Act* for the completion of a second medical certificate by a physician there. Not all hospitals are designated under the *MH Act*.

If a second physician certifies the person in the non-designated hospital, the patient can be detained there for up to five days before being transported to a designated hospital.

If the second medical certificate is completed at the designated facility within 48 hours of the first, the person can be admitted as an involuntary patient for up to one month.

If the physician completes a renewal certificate (Form 6) within 30 days, the involuntary admission can be extended but must be renewed within specified intervals or the authority lapses and the client is no longer subject to the *MH Act* certification.

A patient may be granted leave under s. 37 of the *MHA* to access community programs or for various other reasons the physician considers appropriate.

Where the leave extends beyond 14 days, a Form 20 must be completed. This form may specify conditions of the extended leave. The conditions on Form 20 do not require renewal unless the conditions change.

The granting of extended leave does not reduce the authority of the *MH Act* and the patient can be returned to the designated facility involuntarily through a warrant issued by the hospital director.

A patient can be discharged from involuntary status at any time prior to the expiration of a medical certificate or renewal certificate with the consent of the patient and doctor, a court order or approval of a hospital review panel.

An error or lapse in the renewal process will also void certification under the *MH Act*.

³⁰ *Guide to the Mental Health Act*, B.C. Ministry of Health, 2005 edition

Appendix F: Ministry's October 2010 *Preventing Youth Suicide: A Guide for Practitioners*

Table 2 summarizes the risk and protective factors for suicide among youth.

Key Context	Predisposing Factors	Contributing Factors	Precipitating Factors	Protective Factors
Individual	<ul style="list-style-type: none"> • previous suicide attempt • depression or other mental disorder (e.g. substance use disorder, anxiety, bipolar disorder, conduct disorder) • hopelessness • current suicidal thoughts/wish to die • history of childhood neglect, sexual or physical abuse 	<ul style="list-style-type: none"> • rigid cognitive style • poor coping skills • substance misuse • gay, lesbian, bisexual or transgendered sexual orientation • impulsivity • aggression • hypersensitivity/anxiety 	<ul style="list-style-type: none"> • loss • personal failure • humiliation • individual trauma • health crisis 	<ul style="list-style-type: none"> • individual coping and problem solving skills • willingness to seek help • good physical and mental health • experience/feelings of competence • strong cultural identity and spiritual beliefs
Family	<ul style="list-style-type: none"> • family history of suicidal behaviour/suicide • family history of mental disorder • family history of child maltreatment • early childhood loss/separation or deprivation 	<ul style="list-style-type: none"> • family discord • punitive parenting • impaired parent-child relationships 	<ul style="list-style-type: none"> • loss of significant family member • death of a family member, especially by suicide • recent conflict 	<ul style="list-style-type: none"> • family cohesion and warmth • positive parent-child connection • adults modeling healthy adjustment • active parental supervision • high and realistic expectations
Peers	<ul style="list-style-type: none"> • social isolation and alienation 	<ul style="list-style-type: none"> • negative youth attitudes toward seeking adult assistance • poor peer relationships • peer modeling of suicidal behaviours 	<ul style="list-style-type: none"> • teasing/cruelty/bullying • interpersonal loss or conflict • rejection • peer death, especially by suicide 	<ul style="list-style-type: none"> • social competence • healthy peer modeling • peer acceptance and support
School	<ul style="list-style-type: none"> • long-standing history of negative school experience • lack of meaningful connection to school 	<ul style="list-style-type: none"> • reluctance/uncertainty about how to help among school staff 	<ul style="list-style-type: none"> • failure • expulsion • disciplinary crisis 	<ul style="list-style-type: none"> • success at school • interpersonal connectedness/belonging
Community	<ul style="list-style-type: none"> • multiple suicides • community marginalization • political disenfranchisement • socioeconomic deprivation 	<ul style="list-style-type: none"> • sensational media portrayal of suicide • access to firearms or other lethal methods • reluctance/uncertainty about how to help among key gatekeepers • inaccessible community resources 	<ul style="list-style-type: none"> • high profile/celebrity death, especially by suicide • conflict with the law incarceration 	<ul style="list-style-type: none"> • opportunities for youth participation • availability of resources • community control over local services • cultural/spiritual beliefs against suicide

Appendix G: Agreement

Sixteenth Component Agreement between the Government of the Province of British Columbia represented by the B.C. Public Service Agency and the BCGEU representing employees of the Social, Information & Health Component (03/2014)

APPENDIX 4

Workload

It is in the interest of the Employer and the employees that all employees are aware of their job expectations and responsibilities.

It is the responsibility of supervisors and managers to ensure that staff perform their duties in accordance with Ministry Policies and Procedures and to ensure that procedures are in place to address statutory service demands.

Where an employee is concerned that they cannot complete assignments or respond to urgent matters to fulfil statutory and other obligations to a client(s), it is their responsibility to immediately seek advice and direction from their direct supervisor.

Where work demands and priorities cannot be accomplished within appropriate time frames, supervisors must consult with management and management will determine methods and procedures regarding work demands and priorities to ensure that service quality is maintained by employees and the Employer.

To assist in achieving the above objectives, the following procedures shall be utilized when an employee is of the opinion that they are unable to fulfil statutory and other obligations to a client(s) because of their work demands. All participants in these procedures will act in a timely and expeditious fashion at each stage. Where the employee is not satisfied with the timeliness of the response at any stage, they may proceed to the next stage.

Stage 1

The employee shall discuss the matter with their direct supervisor and specify what work demands are causing them to be unable to fulfil the statutory and other obligations of their job. The direct supervisor will direct the employee as to the manner in which the employee should proceed in order for the employee to carry out their assigned duties. Within 14 days the supervisor will attempt to resolve the matter.

Stage 2

If after the completion of Stage 1, the employee continues to hold the opinion that they are unable to fulfil statutory and other obligations to a client(s) because of the specified work demands, then the employee will advise their direct supervisor, in writing on the agreed form, of this fact, giving reasons and details of the work demands which give rise to the employee's continuing view that they are unable to fulfil the statutory and other obligations of their job. These details shall include identification of the specific legislative and other provisions which the employee believes they are unable to fulfil.

A designated representative of the Ministry, who is excluded from the bargaining unit, will develop with the supervisor a written direction to the employee within 14 days as to how the employee is to proceed in order for the employee to fulfil statutory and other obligations to a client(s). Responsibility for any consequences of complying with the direction will not rest with the employee. **The designated representative of the ministry shall ensure that a** copy of the documentation including the written direction will be forwarded to the next level of excluded manager and to the local union chair through the union area office.

Stage 3

Should the employee continue to hold the opinion that they are unable to fulfil their statutory and other obligations after the completion of Stage 2, the employee may refer the matter, in writing, to the Article 29 Committee. The Article 29 Committee shall develop process and procedures appropriate to the Ministry context to address the issues, including establishing sub-committees where appropriate. The Article 29 Committee will provide a response within 30 days of the matter being reviewed at the Committee. The employee will be provided with a copy of this response in writing. Responsibility for any consequences of complying with the direction will not rest with the employee.

A copy of the complete documentation regarding the matter will be provided to the Deputy Minister.

This appendix is not subject to the grievance or arbitration procedures of Articles 8 and 9 of the Master collective agreement.

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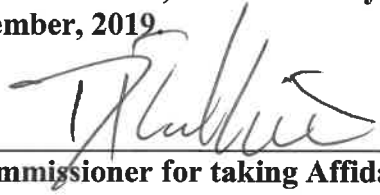
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REPRESENTATIVE FOR
CHILDREN AND YOUTH

**This is Exhibit "K" referred to in the
Affidavit of Mary Ellen Turpel-Lafond,
sworn before me, on this 7th day of
November, 2019.**

A handwritten signature in black ink, appearing to read "T. K. H. W.", is written over a horizontal line.

A commissioner for taking Affidavits



REPRESENTATIVE FOR
CHILDREN AND YOUTH

Children at Risk:
*The Case for a Better Response
to Parental Addiction*

Investigative Report

June 2014

June 24, 2014

The Honourable Linda Reid
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Ms. Speaker,

I am pleased to submit the report *Children at Risk: The Case for a Better Response to Parental Addiction* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of critical injuries and deaths of children receiving reviewable services.

Sincerely,

A handwritten signature in black ink, reading "meturpellafond", written in a cursive style.

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Craig James
Clerk of the Legislative Assembly

Jane Thornthwaite
Chair, Select Standing Committee on Children and Youth



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Executive Summary

When it comes to social work, protection of the child's best interests should trump everything else. Chief among those interests is the physical safety of a vulnerable child.

This report by the Representative for Children and Youth details the story of one British Columbia child who was not adequately protected because his safety and well-being were never made top priorities by the Ministry of Children and Family Development (MCFD). As a result, the 10-year-old boy suffered serious spinal and head injuries in a motor vehicle incident – injuries that are likely to affect him for the rest of his life.

This is the story of how parental substance misuse and addiction can have a detrimental effect on the lives of children. The boy in this case should not have been under the supervision of his mother and her boyfriend at all, let alone riding in a vehicle with these two adults who had been drinking that day as they visited a ski hill with the child.

Most importantly, this report recommends improvements that must be made to B.C.'s child protection and health care systems so that this boy's story is not repeated.

MCFD does not track the percentage of its child protection cases in which parental substance misuse or addiction are a factor. But anecdotally, ministry workers have expressed belief that the number is extremely high. In fact, in a 2002 survey of MCFD workers, staff estimated that 70 per cent of their child protection cases included substance misuse by the mother. According to the ministry's own practice guidelines, substance abuse by a parent is *"a dominant reality in child protection work."*

In this boy's case, the mother had a long history of addiction including use of cocaine, amphetamines and opiates. The ministry was aware of these problems and aware that the child was at risk if left under the mother's care. MCFD was also aware that the child's maternal grandparents minimized the mother's substance problems and continually failed to follow safety plans by allowing the child to be supervised solely by the mother.

Despite five child protection reports and repeatedly ignored safety plans over nine years, MCFD did not take concrete action to remove the boy from the care of his family until after the motor vehicle incident that led to a five-month stay in hospital and permanent disability.

So what went wrong here? How were this child's best interests and safety not made the paramount concerns? The Representative's investigation turned up a number of reasons, which lead to the recommendations in this report.

While MCFD has had a policy in place since 2001 that spells out how to deal with issues of parental substance misuse and addiction, it seems that this policy is not widely used. In this child's case, only one of the 10 workers, including supervisors, assigned to the file over nine years had any formal training on how to work with families challenged by

addiction. Only one of the workers had heard of the 2001 MCFD policy and none of that policy's tools were used in this case.

As well, MCFD could provide the Representative's investigators with no information on overall funding of worker training on this subject as there is no dedicated budget within MCFD for training to address issues of parental substance misuse.

Another major factor in this case was the capacity of the child's elderly grandparents to care for him and to ensure he was protected from his mother's addiction. The report also finds that the ministry failed to properly engage the extended family in the child's care and safety planning and that their co-operation was difficult to obtain due to the denial and minimization that are such common family dynamics in cases of addiction.

The poor relationship between the ministry and the family led to the child suffering neglect and being repeatedly put at risk. As the mother's addictions intensified, the family's relationship with MCFD deteriorated leading, ultimately, to the critical injuries. Lost in this broken relationship between the family and ministry were the child's best interests.

Therefore, the Representative recommends in this report that MCFD take immediate steps to ensure that child protection practice is resolutely focused on serving the best interests of the child over any other interests – including the preservation of the family unit – in line with the principles articulated in the *Child, Family and Community Service Act (CFCS Act)*.

This recommendation includes a particular focus on parental substance use. It calls for the ministry to make specialist substance use consultants available in every service area of B.C. to assist in effective safety planning for children and, where appropriate, to assist in developing engagement strategies and support for family members.

The recommendation also speaks specifically to situations in which placement with members of the extended family is being contemplated for a child. It calls for a timely assessment of both the needs of the child and the capacity of the prospective relatives to meet those needs prior to a long-term placement.

The Representative is also recommending that MCFD create a learning tool, based on the findings of this report, to be disseminated to executive directors of practice, community service managers and team leaders across the province, along with directions on how to facilitate organizational learning using this tool.

Another finding of the report is that addiction services in B.C. differ widely from community to community and region to region. In this case, the mother may have received more effective help had she not encountered wait-lists in her initial attempts to seek treatment or been left to move in with a fellow addict following treatment. The report finds that there is a need in B.C. for a trauma-informed approach to addiction that is flexible to the unique needs of those being treated.

The Representative recommends that MCFD and the Ministry of Health work together to create a comprehensive addictions strategy and a system of care for parents with substance use issues. This effort must focus on filling the currently existing gaps in service, including supports for parents, children and other involved family members, and provide accessible and effective services.

Included in this recommendation is a call for the two ministries to provide priority access to addictions treatment and tailored, timely services for parents in cases where there are active child protection concerns.

Introduction

On a winter evening in January 2009, the child who is the subject of this report and his mother were passengers in a vehicle driven by the mother's boyfriend. Although he had been placed in the care of his grandparents, who were told to supervise all visits with his mother, this child with complex needs was with two intoxicated adults while they were travelling on a rural highway. Their vehicle crossed the centre line of the highway and hit an oncoming car.

The 10-year-old child sustained critical injuries, including damage to his spine and a closed-head injury.¹ His mother suffered injuries to her hand and wrist. The passenger of the other vehicle also sustained serious injuries, which would require two years for a full recovery. The mother's boyfriend was witnessed by several citizens fleeing the scene of the accident on foot and was later found by police at his home. According to the police report to Crown Counsel, he suffered a sore neck and shoulder and sustained bruising to his body as a result of the crash.

At the time of the motor vehicle incident, this family was receiving services from a child protection team at the local MCFD office. The impact of the mother's substance misuse had been a recurring child protection concern during the previous eight years. As a result, the child had often been in the care of his maternal grandparents.

Several months before the incident, the grandparents, both in their 70s, had taken over the care of this child with complex needs and had been instructed by MCFD not to allow the mother to care for the child without adequate supervision. However, neither grandparent was present on the evening of the motor vehicle collision.

After receiving a report of this critical injury in accordance with the *Representative for Children and Youth Act (RCY Act)*², the Representative undertook a review, concluding that a full investigation was warranted.

The objective of a Representative's investigation is to examine whether policies or practices of a reviewable service or public body may have contributed to the death or critical injury of a child. Essentially, an investigation seeks answers to the questions that inevitably arise when a child is harmed and the circumstances suggest that the incident could have been preventable, including:

- Why did this happen?
- How did it happen?
- Has anything changed as a result?
- Should anything change as a result?

¹ Closed-head injuries are a type of traumatic brain injury in which the skull and dura mater remain intact. (source: Wikipedia.org)

² *Representative for Children and Youth Act* [SBC 2006] c. 29, s. 11.

In the words of the Honourable Ted Hughes in his *BC Children and Youth Review* (2006), in cases such as these it is necessary to “*understand what went wrong and what went right.*”³

In the process of answering these questions, several points became clear:

- The issue of parental substance misuse is widespread among child protection caseloads;
- The impact of parental substance misuse on children’s well-being can be extremely detrimental and long-term⁴;
- Overcoming the detrimental impacts of substance misuse is extremely difficult.

During the investigation, it also became apparent that this family was served by front-line workers who demonstrated an impressive dedication to helping families and protecting children. It also became evident through this investigation that the child benefited from a loving family. Unfortunately, these favourable circumstances were not enough to protect him.

This report uses one specific case and one child’s life to illustrate the gaps and shortcomings within the child-serving system when it comes to addressing parental substance misuse. In his review, Hughes wrote that the primary purpose of an investigation such as this is to “*point the way to continuous improvements in policy and practice, so that future injuries or deaths can be prevented.*”

It should be noted that this case is not unique, even though the injuries suffered by the child were extreme. Many of the circumstances of this case are, for vulnerable children, all too common.

In this report, care has been taken to avoid identifying the child, now 15-years-old, and his family members by name or location. This is out of respect for the privacy of the child and his family.

³ *BC Children and Youth Review*, Hughes, E.N. (2006)

⁴ Several studies have revealed the devastating impact of parental addiction including a recent Representative’s report *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm*, in which 75 per cent of the mothers of the youth in that aggregate review struggled with substance use issues as well as others. Also see Dube (2003) and Felitti (1998).

Methodology

The Representative's investigation focused on a nine-year time period, from when the family first began receiving services from MCFD to the date of the child's critical injury.

In order to conduct an investigation pursuant to s. 12 of the *RCY Act*, the Representative's Office gathered information from a variety of sources. Documentary evidence was acquired from hospitals, schools, courts, the police and government offices. Interviews were conducted with 20 private individuals and professionals. Research was conducted into best practices in other jurisdictions. Services available to those dealing with a substance use problem were reviewed. Much of the personal information was acquired in accordance with s. 14 of the *RCY Act*, which gives the Representative's Office the power to request information from government bodies.

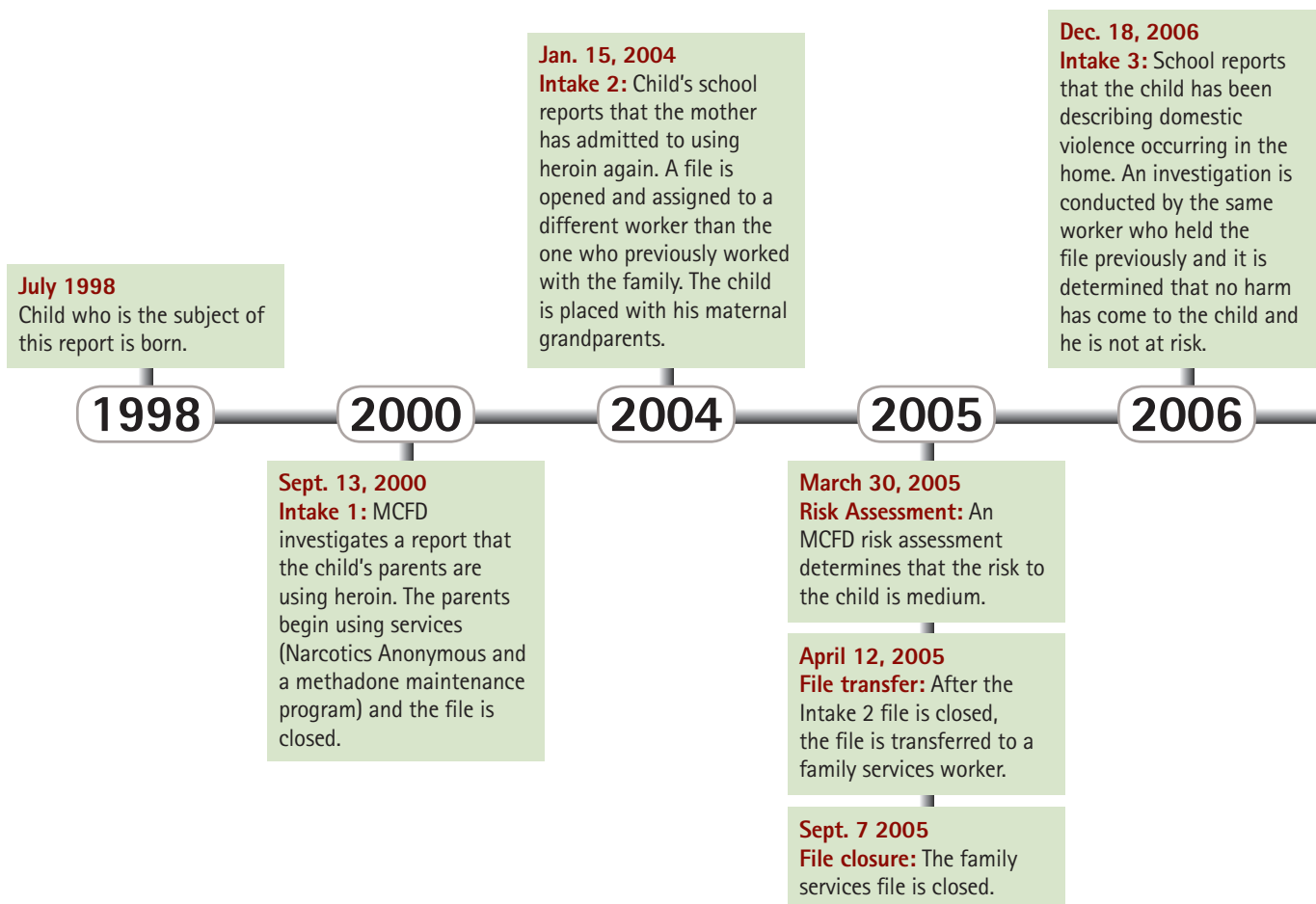
To avoid further traumatizing the child who is the subject of this report, he was not interviewed as part of the investigation. However, two of the Representative's investigators met with the child to see how he was doing.

The Representative's Multidisciplinary Team (see Appendix C) was provided with draft findings near the completion of the investigation for its review and input. An expert panel was also convened and provided advice on the report and the development of recommendations.

To provide for administrative fairness, educational, medical and government organizations that were involved in the investigation were given an opportunity to review this report and provide comments on the facts of this case prior to this report being finalized.



Timeline of Significant Events



Jan. 18, 2008

Intake 4: The mother is brought to the hospital by friends and reports having used crack, cocaine and amphetamines on and off for the past four months. The child is with his maternal grandparents and remains in their care. An investigation is conducted by the same worker who previously held the file. After several failed attempts to engage the mother in services, the file is closed after the family is told verbally and in writing to keep the child with the grandparents until the mother has been clean and sober for six months.

Feb. 15, 2008

Risk Assessment: An MCFD risk assessment determines that the risk to the child is medium.

April-May 2008

Treatment: The mother checks into a treatment centre and completes the two-month recovery program. The child is returned to her care.

2008

Aug. 12, 2008

Intake 5: The ministry receives a report that the mother is using substances regularly while caring for the child. An investigation is initiated by a worker assigned to the family's file.

Aug. 19, 2008

Safety Plan: The mother and the grandmother sign a safety plan that stipulates that the child will reside with the grandmother and that only a responsible adult will supervise the mother and child when the grandparents are unable to do so.

End of August, 2008

Move: The mother moves in with the grandparents and the child.

Sept. 9, 2008

Family Group Conference: A conference is held with the mother, grandmother, two service providers and ministry workers. A service plan is agreed upon.

October, 2008

Drug Test Results: Results from the drug test taken when the investigation was initiated come back indicating regular use by the mother. It is also becoming evident that the services laid out in the service plan are not being used.

Oct. 31, 2008

Risk Assessment: An MCFD risk assessment determines that the risk to the child is high.

Nov. 17, 2008

File Transfer and Letter: A letter is sent to the mother by the newly assigned family services worker. The letter outlines the need for the mother to complete treatment and undergo counselling. There is no response to this letter and numerous attempts to set up a meeting with the family fail.

Jan. 10, 2009

Critical Injury: The child is involved in a motor vehicle incident and suffers a critical injury while in the unsupervised care of his mother.

2009

Jan. 12, 2009

Removal: The child is removed from his mother's care under an interim custody order.

Chronology

The Child's Family

The child who is the focus of this report was born in July 1998 and is the only child of his parents. The hospital intake form indicated that he was healthy at birth with the “single parent” and “inadequate support systems” boxes both checked on the form.

Following the child's birth, he resided with his mother in the home of his maternal grandparents, and later they moved in with the child's father in the same community. The grandmother told the Representative's investigators that shortly after the child's birth, the mother and father began living together and both soon began using heroin. The grandmother speculated that post-partum depression may have had an impact on her daughter, leading to her drug use.

The father had previously suffered an injury in a motor vehicle incident and experienced chronic pain as a result. According to his correspondence with the Family Maintenance Enforcement Program,⁵ he began using illegal drugs in order to manage his pain.

Throughout much of the child's life, he has resided with his mother, his maternal grandparents or all three together. His grandparents have provided a significant amount of care and have often stepped in when the child's mother was unable to care for her son due to struggles with addiction. Now in their late 70s and early 80s, they continue to care for the child, whose complex behavioural, social and learning challenges of unknown origin have been compounded by the injuries sustained in the 2009 motor vehicle incident.

The Child's Life

First Report to the Ministry

On Sept. 13, 2000, when the child was two-years-old, MCFD received a child protection report alleging that the parents were using heroin while caring for him. The ministry opened an intake file and began an investigation. The child protection concerns were “*neglect by a parent with a likelihood of physical harm.*”⁶ A social worker visited the home, interviewed the parents and spoke with the maternal grandparents as well as other family members and a doctor involved in the methadone program.

The MCFD investigation determined that, due to the parents' heroin addiction, the grandparents were actively involved in monitoring the child's safety and well-being. At this time, the grandparents were in their mid- to late-60s. Both of the child's parents agreed to get addiction services and attend support groups, counselling and methadone treatment.

⁵ The British Columbia Family Maintenance Enforcement Program monitors and enforces maintenance orders and agreements for either child support or spousal support.

⁶ S. 13 of the *Child, Family and Community Service Act (CFCS Act)*.

One month after this investigation began, the child was seen by a pediatrician because he was exhibiting head-banging behaviour. The physician's report stated: *"Head banging is a common unharmed behaviour in infants and toddlers. Reassurance and providing love and security is all that is needed. Proper discipline is needed as well."*

The Representative's investigators could find no record of MCFD being made aware of the pediatrician's assessment, nor any evidence of what, if any, actions occurred as a result of these suggestions.

The MCFD investigation concluded that there was no immediate risk to the child's safety and that there were no obvious signs of neglect. After more than four months of involvement with the family, the MCFD worker concluded that the parents had participated in all services as required and were no longer using heroin. The intake was closed on Jan. 26, 2001. A letter from the social worker to the family on this date stated: *"To date, you have been able to complete all of the expectations that you agreed to meet and you are both continuing your recovery in a responsible manner. As such, I have made a decision to close your file with the MCFD at this time."*

Prior to and following this investigation, the grandparents checked on the child and his parents regularly and occasionally took over caring for him for brief periods of time. The mother continued with the methadone program that she commenced during the ministry's involvement; however, her medical record indicates that she may have continued to inject other drugs. The child's father continued to struggle with substance use and the injuries resulting from a motor vehicle incident and he was no longer able to operate his small business. The mother applied for income assistance for herself and the child on Nov. 19, 2001, although she has had periods of low-wage employment in retail stores and fast food restaurants.

The mother told the Representative's investigators that the father was occasionally violent toward her and that they eventually ended the relationship when the child was approximately four-years-old.

When the child was almost five-years-old, he was examined by a number of physicians due to concerns about his behaviours. These included not interacting appropriately with his peers, behaving aggressively, demonstrating unusual fears of eating in front of others and fears of using the bathroom at school. Additional concerns were raised regarding his challenges with comprehension, delayed speech and lack of toilet training. A pediatrician was concerned that the child played violent video games and raised this issue with his mother.

In a letter to the child's general practitioner, dated April 3, 2003, the same pediatrician stated that the child was seen for *"assessment with regards to concerns of behavioural problems and developmental delay."*

"The concern about his behaviour relates mostly to his tendency to be physically abusive to other children and my discussion with mom did not elicit any particular concerns about his development," the pediatrician wrote, later adding: *"[The father] is heavily involved*

in computer building and computer games. He apparently encourages [the child] to play those games and basically [allows] unregulated access to the child which we thought was quite inappropriate for his age to have access to those types of games that have a high violence content.”

The pediatrician also wrote: *“In any case, the long discussion appears to have provided some ideas to mom who seems satisfied with the conversation and intent on making some changes in the child’s life.”*

After the child began Kindergarten in September 2003, he underwent an assessment by his school and a second assessment by Sunny Hill Health Center for Children in Vancouver as a result of the concerns raised previously by both physicians and his school. The school assessment determined that the child had intensive behaviour intervention needs.⁷ The Sunny Hill assessment determined that he had a number of challenges with his ability to pay attention, social isolation and sensory integration, which were impacting his ability to learn and to interact with others. That assessment also noted that the child had difficulty managing anger: *“Primary concerns expressed by the school and family involve difficulties with anger management, aggressive behaviour, attention, social skills and peer relationships.”*

Sunny Hill recommended a highly structured school environment for the child as well as a number of educational supports such as a speech pathologist, a counsellor, and a learning assistant. Sunny Hill also recommended that the child participate in after-school day care programming to develop his social skills.

The child’s school implemented the Sunny Hill recommendations. A child and youth care worker was also assigned to support him by assisting the child in interacting with his peers, developing his self-esteem and helping him to feel comfortable in a classroom setting. The child and youth care worker spent one hour with the child each week. The worker noted that the child appeared to have difficulty regulating his emotions and that at times *“he could just blow up.”*

Halfway through the Kindergarten year, on Jan. 12, 2004, a school district counsellor met with the mother regarding the child’s needs. According to information on the school file, the mother cried throughout the meeting. The counsellor told her that *“her job is to parent,”* that the child needed a consistent bedtime and that he should be denied computer access for one month. When later asked by the Representative’s investigators, the counsellor could not recall the reasons for his comments.

The Sunny Hill assessment also noted that the child’s mother was on a wait-list for inpatient addiction treatment at the time and that there had been a referral to family support services. However, investigators could find no further information to indicate that the mother received these services.

⁷ According to the Ministry of Education’s policy document *Special Education Services: A Manual of Policies, Procedures and Guidelines*, students are eligible for special education funding when they display “antisocial, extremely disruptive behaviour in most environments” and the behaviours persist over time (Ministry of Education, 2011).

Second Report to the Ministry

Three days after the mother met with the school counsellor – on Jan. 15, 2004 – the ministry received a child protection report from the child’s school that the mother had admitted to using drugs and was having difficulty coping. The ministry was told that the mother had stated “*I can’t do this anymore,*” that the child had missed a number of days of school and that, even when he did attend, he was behaving violently.

The child protection report was assigned to a social worker who met with the mother and the grandmother. The worker assessed the child’s mother as having difficulty coping with everyday life. According to the worker, during the meeting the child’s mother reluctantly agreed to participate in a substance use treatment program. It also appeared to the worker that the child’s mother had coached the child to lie to the grandmother regarding his school attendance. During this school year, the child missed a total of 21 days of Kindergarten.

The mother was referred to residential treatment and counselling but she did not participate in either. The ministry worker told the Representative’s investigators that the mother appeared to oscillate between committing to undergo treatment and then refusing to participate.

As a result of the concerns reported, the grandmother, then 68-years-old, took over the child’s care on Jan. 20, 2004. The grandmother was told by the social worker that the mother was not to be given unsupervised access, meaning that the child could not be left in the mother’s care without the grandmother or another responsible adult present to supervise.

The worker later told the Representative’s investigators that she believed the impact to the child as a result of the mother’s drug use was “*total . . . chronic neglect*” and the worker viewed the mother’s substance use as the reason the child was often left alone to watch television or play video games. The worker coded the investigation as “*neglect by parent with likelihood of physical harm and unable to care,*” based on s. 13 of the *Child, Family and Community Service Act (CFCS Act)*.⁸

On Jan. 27, 2004, school staff and a ministry worker arranged for a care team to be set up for the child. At this point, the child was described by his child and youth care workers as being “*totally out of control.*” The care team consisted of school staff, ministry social workers and other professionals involved with monitoring the child. The team met regularly during the year to establish and maintain a school environment that could better support him and keep him on track. School staff later told the Representative’s investigators that at this time the child continued to have difficulty with social skills but was friendly and also appeared to be progressing well while he was in the care of his grandmother.

⁸ *Child, Family and Community Service Act*, RSBC 1996, C. 46.

During this time, the child's mother was receiving income assistance benefits from the Ministry of Employment and Income Assistance, now known as the Ministry of Social Development and Social Innovation (MSDSI). In February 2004, she was approved to receive benefits as a person with persistent multiple barriers to employment (PPMB). According to the medical report completed by the mother's doctor to demonstrate her eligibility for PPMB, the mother suffered from "*severe depression, chronic fatigue, low energy and motivation.*" The mother continued to qualify for these benefits for the duration of the nine-year time period covered by this report.

Despite clear direction given to the grandmother by the MCFD social worker to not allow the mother unsupervised access to the child, the social worker discovered that the grandmother had left the child with his mother for an entire day. It is unclear to the Representative's investigators when this occurred, but the grandmother reported it to the MCFD social worker in May 2004. Upon the grandmother's return on this occasion, she found the child had missed school that day and had been playing video games. The worker was concerned that the grandmother had not complied with her directions but the worker took no further action.

The worker discussed with the maternal grandmother the possibility of applying for permanent custody of the child. The grandmother felt such a step was unnecessary because she believed that the mother would not attempt to remove the child from her care.

The worker recalled speaking to the grandmother on June 24, 2004. The worker contacted her again on June 30 and July 14 but did not receive a response. To follow up, the worker went to the grandmother's home on July 19 and found that the child was again in the sole care of his mother, contrary to the agreement that had been made with the grandmother. The worker later told the Representative's investigators she was alarmed to find that the mother had been given unsupervised access to the child by the grandmother. However, the worker assessed the child as being well cared for despite not being taken to daycare that day. The worker took no further action. The worker also described the grandmother as "*strong,*" "*predictable,*" "*consistent*" and "*good*" with the child and his mother.

When the child was in Grade 1, he was diagnosed with Tourette syndrome and attention deficit hyperactivity disorder (ADHD) by a physician at BC Children's Hospital. File information does not indicate what led to the assessment or who referred him. The report suggested that some of his Tourette symptoms were associated with his excessive exposure to computers and noted that some of the symptoms appeared to diminish when the child was in the care of his grandmother and had more consistency in his home environment.

The worker wanted to conduct a Comprehensive Risk Assessment (CRA) and a Risk Reduction Service Plan, after which the file would be transferred to a family service worker to work with the mother on reducing the risks to the child identified in the CRA. However, the worker was unable to get the mother to meet with her to complete either of these documents. The worker told the Representative's investigators that she attempted to engage the mother for approximately 13 months. Eventually, the worker completed

both documents without the mother's participation. The CRA determined that the child was at medium risk when he was in the care of his mother. The Risk Reduction Service Plan required the mother to complete a drug treatment program by May 12, 2005.

The file was transferred to the family service worker approximately one month after the CRA was completed, on April 12, 2005, and closed in September 2005 because the family service worker believed that the mother had no interest in taking over the child's care from his grandmother. The worker also closed the file because she believed that the child's mother was not engaging in support services other than occasional visits to a counsellor.

In February and June 2005, the mother was evicted from two different homes. During that same year, she began a relationship with an individual who had a history of mental health problems.

Comprehensive Risk Assessment (CRA):

a process that analyzes and documents the risk of harm to a child and the mitigating strengths of the family. Risk assessment includes a review of previous child protection reports regarding the family, identification of risk factors and the potential for future harm to the child. Twenty-three different risk areas are looked at and given a risk rating from 0 to 4. If a rating of 3 or 4 is received, it is considered a high risk factor for that area. Some short descriptions are provided to explain what each rating would look like. For example, under the risk factor of Family Violence, *"a rating of 4 is described as "repeated or serious physical violence or substantial risk of serious physical violence in household."* A CRA is supposed to be completed whenever a child is found in need of protection.

Report of Violence

The maternal grandmother returned the child to his mother's care when he was in Grade 1 or 2; the Representative's investigators could not determine the exact date that this occurred.

According to school staff, the child's behaviour was improving and he was no longer as explosive. He had an occupational therapist and continued to benefit from a counsellor, child and youth care worker and educational assistant. His child and youth care worker at the time described him as a sweet child who was well liked by his friends. His behaviour in school no longer required an intensive behaviour plan but the school continued to use an Individual Education Plan (IEP).⁹

⁹ An Individual Education Plan is mandated by the Ministry of Education, ministerial order 638/95, to provide individualized plans to students identified with special needs and who require: more than minor adaptations to educational material or instructional or assessment methods; the expected learning outcomes to be modified; and require more than 15 hours of remedial help to meet the modified expected learning outcomes from someone other than the classroom teacher. Changes to policy have occurred over time. For the current ministerial order see: <http://www.bced.gov.bc.ca/legislation/schoollaw/e/m638-95.pdf>

A year-end review of the child's IEP was conducted by the school at the end of his Grade 2 year. It found improvement in his socialization and a decrease in his social anxieties. The child continued to demonstrate improvements, despite being frequently late for school.

Third Report to the Ministry

When the child was in Grade 3, concerns were reported to the ministry regarding possible domestic violence between the mother and her current boyfriend, based on statements the child had made at school. The child stated to school staff that he had heard the boyfriend slap his mother around. The child also reported seeing his mother with black eyes and listening to his mother being verbally abused by her boyfriend. He also stated that the mother's boyfriend would not allow her to phone police. At this time, employees at the child's school noted that the child had been exhibiting aggressive behaviours including pushing and punching others.

On Dec. 18, 2006, the ministry opened an intake file and conducted an investigation within days of receiving the report. This marked the third MCFD investigation into the child's safety. The social worker who conducted this investigation was the same family service worker who had received the file in 2005. The worker interviewed the child and staff at the child's school.

The child disclosed that he had observed his mother and her boyfriend drinking alcohol daily and that he had also witnessed verbal abuse and demonstrated a punching motion to the worker to show what he had observed. The worker later told the Representative's investigators that the child was difficult to interview and that he did not disclose that he had witnessed his mother being "slapped around" or having black eyes, which was contrary to the initial child protection report. The worker said that she believed the child was instead describing something he had only overheard. The worker considered the child to be consumed by violent video games, but concluded that he had not disclosed any abuse or neglect despite the statements made at school and during the interview.

The worker spoke with the mother, grandparents and the mother's landlords as part of the child protection investigation. School staff noted that, despite the grandmother being significantly involved in the child's care, his behavioural challenges were increasing.

After the interviews with the child, his family and the mother's landlords, the worker determined that there was no evidence of physical abuse or neglect. The worker found that the mother's boyfriend had a loud voice which had scared the child and had led to the child protection report. The worker spoke with the child's mother and gave her information regarding family counselling. The worker closed the file on March 22, 2007.

Three months later, in June 2007, emergency responders reported that the mother had fallen through a glass door at her boyfriend's house, which resulted in cuts to her face and arm. According to the medical file, she told emergency response personnel that she had recently smoked crack cocaine and they noted that she appeared to be very agitated and concerned about the reactions of her boyfriend and mother to her drug use.

Six months later, in December 2007, a child protection report was made to an income assistance worker regarding the mother's alcohol and drug use while caring for the child. The Representative's investigators were unable to find a record of these reported concerns in MCFD files, suggesting the concerns were never passed on.

Third and Fourth Reports to the Ministry

In January 2008, MCFD received another child protection report following the mother's disclosure to hospital staff in the Emergency Room that she had been using substances for the past five months while her son was in her care and that she was currently *"on a binge."*

She tested positive for cocaine, amphetamines and opiates. The mother told the hospital Emergency staff that her son was being cared for by his grandparents.

She had been brought to the hospital by her boyfriend and his mother. The nurse who contacted the ministry said that the mother had sold her car to support her drug use. The nurse also told the ministry that the mother had recently made phone calls to inquire about detoxification services but hung up when told that there was a wait-list.

The ministry opened an intake file on Jan. 18, 2008 and conducted its fourth investigation of the child's family. The social worker consulted with the team leader and they determined that the child's placement in the care of the grandparents, now in their early- to mid-70s, was an appropriate safety plan.

The child was now nine-years-old and in Grade 4. As part of the investigation, the MCFD worker attended the child's school and took him out of class to interview him. During the interview, the worker informed the child that his mother was using substances and the child became very upset. When the worker finished the interview, she returned the child to his classroom.

The mother's boyfriend later told the Representative's investigators that during this time she was becoming increasingly addicted to substances and was having difficulty coping with daily activities.

In February 2008, the ministry completed another CRA on the family. It found the child to be once again at medium risk and noted that the grandparents provided him with stability and adequate care when his mother was unable to do so. The CRA referenced the mother's boyfriend but it did not appear to consider him as having a significant role in the child's life or consider any potential risk he may have posed to the child.

The child's previous disclosure of domestic violence was not included in the assessment. Eight of 23 areas of risk were not reassessed — the assessment simply stated *"no updates"* for those areas. In an interview for this investigation, the worker who completed the CRA explained that she used that phrase when she believed that the risk had not changed in a given area.

According to MCFD file information, the worker made several attempts to meet with the mother to gather more information, making unannounced home visits and also scheduling home or office visits. However, a meeting with the mother never occurred.

The team leader told the Representative's investigators that in these cases, the ministry generally emphasized securing some stability for the child rather than assisting the mother with addiction support as the mother did not appear to be engaging in her recovery.

On March 6, 2008, the worker learned in a conversation with the grandmother at the MCFD office that the grandmother had allowed the mother an unsupervised overnight visit with the child, which was contrary to the agreed-upon safety plan. The worker told the Representative's investigators that the grandmother reported being very angry when she came home and found the mother sleeping and the child playing video games. The grandmother told the worker this would not happen again.

The worker determined the child was in need of protection. But after consulting with the team leader, a decision was made to close the file because the grandparents were considered to be adequately ensuring the child's safety and well-being.

The worker wrote a letter to the grandparents, stating that the child must remain with them as part of the agreed-upon safety plan and that, if the mother wanted to work toward having the child in her care, she was required to first contact the ministry. The letter recommended that the mother complete a residential treatment program and be clean for six months before the child was returned to her care. A copy of this letter was also sent to the mother. When asked about this letter by the ministry several months later, the grandparents and the mother stated that they had never received it.

The worker told the Representative's investigators that she spoke to the grandmother prior to the file closure and explained that the child's mother would have to abstain from drug use for a significant length of time in order for the child to return to her care. The worker also reported that she made an offer to the grandmother to keep the family service file open so that further support could be provided; however, the grandmother declined the offer. The file was closed on March 12, 2008.

Shortly after the file was closed, the child was assessed by an occupational therapist. This was not the first time he had been referred to the occupational therapist by his school for concerns related to motor skills and sensory processing. The therapist determined that:

- The child's social skills continued to improve but he still required assistance in this area;
- The child had difficulties with sensory integration and required time to process sensory information;
- The child continued to have social anxieties and unusual fears.

Several recommendations were made, including adaptations to the child's classroom, exercise strategies, anxiety management strategies and counselling for the child to help him address his anxieties and fears.

In May 2008, the mother began a 60-day residential treatment program to which she had been referred by the ministry worker. The mother explained that she entered treatment at this time rather than earlier because she *"wasn't gonna be told to do it, I had to do it on my own . . . I put myself in there."* The mother had recently lived for several months with someone else who struggled with addiction and believed that this

experience gave her an opportunity to observe addictive behaviour and gain insight into her own challenges.

A few days after the mother had completed treatment, the grandmother returned the child to the mother's care. The mother later told the Representative's investigators that the 10-year-old child was only in her care part of the time. The mother was not provided with access to any after-care supports. The ministry was not aware that the child was in the mother's care at this time.

In July 2008, the mother failed to attend some routine appointments with MSDSI to discuss her continued eligibility for the PPMB program. The mother told the Representative's investigators that she had relapsed after she moved back into a home with the roommate who was also struggling with addiction and *"it was around me as soon as I got home."*

Fifth Report to the Ministry

In August 2008, six weeks after the child's mother had completed substance use treatment, the ministry received a child protection report that the mother had been using cocaine regularly and had the child in her care. The caller reported that the mother's substance use had begun immediately upon her return from treatment and that the child was suffering from neglect. The caller also reported that the child's grandparents were not protecting the child from the alleged neglect.

The ministry opened a new intake file on Aug. 12, 2008 and a social worker conducted a home visit to the mother's home. During the visit, the child was playing in his room. The worker said that the child was not willing to engage in a conversation with her. The worker found that the cleanliness of the home met community standards, but that the mother looked unwell. The mother admitted to the worker that she had relapsed twice since completing addiction treatment. The worker informed the mother that she would have to complete a drug test to enable a thorough assessment of the reported child protection concerns. The worker subsequently told the Representative's investigators that she believed a drug test was necessary in order to confirm the extent of the mother's substance use.

The grandmother told the ministry worker that she had not noticed anything unusual in the mother's behaviour that would indicate that she was again using substances. The grandmother told the worker that she had seen the mother and the child almost every day. The grandmother also told the worker that the boyfriend frequently visited the mother's home.

Drug Testing

Use of drug tests by MCFD workers varies from office to office. Each ministry region has a guideline to assist workers in using their professional judgment in this matter. The method of drug testing depends upon the service provider used and the substance being tested for. In this mother's case, the worker utilized a service that conducted tests using hair samples and provided results in approximately six to eight weeks.

After the conversation with the grandmother, the social worker consulted with the team leader and developed another safety plan for the child as an interim measure until the results of the mother's drug test were available to the ministry. The safety plan called for the child to reside with the grandparents, who would not allow the mother unsupervised access to the child.

After consulting with the team leader and developing the interim safety plan, the worker arranged a meeting with the mother and grandmother at the ministry office. On Aug. 14, 2008, the social worker met first with the mother. The worker questioned the mother about the things that triggered her to relapse into substance use. The mother told the worker that she felt overwhelmed and that she may have taken over care of her child too soon but that she did not want the child's grandparents to be burdened with the responsibility because they had health issues.

When the worker explained the interim safety plan to the mother and told her that the child would have to be in the care of the grandparents, the mother became angry. She told the worker that she did not want her parents to know she was using drugs because she feared they would be angry. The worker obtained a hair sample from the mother for the purposes of drug-testing and the mother also signed a Risk Reduction Service Plan in which she committed to:

- seek medical assistance or assessment of any mental health concerns;
- follow through with all recommendations made by her doctor;
- seek family support; and
- participate in substance use counselling.

The worker informed the grandmother of the safety plan for the child. After a discussion about warning signs, the worker believed that the grandmother could accurately detect when the mother was using substances. The worker realized that the grandmother had not detected the mother's recent drug use but attributed this to the fact that the mother had been actively hiding it.

The worker noted that the grandmother appeared to be minimizing the extent of her daughter's drug use and that the grandmother did not believe the contents of the most recent child protection report. However, the worker believed that the anger exhibited by the grandmother over her daughter's actions was evidence that the grandmother was taking the issue seriously.

The worker recommended that the grandmother participate in addiction education, counselling or a support group. However, the Representative's investigators could find no evidence of referral to such supports.

Following the meeting with the grandmother, the worker did not believe that the health of the grandparents was an issue in their ability to care for a 10-year-old boy with complex needs. It appears no steps were taken to assess whether the health of either grandparent was an issue despite the mother raising the concern and the fact that the grandparents were in their mid-70s. Whether the grandparents were capable

of preventing the mother from taking the child with her whenever she desired does not appear to have been considered.

On Aug. 19, 2008, the mother and grandmother signed a safety plan, agreeing to the following conditions:

1. *The child shall reside with the maternal grandmother*
2. *The mother may move into the home of the maternal grandmother*
3. *The grandmother will reasonably supervise the mother and the child while in the family home*
4. *The grandmother will not allow the mother and the son to be alone in the home at any time*
5. *The grandmother will arrange for a responsible adult (e.g. not the mother's friends) to supervise the mother and the child when the grandmother is unable to supervise*
6. *The mother will not be present in the family home if she is under the influence and shall not return to the home within 24 hours of using*
7. *The grandmother will inform the social worker of any concerns/suspicion of drug use.*

Despite the worker's view that the grandmother was resistant and appeared to minimize the mother's substance use, the worker was confident that the grandparents would comply with this safety plan for the child's care. The worker believed the safety plan would protect the child if the grandmother had "*the right education and support*" and if the family understood the severity of the issue. However, based on the worker's own evidence from meetings with the mother and grandmother, it does not appear that the family understood the severity of the mother's substance use. Nevertheless, the worker did not believe that the grandmother required any support as the child's caregiver.

In addition to agreeing to the safety plan, the mother and grandmother also agreed to participate in a family group conference. The worker believed that this process could help the family understand the serious nature of the child protection concerns and provide an opportunity for them to participate in developing a permanent plan for the child's care.

The family group conference coordinator believed the conference would help facilitate services for the mother such as counselling, support groups and parenting education, which would in turn address the reported concerns regarding the child's neglect.

When the coordinator contacted the family to prepare them for the conference, they appeared reluctant to participate and the mother and grandmother denied there were any concerns about the mother's substance use. The coordinator shared this information with the social worker.

In preparation for the conference, the social worker completed a review of the family's file. The worker told the Representative's investigators that the purpose of this review was to understand the scope of the mother's substance use so that it could be made clear to the family during the conference.

By the time the conference was held, on Sept. 9, 2008, the mother had moved into the grandparents' home and was residing there with the child. The mother, grandmother, the intake worker and two community service providers attended the conference. The grandfather did not attend because his health was poor. The result of the conference was the creation of another plan, in addition to the previously agreed-upon safety plan, which was signed by the mother and the grandmother. The new plan included:

1. *The mother will work with a drug and alcohol counsellor. The mother will keep the appointments and follow through with counsellor recommendations*
2. *The mother and grandmother will participate in the Positive Parenting Group as soon as possible. The mother and grandmother will also engage in individual parenting sessions*
3. *The mother and grandmother will ensure that the child participates in counselling sessions with a therapist.*

The grandmother told the Representative's investigators that she found the conference useful as it appeared to help the mother understand that the child required an adequate caregiver. The grandmother also said that it also increased her own understanding of the child's need for permanent and stable care.

One month after the family group conference, the ministry received the results of the mother's drug test. The test results showed a much higher level of use than the mother had admitted to the social worker. When the social worker shared the results of the test with the grandmother, the grandmother appeared to be angry with her daughter.

On Oct. 31, 2008, the worker completed the third CRA, which determined that the child was at high risk. The assessment also indicated that the grandmother minimized the mother's substance use and that this resulted in the grandmother enabling the mother to continue this behaviour. Further, the CRA indicated that the grandmother believed it was unnecessary to supervise visits between the child and his mother. The grandmother also denied that the mother had relapsed as described in the most recent child protection report. Once again, the issue of any potential risk posed by the mother's boyfriend was not included in the CRA.

The file was transferred to a family service worker for follow up on Oct. 21, 2008. The family service worker told the Representative's investigators that, when she took over responsibility for the file, there was a safety plan for the child in place. This worker sent a letter to the mother on Nov. 17, 2008, indicating that the child's need for a consistent, stable and healthy caregiver had not yet been addressed and that the mother was expected to complete a residential treatment program as well as one-to-one addictions counselling. The mother was asked to meet with the social worker if she was unable or unwilling to address child protection concerns by utilizing these services.

The worker did not receive a response to the letter. The worker interpreted the lack of response as an indication that the mother was currently using substances. As a result, the worker planned to have the grandparents care for the child through a more permanent custody arrangement.

In December 2008, the family service worker attempted to set up a meeting with the family regarding the child's need for stability. When the worker spoke with the grandmother and suggested another family group conference, the grandmother resisted the idea but agreed to meet with the worker in person. It was not clear to the Representative's investigators why the worker believed a second family group conference would be helpful. During the next month, a number of attempts to meet were cancelled or missed for various reasons.

On Jan. 7, 2009, the worker called the grandmother to arrange a meeting. The grandmother told the worker she did not think that long-term planning was necessary and then ended the phone call by hanging up.

The worker consulted with the acting team leader and was advised that an unannounced home visit to the grandparents' residence was necessary in order to determine whether the child was safe. The ministry determined that the child could not continue to reside with the grandparents if they were unwilling to cooperate with MCFD or apply for custody, and that it was necessary to meet with the grandparents in order to make that decision.

The worker was unable to complete a planned home visit on Jan. 7, 2009 due to poor road conditions. She also attempted to contact the child's school but received a busy signal all three times that she called.

The Critical Injury

Three days later, on Jan. 10, 2009, the child, the mother and the mother's boyfriend were involved in a motor vehicle incident as they were returning home from a day of tobogganing. Contrary to the safety plan agreed upon with the MCFD social worker, neither the grandmother nor any other appropriate supervisor was present. The mother's boyfriend was driving the vehicle, which crossed the centre line of a busy road at a high rate of speed. Their vehicle struck an oncoming vehicle head-on. Contrary to BCAA recommendations, the child was wearing only a lap belt and not restrained with a shoulder belt.¹⁰

According to police evidence, whether the boyfriend was intoxicated at the time of the accident could not be established because he consumed alcohol immediately following the incident. Hospital records indicate that the mother's blood-alcohol content shortly after the incident was over the legal limit, at 140 milligrams of alcohol per 100 millilitres of blood (0.14). Hospital records also indicated that the mother admitted to staff at the hospital that she and her boyfriend had consumed alcohol prior to the incident.

The mother sustained minor injuries. The child suffered severe trauma, including a closed head injury, spinal fracture, ligament damage, lung contusions and a laceration to his right arm. He required surgery to have his skull reconnected to his spine, as well as a

¹⁰ The BCAA website states that children must use a lap/shoulder seat belt if one is available, even if that means they must sit in the front passenger seat. <http://www.bcaaroadsafety.com/child-passenger-safety/children-over-9-years-old/>; Vancouver Island Car Seat Technicians website states that a lap-only belt places a passenger at increased risk of neck injuries. <http://vicarseattechs.com/stage-4-seat-belt/>

tracheostomy. The police report stated that police were advised by the hospital that his chances of survival were considered to be 50 per cent.

Upon the child's admission to the hospital, the hospital social worker performed an initial assessment. Her notes from this assessment state that the grandmother *"reported MCFD is involved with the family, however she is not in agreement with some Ministry 'rules.'"* The notes go on to state that the grandmother *"mentioned MCFD has asked for [the child] not to be alone with Mom, but she feels strongly that mom has a right to be trusted with her son."*

The hospital social worker also met with the mother and made the following note regarding this conversation: *"[The mother] reported she and her boyfriend took [the child] tobogganing at [local mountain] today. Unfortunately, [the mother] and her boyfriend were drinking during today's outdoor fun, before the accident."*

Within a few days of the incident, the child was in critical but stable condition. He had a gastric-tube inserted due to difficulty with swallowing as a result of the brain injury. He remained in the hospital for five months.

After the Incident

When the ministry was informed of the incident, the worker decided to immediately remove the child from the grandparents' care on the basis that the agreed-upon safety plan had not protected the child from harm. At this time, the worker made the following observation in the file: *"A previous file review suggests that [the grandparents] have been the child's safety plan in the past but they seem to keep giving [the child] back to [the mother's] care and she continues to relapse."* The child was legally removed from the care of his mother within a few days of his critical injury. The immediate effect of this was that his family could not make decisions regarding his care and treatment by the hospital.

When the child was discharged from hospital on June 26, 2009, he was released back into the grandparents' care under a Supervision Order, which placed the child in the custody of the grandparents under the supervision of MCFD, pursuant to s. 41(1)(b) of the *CFCAS Act*. The duration of the Supervision Order was three months, following which the ministry successfully applied to have it extended for another six months. Shortly before the order expired on April 6, 2010, MCFD began the process of applying for the child to be permanently removed from the mother's care and to be placed permanently in care of the ministry.

In 2010, the grandparents successfully applied for custody of the child pursuant to the *Family Relations Act (FRA)*¹¹ and the ministry closed the family service file immediately afterwards. The child is currently in the care and custody of his grandparents, both over the age of 80.

¹¹ *Family Relations Act* [RSBC 1996] c. 128.

Interviews with the grandparents and school personnel indicate that the 15-year-old child still experiences some effects from his injury. The movement of his limbs on the right side is still impaired, affecting his gait and his writing. His writing and speech are both much slower than they were prior to the injuries. These effects have led to incidents at school in which he has become upset and agitated, sometimes hitting himself in the head and saying “*my brain is broken.*” The child can perform in line with academic expectations if he is given a significantly longer period of time to complete tasks and given some tools, such as a computer, to assist with completing his work.

According to interviews with family and school staff, he has continued to experience difficulty with his speech and has continued to have a right hemiparesis which impacts his ability to perform tasks such as writing. He also experiences ongoing emotional trauma from the incident and continues to experience significant frustration and anxiety as a result of his injuries.

Analysis

Parental Substance Misuse

An estimated eight per cent of children ages 17 years and younger live with an alcohol-dependent parent while an estimated four per cent live with a drug-dependent parent.¹² There is significant evidence of the detrimental impact of addiction on parenting and child safety, such as neglect, trauma and accident-related fatalities.¹³ Many, but not all, families with one or more parents with substance use issues will come to the attention of child protection authorities. One study found that substance-addicted mothers were more likely to receive child protection services if they were younger and had fewer supports available to them.¹⁴

It is impossible to determine the percentage of parents with substance use problems involved in a typical child protection caseload as these statistics are not collected by MCFD. However, one survey conducted in 2002 of 40 child protection workers in B.C. found they estimated substance-using mothers to comprise approximately 70 per cent of their caseloads.¹⁵ The U.S. Department of Health and Human Services reported that between one-third and two-thirds of children in child welfare services were affected by parental substance misuse.¹⁶ One 2007 study of children in foster care in the U.S. found that in 87 per cent of the families with children in foster care, at least one parent was using drugs or alcohol; and in 67 per cent of families, both parents were using.¹⁷ Given the prevalence of parental substance misuse as a child protection concern and that it is a “dominant reality in child protection work,”¹⁸ it would seem imperative to invest resources in dealing as effectively as possible with this issue.

¹² LX Huang, FG Cerbone, & FG Gforerer, (1998) Children at risk because of parental substance abuse. In *Analyses of Substance Abuse and Treatment Need Issues*. Rockville, MD: Office of Applied Statistics, Substance Abuse and Mental Health Services Administration.

¹³ K Street, P Whittlingum, P Gibson, P Cairns & M Ellis, (2007) Is adequate parenting compatible with maternal drug use? A 5-year follow-up. *Child: Care, health and Development*, 24(2):204-206.; K Wells, (2009) Substance abuse and Child Maltreatment *Pediatric Clinics of North America* 56:345-362.

¹⁴ K Lussier, M Laventure & K Bertrand, (2010) Parenting and Maternal Substance Addiction: Factors Affecting Utilization of Child Protective Services. In *Substance Use Misuse*, 2010 Aug, 45(10).

¹⁵ SM Weaver, (2006) “‘Work with Me:’ Training for Best Practice With Substance-Using Mothers – Diminishing Risk by Promoting Strengths”, International Conference Towards Strength Based Strategies that Work with Individuals, Groups and Communities 10 – 12 November 2006 – Hyderabad – India. Retrieved from http://www.strengthsbasedpractice.com.au/Inaugural_Conference.htm.

¹⁶ U.S. Dept. Of Health and Human Services. (1999) *Blending Perspectives and Building Common Ground. A Report to Congress on Substance Abuse and Child Protection*. Washington, D.C.: U.S. Government Printing Office.

¹⁷ DK Smith, AB Johnson, KC Pears, PA Fisher, DS DeGarmo, (2007) Child maltreatment and foster care: Unpacking the effects of prenatal and postnatal parental substance abuse. *Child Maltreatment*, 12, 150-162.

¹⁸ Ministry of Children and Family Development, (2001) *Practice Guidelines for Assessing Parental Substance Use as a Risk Factor in Child Protection Cases*, Victoria, B.C. p.5.

This problem is also tremendously difficult to overcome for struggling families. Parents with substance use disorders involved in the child welfare system have the lowest likelihood of successful reunification with their children and their children are often in foster care longer than other families.¹⁹ Gaining the cooperation of substance misusing parents in child protection work is very challenging as a result of the denial and resistance inherent in having a substance misuse problem.²⁰ This resistance could be aggravated by a lack of training of workers on substance use issues, particularly on strengths-based approaches as well as a lack of understanding of the culture of substance use, a larger culture of shame and blame that makes getting help difficult and criminalization that drives people to hide their use.²¹ As family members can also become embroiled in this denial and minimization of the problem, it follows that gaining the cooperation of the rest of the family in tackling the child protection concerns can also be a challenge.²² Engaging with substance using parents was also noted as a significant challenge by the social workers interviewed by the Representative's investigators for this report.

Current Approaches

One worker interviewed said that practice in engaging parents was “*all over the place*” and was different depending on which MCFD office was involved. Evidently, the ministry response to the challenge of parental substance misuse is to complete assessments in the usual manner rather than to apply a specialized policy, skill or knowledge base. This practice is the same in several other jurisdictions including Ontario and the United Kingdom.²³

Of the 10 workers and team leaders assigned to this child's file over a nine-year period, only one had any formal training in how to work with families challenged by addiction. A survey from 2002 indicated that BC child protection workers at that time were not well informed about drug-use or current theories or models of assessment and intervention, indicating that this lack of applicable skills and knowledge in the issue of parental addiction is not recent.²⁴

While the ministry has issued a policy specifically focusing on working with parents with problematic substance use, only one of the 10 workers and team leaders who were assigned to this child's file referred to using it in her work. Most workers questioned by the Representative's investigators had never heard of the policy.

¹⁹ KA Gregoire, & DJ Schultz, (2001) Substance-abusing and child welfare parents: Treatment and child placement outcomes. *Child Welfare*, 80, 433-452.

²⁰ D Forrester & J Harwin, (2011) *Parents Who Misuse Drugs and Alcohol: Effective Interventions in Social Work and Child Protection*. John Wiley & Sons, Ltd. Chichester ; Taylor A. and Kroll B. Working with Parental Substance Misuse: Dilemmas for Practice. *British Journal of Social Work* (2004) 34 (8): 1115-1132, p. 1121.

²¹ S Weaver, Make it More Welcome: Best-Practice Child Welfare Work With Substance-Using Mothers – Diminishing Risks by Promoting Strengths in S Boyd & L Marcellus (2007) *With Child: Substance Use During Pregnancy: A Woman-Centred Approach*, Fernwood Publishing.

²² Taylor & Kroll, (2004), see note above; Schafer G., Family Functioning in families with alcohol and other drug addiction *Social Police Journal of New Zealand*, June 2011, Issue 37, 1.

²³ D Forrester & J Harwin, (2011) *Parents Who Misuse Drugs and Alcohol: Effective Interventions in Social Work and Child Protection*. John Wiley & Sons, Ltd. Chichester.

²⁴ Weaver, (2006), see note 15.

That policy document – *Practice Guidelines for Assessing Parental Substance Use as a Risk Factor in Child Protection Cases* – was produced in 2001 and is meant to be used when a CRA is being completed. It includes several tools to assist with assessment and planning, including a questionnaire for assessing the parents' substance use and an addiction planning screen. Neither of these tools was used in this child's file.

The guidelines also refer to the importance of corroborating the parents' report of their use, working with other professionals involved and the use of Supervision Orders to monitor the family. Despite these helpful elements, this policy does not appear to have widespread use, at least not in the office or region where this child and his family live.

In 2012, the ministry implemented a Child Protection Response Model (CPRM) to replace many of its previous Child and Family Development Service Standards. The CPRM does not include any specialized policy or procedure for addressing parental substance misuse but does emphasize some effective practice responses such as the promotion of collaboration with other professionals and an emphasis on concurrent planning (making efforts to return a child home to parents while also developing an alternate permanency plan). However, without a specialized and informed approach to the issue of parental substance misuse, it falls short of being an adequate response to this issue.

Addressing parental substance misuse and its impact on child safety and development is complex and critical work requiring strong clinical knowledge and supervision. Unfortunately, MCFD was not able to provide information on overall funding of worker training on this issue as it has no dedicated budget for addiction or parental substance misuse training. A review of worker training on the topic in the mid-2000s found the offerings to be “*short-lived, scanty and unavailable since 1999.*”²⁵

The Representative finds it unacceptable that ministry practice is not better informed by knowledge regarding addiction and relevant effective interventions. Current efforts to ensure that child protection workers have the skills necessary to engage families in cases of parental substance misuse are inadequate. Given the impact on families, children and communities, much more focus on this issue is warranted.

Other Approaches

In the U.S., a need has arisen to find effective responses to the issue of parental substance misuse as a result of recently legislated limits on the length of time children can live in government care. This has led to the proliferation of drug and alcohol courts. By 2006, there were more than 180 of these courts in 43 states.²⁶ By June 2010, there were more than 2,600 courts in all 50 states.²⁷ They often include individualized care plans, an integrated team, more coordinated service delivery, relapse support and accessible, appropriate treatment resources. They can also include family-based treatment and family workers who assist families in navigating and accessing the social service system.

²⁵ Weaver, (2006), see note 15.

²⁶ Forrester & Harwin, (2011), see note 20.

²⁷ National Council on Alcoholism and Drug Dependence, Inc. website, accessed June 5, 2013. <http://www.ncadd.org/index.php/learn-about-drugs/drugs-and-crime>

Results of these programs have been positive, with parents who take part being more likely to complete treatment and their children less likely to go into care.²⁸ Some researchers have noted that significant attention was paid to ensuring workers had sufficient skills.²⁹ Other initiatives in the U.S. include a greater emphasis on the need for collaborative work between the different systems that these families encounter to ensure that they are supported as well as possible.³⁰

Fragmented service systems can be a barrier to treatment for women with children as can wait-lists, admission criteria, low self-esteem and a fear of feeling the stigma towards women who are mothering and have substance use problems. Further, a lack of support for women's needs as parents may make some mothers reluctant to enter into treatment as they may fear losing their children or struggling with a lack of secure child care arrangements.³¹

Motivational interviewing, a counselling approach that works on engaging with client motivations to change behaviour, is gaining recognition as an effective approach in dealing with individuals with addiction problems and in gaining the cooperation of parents to work with child protection professionals.³² One study found that a social service program focused on enhancing family functioning led to a higher likelihood of successful reunification for families struggling with parental substance use.³³

Other possible responses to the issue of parental substance misuse include having a substance misuse expert assigned to each child protection team, having a checklist or protocol to assist with conducting assessments, ensuring stronger collaboration between the ministry and the health authorities that treat substance misuse, and training workers regarding the role that families and communities play in substance misuse. Some other possible strategies mentioned by the workers interviewed as part of this investigation included more services for families, smaller caseloads, and greater collaboration with

²⁸ D Knoke, (2009), Strategies to enhance substance abuse treatment for parents involved with child welfare, CECW Information Sheet #72E. Toronto, ON. Canada: University of Toronto Factor-Inwentash Faculty of Social Work; Minnesota Department of Human Services (2006) Through the Eyes of the Child: CJI-AOD Tool Kit – Catch the Vision, children's justice initiative; Center for Substance Abuse Treatment. *Substance Abuse Specialists in Child Welfare Agencies and Dependency Courts Considerations for Program Designers and Evaluators*. HHS Pub. No. (SMA) 10-4557 Rockville, MD: Substance Abuse and Mental Health Services Administration (2010).

²⁹ Forrester & Harwin, (2011), see note 20.

³⁰ EM Breshears, S Yeh, & NK Young, (2009), *Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers*. U.S. Department of Health and Human Services. Rockville, MD: Substance Abuse and Mental Health Services Administration, (2009); U.S. Dept of Health & Human Services, (2009), Parental Substance Use and the Child Welfare System, Bulletins for Professionals Series.

³¹ BC Centre of Excellence for Women's Health, (2010), *Mothering and Substance Use: Approaches to Prevention, Harm Reduction, and Treatment: Gendering the National Framework*. Retrieved from <http://www.coalescing-vc.org/virtualLearning/section2/info-sheets.htm>; N Poole & B Isaac, (2001), Apprehensions: Barriers to Treatment for Substance-Using Mothers. BC Centre of Excellence for Women's Health. Retrieved from <http://www.coalescing-vc.org/virtualLearning/section2/other-documents.htm>; J C Marsh, BD Smith, M Bruni, "Integrated substance abuse and child welfare services for women: A progress review" *Children and Youth Services Review* 33 (2011) 466-472.

³² Breshears, (2009), see note above; Forrester & Harwin, (2011), see note 20.

³³ J Brook, T McDonald, Y Yan, (2012). An analysis of the impact of the Strengthening Families Program on family reunification in child welfare. *Children and Youth Services Review* 34 (2012) 691-695.

involved professionals. Integration and collaboration of addiction and child protection services could lead to a more effective and responsive system³⁴ and has been found to lead to enhanced outcomes for children.³⁵

Addiction Services in B.C.

In B.C., addiction treatment services are provided by the six health authorities as well as privately funded service providers. The public services offered vary significantly across the province and include short-term or long-term residential treatment and day treatment withdrawal management services. For example, Vancouver offers a variety of options as it is a dense urban centre, while a suburban health authority may focus on outpatient and residential treatment models.

A study completed by the Centre for Addiction Research in BC found that of those accessing treatment in B.C. in 2009-2010, alcohol was the primary problem substance in all but one health authority, where it was a close second. However, there are some significant differences across the health authorities in terms of the primary problem substance use. In the Northern Health Authority, the primary problem substance was alcohol (48.3 per cent) while in the Fraser Health Authority, alcohol was at 32.1 per cent, second to cocaine/crack at 34.7 per cent.³⁶

Social workers, health and education professionals informed the Representative's investigators of a number of gaps with respect to treatment services in the community in which the child and his family reside. Although his community is close to an urban centre and is a heavily populated area, the professionals interviewed reported a lack of detoxification services, wait times to get into services and a requirement to telephone daily in order to keep a place on wait-lists. The requirement to make daily phone calls was noted by some as being particularly difficult for those with limited access to a phone and a barrier for those individuals with a short-lived desire to change, a common condition with addiction problems. A need for comprehensive care that addresses issues of poverty, violence and depression that are related to the substance use, as well as programs and services that serve parents and children together, has been noted.³⁷

³⁴ N Poole, (n.d.) *Mothering and Substance Use – Info Sheet 4 Making the Systems Work & Info Sheet 2 Mothering and Substance Use Coalescing on Women and Substance Use: Linking Research, Practice and Policy*, retrieved from <http://www.coalescing-vc.org/virtualLearning/section2/info-sheets.htm>.

³⁵ A Niccols, K Milligan et. al, Integrated programs for mothers with substance abuse issues and their children: A systematic review of studies reporting on child outcomes, *Child Abuse & Neglect* 36 (2012) 308 – 322.; JC Marsh, BD Smith, M Bruni, Integrated substance abuse and child welfare services for women: A progress review, *Children and Youth Services Review* 33 (2011) 466-472.

³⁶ C Chow, J Carsley, (2010). *BC Alcohol and Other Drug Monitoring Project: Addiction treatment in British Columbia for Fiscal 2009/2010*. Centre for Addictions Research of BC.

³⁷ Poole & Isaac, (2001), see note 31.

The mother of the child who is the subject of this report was dealing with depression and domestic violence in conjunction with her addictions. This is not an unusual set of circumstances. Recent studies have shown that many women face a similar combination of issues. In some shelters for women fleeing domestic violence, as many as 50 per cent of the clients are likely to have suffered from depression and post-traumatic stress disorder. The prevalence of substance use disorders among women in these shelters has been estimated to range from 33 per cent to 86 per cent. In substance use treatment centres, 40 per cent of women have been found to also have a major mental health disorder, 67 per cent to have a history of being abused and 50 per cent to be in an abusive relationship.³⁸ Increasingly, it is being recognized that parents struggling with substance use are also likely dealing with trauma.³⁹

This presents important implications for service delivery that have not been widely recognized. The Building Bridges initiative, part of the Woman Abuse Response Program at the BC Women's Hospital and Health Centre, has identified that women who experience a combination of domestic violence, addictions and mental health problems will have difficulty finding appropriate support and services.⁴⁰ Addressing substance misuse should include a trauma-informed approach and the means to address root causes and contributors to substance misuse, including violence in relationships, trauma and mental health problems. Interventions that are designed specifically to address the consequences of trauma in the individual and to facilitate healing are needed. This should include recognizing the survivor's need for respect, connection, information and hope regarding his or her own recovery, the relationship between trauma and its symptoms such as substance misuse.⁴¹

Additionally, treatment services need to be responsive to the unique needs and circumstances of parents by supporting the parent-child relationship, as well as addressing the developmental needs of parents and children.⁴² By attending to both parent and child needs, such specialized services would be in the best interests of children being impacted by their parent's substance use.

³⁸ K Appleyard, LJ Berlin, KD Rosenbalm & KA Dodge, (2011). *Preventing early child maltreatment: Implications from a longitudinal study of maternal abuse history, substance use problems, and offspring victimization*. Society for Prevention Research, 12, 139-149

³⁹ LM Najavits, RD Weiss, & SR Shaw, (1997). The link between substance abuse and posttraumatic stress disorder in women. *The American Journal on Addictions*, 6, 273-283; S Covington, February 2010. *The Addiction-Trauma Connection: Spirals of Recovery and Healing. Presentation at the Regional Partnership Grantee (RPG) Special Topics Meeting*. Continuing the Journey: Strengthening Connections – Improving Outcomes. Arlington, VA.

⁴⁰ J Cory, L Godard, A Abi-Jaoude, & L Wallace, (2010). *Building Bridges: Linking Woman Abuse, Substance Use and Mental Ill Health, Woman Abuse Response Program* – BC Women's Hospital and Health Centre, Vancouver, BC.

⁴¹ National Centre for Trauma-Informed Care. (2013). *Trauma-informed care and trauma services. Substance Abuse and Mental Health Services Administration*. Retrieved from: <http://www.samhsa.gov/nctic/trauma.asp>

⁴² Poole, see note 34.

Noticeably lacking for the mother of this child – and in the system generally – is case management by a central worker or agency. Without a thorough assessment of an individual's substance use problem, including their history, concerns and needs, it is difficult to determine which service would be an appropriate match. Offering a service responsive to his or her needs can considerably decrease an individual's resistance to accepting treatment.

Public treatment options in B.C. require improvement. While the previous discussion is focused on a consideration of public addiction services, many of these comments may apply to private treatment options as well.

Findings

MCFD was aware that the child who is the subject of this report was suffering neglect as a result of his mother's addiction for a number of years before he sustained a critical injury through a motor vehicle incident in January 2009. In 2008, after child protection concerns had been reported and documented about this child for the fifth time, the child welfare system could have responded in a more tangible way but did not. While the mother's struggle with addiction intensified, the family's relationship with MCFD deteriorated.

This child was repeatedly placed at risk due to his mother's struggle with addiction and the family had demonstrated a lack of engagement with child protection workers for at least one year prior to his critical injury. Yet there was no tangible, legally binding agreement put in place that would allow MCFD to have supervisory oversight of the child.

Instead, the ministry removed the child from his mother's care only after he had suffered a traumatic injury and remained in hospital for five months.

Overall Finding: *The reliance on family members to follow through with a safety plan that they themselves did not endorse was questionable at best. This approach appears to have been the result of two main flaws with child protection practice – poor clinical supervision and a lack of knowledge in the areas of substance misuse and how to effectively engage families. As a result of these systemic shortcomings, appropriate protective action, such as a Supervision Order or a Temporary Custody Order through the CFCS Act, was not taken.*

Child Welfare Services

Finding: *The child welfare practice was not effective in engaging this child's family.*

The family did not share MCFD's perspective on the child protection issues. On more than one occasion, the family did not return ministry phone calls, the mother was given unsupervised access to her child contrary to ministry direction and the grandparents returned the child to the mother's care without consulting with MCFD. Furthermore, it is possible that an adversarial approach toward the mother made her reluctant to work with MCFD.

The Representative's investigators found that the plan from the family group conference was vague and lacked clarity. It included no concrete, measurable steps or timelines specific to the child and his needs. Other than participation in a parenting group with the grandmother, the plan appeared to focus solely on the mother. Prior to the conference, the social worker was aware of the mother's tendency to deny her substance use, and was also aware of the grandmother's "resistance" and "minimizing" of the mother's substance use issues that had previously resulted in the child being neglected.

Given this history, the Representative believes that it would have been reasonable to presume that the family was unlikely to follow through on a plan, particularly one that

lacked meaningful targets or timelines and appeared to be without consequences for non-compliance.

In the lead-up to the family group conference, both the mother and grandmother minimized the substance misuse problem and the grandmother revealed that she had doubts about the safety plan. The mother and grandmother did not follow through with the safety plan agreed to at the family group conference. According to the CRA completed in October 2008, the grandmother was reluctant to accept that the mother had relapsed or that supervised visits were necessary.

Finally, in November 2008 and thereafter, the family largely ignored or avoided meeting with the social worker. According to the initial social worker assessment at the hospital, the grandmother expressed a disagreement with the ministry “rules” and did not share the belief that supervised access for the mother was a necessary precaution. The failure to acquire the family’s cooperation was evident throughout MCFD’s nine-year involvement.

However, it does not appear that this shortcoming was evident to ministry social workers until near the time of the critical injury when the worker determined that a home visit was necessary. Though several of the workers assigned to the file attempted to engage the family, in the end these attempts failed as the knowledge and skills required to secure the family’s cooperation and partnership were simply not present.

Furthermore, while being raised by family members is a worthy goal for the long-term plan of a child, this route should not be taken without an adequate assessment of the parenting capacity of the family members involved. Family members of those who are addicted will often be impacted by the illness as well.⁴³

Supervision

Finding: *Case management supervision of this child protection case was inadequate.*

Case management supervision was inconsistent at best and almost nonexistent. Although it appears that monthly supervision appointments were aspired to, they were often derailed by the consultation required on more urgent cases. According to the individual who was the team leader while this family received services, the local ministry office did not usually hold regularly scheduled supervision sessions. If the worker felt that there was nothing to consult on in a case in which a parent would not commit to getting help, then clinical supervision did not happen.

This suggests two possible issues. First, that consultation on urgent cases occurred while cases of a less urgent nature might have been frequently overlooked. Second, the decision as to whether consultation was needed was left up to the worker. Both of these situations are problematic. In the former case, a child protection matter which may not be urgent may nevertheless eclipse others in terms of importance. In the latter case, a worker may feel

⁴³ Laurie Knis-Matthews PhD (2007): *The Role of Spouses and Extended Family Members as Primary Caretakers of Children During a Parent’s Drug Addiction, Occupational Therapy in Mental Health*, 23:1, 1-19.

that his or her plan or information gathering to date has been sufficient when it has not. Even adequate work can benefit from the insight of an experienced supervisor. Some of the workers interviewed told the Representative's investigators that if a parent is not engaging in services and the child has been placed elsewhere, there is no need for consultation.

A related issue is the qualifications of the person tasked with providing case supervision. Often the supervisor role is filled by someone who is acting in the position on a temporary basis. This is usually someone who has seniority on a child protection team; however, no training is required to be placed in an acting supervisory position. The evidence provided by workers in this investigation indicates that an office may frequently be supervised by a worker who has had no training for that role and who is also expected to provide service to his or her caseload of files. In the 1990s, MCFD team leaders received weeks of training that included components on administration, finances and case supervision. Current MCFD training for team leaders includes a two-day workshop on clinical supervision.

The lack of consistent clinical supervision may provide an explanation about why none of the ministry workers considered a middle road between removing the child from his mother's or grandparents' home and leaving him unmonitored. There are several provisions under the *CFCS Act*⁴⁴ that would have had the strength of a formal legal order requiring the family to access services or allowing the ministry to closely monitor the child's care.

A lack of case management supervision may also explain why the CRAs in this case were insufficient. A thorough assessment considers every aspect of a family's strengths as well as its risks, even if they appear to be unchanged. Also, a thorough assessment goes beyond the presenting issues to fully examine the impacts of those issues on the child. Unfortunately, it does not appear that the assessments were used to inform the work done with this family but, rather, they were considered paperwork that needed to be completed before a file could be transferred.

In the second intake, a CRA was not completed until 13 months after the file had first been opened and just before the file was transferred to a family service worker. Similarly, in the fifth intake, the CRA was completed six weeks after the worker had determined the course of action for the file and just before the file was transferred to a family service worker.

In the third intake, the CRA was not changed when new information was received and the social worker did not consider the risk to the child while in the grandparents' care even though this worker discovered that the grandmother had allowed the mother unsupervised access. For the third intake, it does not appear that a CRA was completed, despite the serious disclosures of domestic violence made by the child.

MCFD Service Standard 18 states that strategies to keep a child safe must be based on "*a careful assessment of identified strengths and risks.*" However, the child protection

⁴⁴ For example, s. 41(1)(a) or s. 35.2(d).

assessments did not include all information and were not used to determine practice decisions. Instead, these were usually made informally, leaving the risk assessment to be completed after key decisions had already been made.

Additionally, the child welfare practice was not informed by a thorough assessment of the mother's history and needs in regards to her addictions. Most of the workers pushed for the mother to receive residential treatment; however, this treatment option did not appear to be based on an assessment of the mother's situation and may not have been an appropriate match of service to needs.

Caregivers' Support Services

Finding: *This family was not adequately supported by services from MCFD or the provincial health system.*

Raising a child with complex needs while simultaneously supporting an adult child with addictions presented many challenges for the grandparents. They would have benefited greatly from services to help provide the child with developmentally appropriate activities, provide childcare or homemaking assistance, and supply the family with knowledge and support to help deal with the mother's substance use problem.

One of the workers who spoke with the Representative's investigators said that the child's family could properly care for him if they were given *"the right education and support."* To this end, this worker suggested a family support group to the grandmother and was responsible for holding the family group conference in which a service plan was signed that included counselling and parenting education for the grandmother. However, there was no recognition of the support that the elderly grandparents, one with failing health, might require to access these services. There was also no attempt to assess the capacity of the grandparents to care for a child with complex needs.

At times, this family did not make use of services that were offered or suggested, such as respite. They appeared to have a general reluctance to use professional services and the ministry appeared unable to engage them. Provision of services to families is governed by Ministry Child and Family Service Standard 7, which states that current research demonstrates the importance of *"a trusting relationship with a family and an agreement to work together to resolve issues"* in achieving positive outcomes for families. Unfortunately, it does not appear that such a relationship was established in this case.

Pervasive in the child protection service in this file is a reliance on the grandmother, not only to care for the child but also to assess when the mother was an adequate caregiver and, at times, to prevent the mother from spending time with her own child. This placed the grandmother in a difficult position, one which might have been workable if she had been better supported. Furthermore, the grandmother either did not detect or did not report the substance use that gave rise to the fifth child protection report and had minimized the mother's substance misuse problem during this intake. Under these circumstances, the plan of relying on the grandmother to ensure the child's safety was seriously problematic.

Addiction Services

Finding: *The mother's service needs as an individual struggling with addictions were not effectively met.*

In the fourth intake, the ministry was informed that the mother had recently taken the steps of contacting local detoxification services but became discouraged when she was told that there was a wait-list. When the mother did finally access a treatment program several months later, it was because there was an immediate opening available. As a person with a substance misuse problem will often oscillate between reluctance and interest in accessing treatment, the immediate availability of services can be instrumental to recovery.

The mother reported that she relapsed soon after completing treatment because her home environment included a roommate who was an addict. Some post-treatment care or a transitory program could have assisted the mother in planning for a home environment that was more supportive of her recovery and attended to her role as mother.

From social workers to school personnel, substance use experts and the mental health nurse interviewed for this report, all were in agreement about the lack of readily available treatment services. A full spectrum of out-patient and residential treatments as well as after-care are also severely lacking in quantity. Wait-lists are common, rendering a wrap-around concept of services near impossible to implement. Most importantly, case management to assess and match those who struggle with substance use with the most beneficial services is non-existent.

Education

Finding: *The child was most consistently supported and served by his school.*

The child's best support came from his school, where he had the benefit of a child and youth care worker, an educational assistant and a school-based counsellor. These supports were implemented almost immediately upon the recommendations made by the Sunny Hill Health Centre for Children. It is clear that many of his strengths are due in part to the support he has been provided at his school and his behaviours showed progress after he had been in the school setting for awhile. His behaviour escalated again sometime later; however, this was likely a result of the issues at his home that he disclosed in the third intake.

Unfortunately, the support services which were instrumental to the child's well-being have been eroded during the last several years. The school district has gone from having five full-time counsellors to having the equivalent of 0.8 of a single position. School-based child and youth workers have been cut back as well despite already carrying caseloads that had them feeling "*stretched*," as one of the child's previous child and youth workers described it, in seeing eight or nine children during the course of a five-hour school day. For a vulnerable child such as the one who is the subject of this report, losing these services could result in unmet developmental and emotional needs.

Recommendations

Recommendation 1

That MCFD take immediate steps to ensure that child protection practice is resolutely focused on serving the best interests of the child over any other interests, including the preservation of the family unit, in line with the principles articulated in the *Child, Family and Community Service Act*.

Details:

To support this work, particularly in the context of parental substance use, MCFD should ensure that:

- specialist substance use consultants be made available in every service area to assist in effective safety planning for children and, where appropriate, to assist in developing engagement strategies and support for family members.
- in situations where placement with relatives, including grandparents, is being contemplated for a child, a timely assessment of both the needs of the child and the capacity of the prospective relatives to meet those needs occurs prior to a long-term placement.
- MCFD create a learning tool, based on the findings of this report, to be disseminated to executive directors of practice, community service managers and team leaders across the province, along with directions on how to facilitate organizational learning using this tool.

A plan outlining steps to be taken in response to this recommendation should be provided to the Representative by Jan. 30, 2015.

Recommendation 2

That MCFD work with the Ministry of Health to create a comprehensive addictions strategy and a system of care for parents with substance use issues. This effort must focus on filling the currently existing gaps in service, including supports for parents, children and other involved family members, and provide accessible and effective services.

Details:

- MCFD and the Ministry of Health are to design and implement policy to provide priority access to addictions treatment for parents in cases where there are active child protection concerns. The services offered must be responsive and tailored to the specific needs of this group.
- The capacity of existing programs that focus on collaborative, holistic and family-friendly services to support parents with substance use issues should be increased to ensure timely access to those services.
- MCFD should take the lead role in creating linkages between services to ensure continuity of care and a constant focus on the best interests of the child.
- Services should be targeted to parents and caregivers and clearer education should be provided to health service providers and others regarding the risks and impacts of parental addiction on children and youth.

A status update on the development of this strategy should be provided to the Representative by Jan. 30, 2015 and implementation of the strategy should begin in the first quarter of fiscal 2015/2016.

Conclusion

B.C.'s child-serving system failed this child and his family in three fundamental ways. First, MCFD workers displayed a lack of knowledge in both their ability to effectively engage with parents who have substance use problems, and the complex task of utilizing family members in providing practical care for the children of drug-addicted parents.

MCFD workers did not fully engage the family, and were slow to detect that the family was not responding to their soft intervention style. While the mother battled an increasingly difficult drug addiction, the grandparents struggled with maintaining their dual roles as caregivers to the grandchild, and supportive parents to their struggling adult daughter.

Second, poor clinical supervision also played a role in the injury of this child. Family dynamics can be complex for workers to navigate, even in the most high-functioning families. The issues related to parental drug addiction, child safety, and multiple, sometimes conflicting, roles for family members intensify family dynamics. Working with families under these conditions requires a robust system of clinical support and supervision to ensure the health, safety, and well-being of children.

Third, the system of services designed to respond to people struggling with problematic substance use on an individual basis failed to provide this family with the services they required. There were few open doors for this parent struggling with an immensely difficult and complicated health problem. Her requests for help were frequently met with wait-lists and the services she did receive were piece-meal did not fully meet her needs.

As a result of these failures of the system, this child will be forever impacted by the injuries acquired in the motor vehicle incident. Problematic parental substance use can have drastic consequences for any child. Children whose lives are impacted by the substance use of their families deserve better.

Glossary

Addiction: the continued use of a mood-altering substance despite adverse dependency consequences.

Attention deficit hyperactivity disorder: a psychiatric and neurobehavioural disorder characterized by either significant difficulties of inattention, or hyperactivity and impulsiveness, or a combination of the two.

Child protection report: a report received by MCFD about a child's need for protection due to suspected abuse or neglect. Every report received is assessed to determine the most appropriate response. Responses include: taking no further action, referring the family to support services, providing a family development response, providing a youth response if the child is a youth, or conducting a child protection investigation.

Detoxification: a process in which a person is treated for the acute physiological effects of halting substance use.

Family service file: the MCFD legal record of services provided to a family through the *CFCS Act* and/or *Adoption Act*.

Family group conference: a type of dispute resolution proceeding designed to enable and assist a family to develop a plan of care. This is a shared decision-making process in which members of a child or youth's family come together with extended family, close friends and members of the community to develop a plan for the child.

Hemiparesis: Weakness on one side of the body.

Intake: the process by which cases are introduced into a MCFD or agency office. Workers are assigned the role of intake worker to receive phone calls or interview persons seeking help in order to determine the nature and extent of the problems.

Persons with Persistent Multiple Barriers: in B.C., income assistance benefits are now provided by the Ministry of Social Development and Social Innovation. Regular benefits provide a single person with a support rate of \$235 per month and a shelter amount of \$375 per month. For an individual who has health and other barriers to employment that meet the eligibility criteria for Person with Persistent Multiple Barrier status, the support rate is \$282.92 per month. If that individual is a single parent, the support rate is \$423.58 per month. For a single parent with one child, the shelter rate is increased to \$570.

Risk Reduction Service Plan: a portion of a service plan that outlines how specific risks to the child will be addressed and reduced.

School counsellor: The school-based counsellor's role is to provide counselling to students who appear to require it, as well as write behaviour plans and make contact with MCFD when appropriate.

Tourette syndrome: an inherited neuropsychiatric disorder with onset in childhood, characterized by multiple physical tics and at least one vocal tic. These tics characteristically wax and wane, can be suppressed temporarily, and are preceded by a premonitory urge. Tourette syndrome is defined as part of a spectrum of tic disorders, which includes transient and chronic tics.

Tracheostomy: also referred to as a tracheotomy, involving making a direct airway in the neck through which a tube is inserted which allows a person to breathe without using his or her nose or mouth.

Substance misuse: the stage when the use of drugs, including alcohol, has a harmful effect on a person's life.

Appendix A: Documents Reviewed During the Representative's Investigation

Case file records

- The mother's MCFD family service file: 2 volumes
- The child's MCFD child service file: 1 volume
- The mother's income assistance file
- The father's and mother's Family Maintenance Enforcement Program files

Medical records

- Medical records for the child's mother
- Medical records for the driver of the vehicle
- Medical records for the child

Police records

- Police file regarding critical incident
- Police records on the mother and father

School records for the child

Interviews conducted in this investigation

- Three family members
- One mental health nurse
- Ten MCFD social workers
- One regional director of practice, MCFD
- Five school personnel

Legislation

- British Columbia *Representative for Children and Youth Act* (2006). Victoria, BC: Queen's Printer.
- British Columbia *Child, Family and Community Service Act* (1996). Victoria, BC: Queen's Printer.

Appendix B:

Representative for Children and Youth Act

Section 12 of the *Representative for Children and Youth Act* (2006) authorizes the Representative for Children and Youth to conduct reviews of critical injuries and deaths of children in care or receiving services from the Ministry of Children and Family Development.

Section 15 authorizes the establishment of a Multidisciplinary Team to provide advice respecting reviews and investigations.

Section 12 – Investigations of critical injuries and deaths

- (1) The representative may investigate the critical injury or death of a child if, after the completion of a review of the critical injury or death of the child under section 11, the representative determines that
 - (a) a reviewable service, or the policies or practices of a public body or director, may have contributed to the critical injury or death, and
 - (b) the critical injury or death
 - (i) was, or may have been, due to one or more of the circumstances set out in section 13 (1) of the *Child, Family and Community Service Act*,
 - (ii) occurred, in the opinion of the representative, in unusual or suspicious circumstances, or
 - (iii) was, or may have been, self-inflicted or inflicted by another person.
- (2) The standing committee may refer to the representative for investigation the critical injury or death of a child.
- (3) After receiving a referral under subsection (2), the representative
 - (a) may investigate the critical injury or death of the child, and
 - (b) if the representative decides not to investigate, must provide to the standing committee a report of the reasons the representative did not investigate.

Section 15 – Multidisciplinary team

In accordance with the regulations, the representative may establish and appoint the members of a multidisciplinary team to provide advice and guidance to the representative respecting the reviews and investigations of critical injuries and deaths of children conducted under this Part.

Appendix C:

Multidisciplinary Team

Under Part 4 of the *Representative for Children and Youth Act* (see Appendix B) the Representative is responsible for investigating critical injuries and deaths of children who have received reviewable services from MCFD within the 12 months before the injury or death. The Act provides for the appointment of a Multidisciplinary Team to assist in this function, and a regulation outlines the terms of appointment of members of the team.

The purpose of the Multidisciplinary Team is to support the Representative's investigations and review program, provide guidance, expertise and consultation in analyzing data resulting from investigation and reviews of injuries and deaths of children who fall within the mandate of the Office, and formulating recommendations for improvements to child-serving systems for the Representative to consider. The overall goal is prevention of injuries and deaths through the study of how and why children are injured or die and the impact of service delivery on the events leading up to the critical incident. Members meet at least quarterly.

The Multidisciplinary Team brings together expertise from the following areas and organizations:

- Ministry of Children and Family Development, Child Protection
- Policing
- BC Coroners Service
- BC Injury Research Prevention Unit
- Aboriginal community
- Pediatric medicine and child maltreatment/child protection specialization
- Nursing
- Education
- Pathology
- Special needs and developmental disabilities
- Public health

Multidisciplinary Team Members

Following is the list of members that comprised the team when the report was reviewed in May 2013:

Dr. Evan Adams – Dr. Adams is the Aboriginal Health Physician Advisor for the Office of the Provincial Health Officer, as well as a family physician. He is a Masters candidate at the Johns Hopkins Bloomberg School of Public Health, a past-president of the Rediscovery International Foundation and a Youth Advisory Committee member at the Vancouver Foundation. He is a member of the Coast Salish Sliammon First Nation.

Lucy Barney - Lillooet Nation, RN, completed her Master of Science in Nursing from the University of British Columbia, and she is currently employed as a perinatal nurse consultant with Perinatal Services BC. She is the vice-president of the Native and Inuit Nurses Association of BC and is a member of other advisory committees. Ms. Barney has assisted in investigations with other provincial and national agencies. Ms. Barney's expertise is Aboriginal health, and she developed the braid theory, which looks at the mind, body and spirit and demonstrates a holistic view on health.

Randy Beck – A/Commr. Beck is the RCMP “E” Division Officer in Charge (OIC) Criminal Operations – Core Policing. He is responsible for the operational oversight of the over 150 RCMP detachments in the Province of British Columbia. A/Commr. Beck has a broad policing background in General Duty, plain clothes investigations (GIS & Major Crimes) and Federal Policing throughout his career across the western provinces of Canada.

Beverley Clifton Percival – Ms. Percival is from the Gitksan Nation and is a negotiator with the Gitksan Hereditary Chiefs' Office in Hazelton. She holds a degree in Anthropology and Sociology and is currently completing a Master of Arts degree at UNBC in First Nations Language and Territory. Ms. Percival has worked as a researcher, museum curator and instructor at the college and university level.

Doug Hughes – Mr. Hughes served as the Provincial Director of Child Welfare for the Province of British Columbia. He has 26 years experience in child welfare as a child protection social worker, community development worker, community services manager, regional executive director and finally as an Assistant Deputy Minister. He graduated from the University of Calgary with a Master of Social Work in 1992.

Dr. Jean Hlady – Dr. Hlady is a clinical professor in the Department of Pediatrics at the University of British Columbia's Faculty of Medicine. She is also a practising pediatrician at BC Children's Hospital and has been the Director of the Child Protection Service Unit for 21 years, providing comprehensive assessments of children in cases of suspected abuse or neglect. Dr. Hlady also served on the Multidisciplinary Team for the Children's Commission.

Norm Leibel – Mr. Leibel is the Deputy Chief Coroner for the BC Coroners Service. He has 25 years of policing experience and 17 years as a coroner. Mr. Leibel has examined the circumstances around child deaths in criminal and non-criminal settings, with the goal of preventing similar deaths in similar circumstances in the future. Mr. Leibel was a member of the Multidisciplinary Team for the Children's Commission.

Sharron Lyons – With 32 years in the field of pediatric nursing, Ms. Lyons currently works as a Registered Nurse at the BC Children's Hospital, is past-president and current treasurer of the Emergency Nurses Group of BC and is an instructor in the provincial Pediatric Emergency Nursing program. Her professional focus has been the assessment and treatment of ill or injured children. She has also contributed to the development of effective child safety programs for organizations such as the BC Crime Prevention Association, the Youth Against Violence Line, the Block Parent Program of Canada and the BC Block Parent Society.

Dr. Ian Pike – Dr. Pike is the Director of the BC Injury Research and Prevention Unit and an Assistant Professor in the Department of Pediatrics in the Faculty of Medicine at the University of British Columbia. His work has been focused on the trends and prevention of unintentional and intentional injury among children and youth.

Dr. Dan Straathof – Dr. Straathof is a forensic pathologist and an expert in the identification, documentation and interpretation of disease and injury to the human body. He is a member of the medical staff at the Royal Columbian Hospital, consults for the BC Children's Hospital and assists the BC Coroners Service on an ongoing basis.

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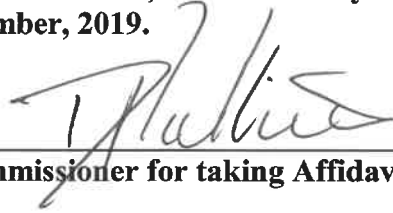
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REPRESENTATIVE FOR
CHILDREN AND YOUTH

**This is Exhibit "L" referred to in the
Affidavit of Mary Ellen Turpel-Lafond,
sworn before me, on this 7th day of
November, 2019.**

A handwritten signature in cursive script, appearing to read "J. Phillips", is written over a horizontal line.

A commissioner for taking Affidavits

On Their Own

Examining the Needs of B.C. Youth
as They Leave Government Care



REPRESENTATIVE FOR
CHILDREN AND YOUTH

April 2014

April 28, 2014

The Honourable Linda Reid
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Ms. Speaker,

I have the honour of submitting this special report, *On Their Own: Examining the Needs of B.C. Youth as They Leave Government Care*, to the Legislative Assembly of British Columbia. This report is prepared in accordance with Section 20 of the *Representative for Children and Youth Act*, which states that the Representative may make a special report to the Legislative Assembly if she considers it necessary to do so.

Sincerely,



Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Ms. Jane Thornthwaite
Chair, Select Standing Committee on Children and Youth

Mr. Craig James
Clerk of the Legislative Assembly

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Executive Summary

Few parents in British Columbia would mark their son or daughter's 19th birthday by walking them to the front door of the family home, shaking their hand, wishing them "good luck" and then ushering them outside.

But that's essentially what happens to many youth in the care of B.C.'s Ministry of Children and Family Development (MCFD) when they turn 19, become adults and "age out" of the provincial care system.

While more and more young British Columbians are now remaining at home into their early 20s and beyond, or relying on their parents and extended family for support with school, living expenses and advice, those kind of supports are not always available for youth leaving care.

More than 8,000 children are in the care of the B.C. government at any one time, with about 700 of them aging out in an average year. When youth in care reach their 19th birthdays, they are considered adults and no longer eligible for protection under the *Child, Family and Community Service Act (CFCS Act)*. The following report by B.C.'s Representative for Children and Youth examines the unique needs of those youth and makes recommendations about how those needs could be better met moving forward.

It's important to recognize the challenges faced by children and youth in care when examining what supports they might require in order to make a successful transition to adulthood. These youth have different life experiences than many of their B.C. counterparts. Many of them have had adverse experiences which can affect their social, emotional, cognitive and physical development and, as a result, many have fallen behind their non-care peers.

Along with those struggles, youth leaving care are often without the family support system that can provide the financial, instructional and emotional base necessary to make the often difficult transition from dependent to independence.

The results can be devastating. Research shows that without adequate transitional supports, young people leaving care are less likely to graduate from high school and attend post-secondary education. They are more likely to have mental health problems, become parents at an early age, experience trouble with employment, be involved in the criminal justice system, receive social assistance, experience homelessness or have substance abuse issues. The costs of our society not helping them are far higher than the costs of providing adequate support at a time when they need it most.

A major factor in whether or not a youth's transition to adulthood will be successful is how well that transition is planned and supported. Therefore, in this report, the Representative recommends that MCFD establish a Youth Secretariat to coordinate

cross-ministerial efforts to ensure successful transitions to adulthood for youth in and from government care.

The Youth Secretariat would lead collaboration between MCFD and the ministries of Health, Education, Advanced Education, Social Development and Social Innovation and Justice to make services more accessible and effective. Chief among its goals would be to lead work on establishing a minimum income support level as well as access to health, dental and vision care for all former youth in care until age 25.

The Representative also recommends that the Ministry of Education begin a targeted initiative in all B.C. school districts to ensure that every youth in care has a career plan to prepare for education and skills training and that these plans be monitored by district superintendents for compliance.

The Representative also recommends legislative steps. In the short-term, she calls for the *CFCS Act* to be amended to permit, on a case-by-case basis, the extension of foster care up to age 25 for youth who are in post-secondary school or training programs. In the long-term, the Representative recommends that legislation such as the United Kingdom's *Children (Leaving Care) Act* be developed for B.C. to deal specifically with the rights and needs of young people leaving care.

The Representative believes educational institutions have a role to play as well, which is why she has challenged B.C.'s post-secondary schools to waive tuition for former children and youth in care. Businesses and the community at large should also help – an effort that has already begun by Coast Capital Savings' recent initiation of a fund to offset living expenses of former in-care youth while they are furthering their education.

However, when any child or youth comes into the care of the B.C. government, the province becomes the parent and assumes responsibility for the nurturing and development of that child. This report calls for government to do what any prudent parent would do – provide the necessary planning, support, advice and resources to give that child the best possible chance of success.



Introduction

Young people have tremendous inherent strengths and a capacity for growth. They successfully navigate many of the challenges they face in their lives. In spite of this, they are more likely to be successful when they are provided with a range of supports geared towards their particular needs.

This is true for all young people. Support equals success. However, many young people leaving government care face significant struggles, with poor short- and long-term outcomes. Those who have been in care are consistently less likely to attain the academic levels and employment stability of those who have lived with their families. Youth in care are also more likely to be homeless, to become young parents or to have mental health challenges. These outcomes may be strongly influenced by their pre-care and in-care experiences.

In previous reports, the Representative has noted severe negative outcomes for young people that can result when rights, interests and needs are not well served while in care. A number of recommendations in these reports address issues faced by children and youth in care that relate to this report, particularly in the area of planning, so children in care can develop important relationships and feel connected. *Much More Than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care* (March 2013) notes that proper planning for the lives of children in the care of the B.C. government must go from being an afterthought to a priority for MCFD, while *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.* (April 2013) discusses poor planning for youth transitioning from youth mental health services into the adult mental health system. *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm* (November 2012) and *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children* (February 2013) also reference poor planning for children in care.

Several recent and significant steps in the development of supports for young people leaving care in B.C. are worth noting:

- Funded by Coast Capital Savings, a trust fund has been established at the Vancouver Foundation to assist former youth in care to pay for costs associated with attending college or university.
- The Vancouver Foundation released the results of a survey highlighting the public's support of increasing the age of leaving care to at least 21 from 19.¹
- Following the Representative's challenge to all B.C.'s post-secondary institutions, Vancouver Island University and the University of British Columbia announced policies to waive tuition fees for young people who have been in care.

- The Representative has been working with MCFD and community partners, including Coast Capital Savings, to enrich the trust fund at the Vancouver Foundation and to encourage other post-secondary institutions to waive tuition fees.
- MCFD has made efforts to improve services, including updating transition manuals for youth leaving care.

In general, though, the processes and resources for leaving care do not adequately support the transition to adulthood. The lack of financial, educational and emotional assistance for these youth means that they often struggle to make ends meet while coping with personal challenges that can range from significant to debilitating. Youth who leave care face a major risk of social and economic exclusion, as they can no longer depend on continuous support from child and family services organizations and are less likely to receive support from their families. Their access to post-secondary education is often limited.

Gathering the information needed to analyze the state of supports for youth in B.C. and comparing them to the identified needs of youth is a complex task. There is no easy way to collect baseline or longer-term outcomes data for the young people served by the child welfare system, nor is there a B.C. or Canadian equivalent of the United States' National Youth in Transition Database. A data collection system that allows us to track who is in care in Canada or B.C. and what happens to them when they leave care does not exist. Nor is there a well developed way of evaluating whether the interventions and programs in place meet the short- and long-term needs of young people in care.

Comparisons are further complicated by the fact that young people in care are not a homogeneous group. Who they are, their circumstances and what they need varies so widely that it is difficult to build an accurate aggregate picture of young people in care.

There is a significant difference between a young woman who has moved from placement to placement and school to school since being brought into care at an early age because she was abused at home, and someone who came into care as a teen because of the accidental death of his parents and who has lived in one foster home and attended one school while under the care of the state. Similarly, there is a significant difference in the circumstances and needs of a young Aboriginal woman who has lived in a kinship care setting in her home community and that of a young Aboriginal man who has lived with a non-Aboriginal foster family and has had little or no contact with his family of origin or community. While it may be a cliché to state that every young person in care needs to be treated as an individual, it is nonetheless true.

The reasons and motivations for leaving care also differ between young people. Some age out of care after reaching the maximum age of support. Given an opportunity, some of these youth would continue to use support. Other young people leave at the earliest possible opportunity and lose supports they may have been eligible to continue to receive. Some young people simply run away and live under the radar of the child welfare

system until their files are closed. The way in which young people leave the child welfare system has a strong influence on how well they do in the short- and long-term.

This report provides a description of the issues and financial supports for youth in care transitioning to adulthood in B.C. It examines the transitional process of young people who have been in care compared to their peers who have not. Estimates are presented of what it costs, in dollar terms, to transition from adolescence to adulthood, and an overview is given of government financial supports that are in place for young people transitioning out of care. Finally, recommendations are made about how to better support young people as they leave care.

Methodology

While there is some excellent qualitative data and a great deal of anecdotal information about youth in care in this province and in other jurisdictions in Canada, there are a number of problems with the available information about young people transitioning out of care, including a dearth of reliable information about the short- and long-term outcomes of these young people. In addition, no solid longitudinal data exists about young people who are transitioning out of care.

It is difficult to generalize the Canadian research findings, as the samples are either too small² or employ data collection methods that make it difficult to determine if the participants are representative of the broader care-leaving population.³

This does not mean that the research collected is not useful, but there must be caution about drawing broad conclusions from studies where the ability to generalize is limited. Few broad-based or comparative evaluations regarding the effectiveness of the current transitional programs have been done. A relatively recent Campbell Review, involving systematic reviews of existing research and evaluation publications, did not come to any firm conclusions about the effectiveness of the independent living program being reviewed.⁴ This highlights a need to conduct more rigorous evaluations of programs to determine if they are meeting the needs of young people.

There is also a lack of in-depth profiles of the young people who are in care in B.C. and other Canadian jurisdictions. There is frequent mention of the disproportionate number of Aboriginal young people in care that does not discuss their diverse circumstances, characteristics and needs. The collection of accurate data regarding Aboriginal youth in care is further complicated by the varying levels of jurisdictions that have responsibility for these youth. This lack of in-depth information is also true of other young people in care. They are often described as a homogeneous group or, at best, sub-groups, with little acknowledgement of individual differences or needs.

This lack of in-depth information is a significant barrier when discussing transitional processes and needs. Further, there is insufficient information about the financial costs for young people transitioning to adulthood. While information is available about the costs of attending post-secondary institutions, there is a lack of information about the costs of setting up and maintaining a household in B.C. or elsewhere in Canada.

To compensate for this lack of information, data has been drawn from diverse sources. Information about the costs of transition for young people in care has been extrapolated from sources related to the cost of independent living for the general youth population and students attending higher education. Some contextual transition outcome materials have been borrowed from other countries. A number of comments made by youth who have recently left care, or by the social workers and foster parents who have worked with them, are included in this report. These diverse sources have painted as full a picture as possible of what is being experienced by youth exiting the care system in B.C.

The results from Canadian studies into the experiences of youth leaving care tend to fall in line with findings from the U.S. and the United Kingdom. However, there should be caution about using data from other jurisdictions to try to understand the needs and/or outcomes of young people leaving care in B.C. and Canada, since there are many differences in the systems and the people they serve. For example, in the U.S., the health outcomes of urban young people without insurance, such as those who are homeless after leaving care, will be very different from a similar homeless youth population in Canada, where high-quality health care services are relatively accessible regardless of ability to pay. Even within Canada it is difficult to make comparisons because of the diversity in programs, policies and environmental contexts.

I think that people assumed that because I was functioning, I was going to school, that I didn't need support. I was a capable young person. And that's where I think the system failed. Just because I was doing well in school or doing well in certain parts of my life does not mean that I don't need other supports.

Former youth in care

Responsibility for Youth in Care in British Columbia

a) Ministry of Children and Family Development

Mandated child welfare services in B.C. are the responsibility of MCFD. The youth in care who are the subject of this report are the ministry's responsibility. Approximately 8,000 children are in care in B.C. every year with about 700 of them aging out of care annually. There is no existing mechanism for following them post-discharge, and so it is not known what happens to them once they leave care.

Child welfare services in B.C. are mandated by the *Child, Family and Community Service Act (CFCS Act)*. Mandated services are provided by regional ministry offices or by 23 delegated Aboriginal Agencies (DAAs) that have signed agreements with the ministry. Through these agreements, the Provincial Director of Child Protection transfers authority to DAAs to undertake child welfare responsibilities. Since child welfare services for First Nations people are the responsibility of the federal government, services are provided under a bi-party agreement with the province, or under a tri-party agreement with the province and DAAs. The actual level of responsibility transferred is negotiated between the ministry and Aboriginal community served by the agency.

Child welfare programs in B.C. are delivered through the ministry's 13 service delivery areas. Each geographical area is typically covered by an intake team that assesses reports, makes community referrals and works with families for up to 30 days. If ongoing service is needed, files are typically transferred to family support or family development response teams. In many areas there are separate teams for youth, for children in the permanent custody of the ministry, and for children for whom the plan is adoption. In some areas, integrated teams provide services from intake through to adoption.

b) The Public Guardian and Trustee

The other provincial agency with responsibilities to youth in care in B.C. is the Office of the Public Guardian and Trustee. Although established under provincial legislation and appointed by the provincial government, the Office operates as an independent agency. Its role is to protect the interests of those who do not have the capacity to manage their own legal and financial affairs. The Public Guardian and Trustee is property guardian for every child who becomes a permanent ward of the province of B.C. In that role, the Public Guardian and Trustee protects the legal and financial interests of children in continuing care.

The Public Guardian and Trustee plays a role when any child or youth in B.C. has an interest in an estate or receives money from an inheritance, accident or compensation settlement, life insurance or similar award. The Office reviews all personal injury settlements, legal contracts, trusts and estates involving minors. It has powers to hold money or property in trust for minors. It may act as litigation guardian, ensuring that children and youth are represented in civil proceedings, and offers financial planning support to its child and youth clients to help youth manage their estates as they transition into adulthood.



The Transition to Adulthood

It should be a simple task to calculate what youth need to transition to adulthood. The costs associated with the transition period are offset against available income. Yet if there is a consistent message from research over the last 20 years, it is that the transition to adulthood has become longer, more complex and much harder to define.⁵ Assessing what is needed to navigate this transition is now a significant public policy challenge.

In the middle of the 20th century, the markers of adulthood in North America were relatively clear.⁶ Most young people left school and moved quickly into employment, set up a home, married and started a family. Plentiful industrial jobs offered social and economic independence. Strong social values of the time channelled young females into adult roles as mothers and wives and young males into roles as breadwinners. By their early 20s, the vast majority of young people had achieved the status of independent adulthood.⁷

This traditional view of a short and relatively simple passage into adulthood is now largely obsolete.⁸ It is based on a relationship between education and employment that has shifted dramatically.⁹ In Western societies, there is an increasing demand for higher education and credentials to enter the workplace. Over the last half century, the number of highly paid unskilled and semi-skilled jobs has decreased, and many transitional supports, such as apprenticeships, have disappeared.¹⁰ In 1961, only 8.5 per cent of Canada's workforce had achieved any kind of post-secondary education.¹¹ In contrast, in 2011, 64.1 per cent of Canadians either had a university degree, a college degree or a trade certificate.¹²

Higher education institutions have responded to the changed marketplace needs by expanding dramatically.¹³ Most Canadian youth now expect to graduate from high school and go on to some form of post-secondary education. A Canadian 2001 study found 77 per cent of women and 66 per cent of men were in post-secondary education by the time they were 22-years-old.¹⁴ Post-secondary education is increasingly seen not as a luxury, but as a necessary step on the long road to adult independence. A person's level of education is one of the best indicators of the likelihood of achieving adult success, permanent employment and a living wage.¹⁵ However, there are significant social and cultural disparities within this indicator. For example, in 2011 48.4 per cent of Aboriginal people had graduated from a post-secondary program compared to 64.1 per cent of the general population with only 9.8 per cent having a university degree versus 26.5 per cent in the non-Aboriginal population.¹⁶

The economic and psychological independence once achieved by young adults by their early 20s is now typically delayed by about a decade.¹⁷ The transition from adolescence to independent adulthood has become so lengthy and complex that researchers believe it should be seen as a new developmental stage.¹⁸ Canadian social policy, however, has yet to catch up and is firmly rooted in a traditional understanding of the transition. Adulthood is defined across a range of policy and legislation as beginning at 18 or 19 years of age, although six of Canada's provinces and territories use 16 as the age when youth are no longer seen as children in need of protection. When it comes to assumptions about capacity and resources for independent living, Canadian social policy makes little distinction between adults in their late teenage years and those in their 40s and 50s.¹⁹

Case Example

Issue

An 18-year-old youth was in care with MCFD since he was six-years-old. Since the age of 16 he requested numerous times to move into independent living. His request was constantly denied without explanation. The youth had no transition plan to support him in leaving care, although he was eventually moved into independent living. The youth was connected to a youth worker who supported him in creating a "start up" list of basic needs that MCFD approved. The youth worker continues to support the youth in learning day-to-day life skills as well as connecting him to community resources.

Observation

Although the youth was eventually supported to move into independent living, the lack of a timely, well-developed and implemented transition plan meant the youth's opportunity to learn life skills prior to reaching the age of 19 had effectively been eliminated. The youth's negative experience, paired with his lack of support, will inevitably impact his transition as he moves into adulthood.

Meeting the Costs of Transition

The transition to adulthood is expensive. Young people associate leaving home with a significant decline in financial security.²⁰ In 2009, the average one-person Canadian household spent \$38,776 per year to cover food, shelter, clothing, household expenses, personal care, health and the normal expenses of daily living.²¹ Of course, many young people cannot afford to live alone, and the real cost for them – many of whom live in shared accommodation with other adults – is hard to determine.

One method to determine the cost for a young person living independently is to look at the one-person household annual spending figure. However, these costs are skewed high because they include the spending habits of the entire adult population, including highly paid professionals.

Another way to estimate costs is to look at how the federal government determines the cost of living for students in student loan programs. The numbers are closer to the costs that young adults will face when they move away from home, although they do not include the additional contributions that students or families are expected to make, and are about 30 per cent lower than actual total costs.

Young people are typically expected to meet these costs through some combination of employment income, government financial support and personal and family resources. While government grants and loans for part-time education support the growing trend for youth to combine schooling with part-time work, they are not intended to cover living expenses.

A typical breakdown of costs at a Canadian university requires 33 per cent of total expenses to be met through savings and earnings. For example, at the University of Victoria the average cost for a Canadian student living away from home for eight months and pursuing a Bachelor of Arts program in 2011 was \$16,244, based on the Moderate Standard of Living Guidelines established by the B.C. Ministry of Advanced Education.²² In such a case, federal and provincial student loans amounted to \$10,880, leaving a shortfall of \$5,364.²³

While the average income for Canadians in 2009 was \$39,300, it was only \$17,700 for 20 to 24-year-olds.²⁴ Estimates of annual incomes are traditionally based on the assumption of full-time employment, however, many entry-level positions do not provide full-time hours.

It is challenging for young people to find full-time employment, especially in difficult economic times. Young people are often the first group to be laid off during a recession and the last to be rehired. As well, those who enter the workforce for the first time during or immediately after a recession are likely to experience the negative consequences of doing so for much of their work career.²⁵ Those who do secure full-time jobs

become ineligible for social assistance, student grants and loans, and many educational scholarships and awards. Youth without post-secondary qualifications are most likely to end up in low-paying, unstable jobs.²⁶

There has been different ways to support myself. At the present time I am supporting myself through student loans and [an after-care financial support program] which is an independent – it's a program for children who have aged out of the foster care system and are now pursuing post secondary schooling. In the past – well I am working part time as well – in the past I have also worked in the sex trade to support myself through school.

Former youth in care

Young people leaving care often struggle to acquire basic household necessities, and cost-of-living estimates generally do not take into account what it might cost a young person to set up a first-time household. In Canada, there is a lack of information on these costs for the general young adult population and, more specifically, for young people transitioning out of care. In the United Kingdom, it has been estimated that it costs a young person leaving care approximately \$3,900 to buy the basic household items needed to establish an apartment.²⁷ We have no clear picture on what these costs would be in B.C.

Social assistance is the primary source of support available to young adults who are not working full-time or going to school.

The average annual income support for a single employable adult in Canada is \$7,300, although this drops to \$6,500 for those between 20- and 24-years-old.²⁸ The current Canadian policy approach is that social assistance should not meet all the needs of employable adults.²⁹ Lower than average living conditions are seen as an incentive for people to move into employment, and it is assumed that employable adults on social assistance can supplement their income with personal resources and community supports.³⁰

Canadian social policy rests on the belief that young people have access to family support to make up any shortfalls. It is federal government policy that parents are expected to plan for and make adequate financial preparation in anticipation of the student's post-secondary education. It is expected that the funding of the student's education will be a priority for the family.³¹ The time taken to transition to adulthood has increased along with young people's reliance on family resources to see them through.³² This has significant negative implications for youth in care.

Research in the U.S. and Europe suggests most young people do not leave home until they feel they have sufficient resources and stable employment.³³ This means that in times of unemployment and recession, young people stay home longer.³⁴ One United Kingdom study conducted prior to the recent recession found that 78 per cent of students still lived with their parents for financial reasons.³⁵ Many find that they simply cannot make it on their own, and leave only to return to the parental nest.³⁶ The 2011

Canadian census showed that 42.3 per cent of young adults ages 20 to 29 that year resided in the parental home either because they had never left or because they had returned home.³⁷ The “boomerang kid” is a response to the changed economic and social circumstances of the 21st century.

As a result of these societal changes, it has been estimated that in the U.S., parents provide an average of \$38,000 in material assistance to each child between the ages of 18 and 34 as they move into adulthood.³⁸ This does not include costs associated with attending post-secondary education. There is little reason to believe that the situation is different in Canada. During the period 1981 to 2001, the percentage of Canadians ages 25 to 34 who were still living at home with their parents more than doubled.³⁹ Parental financial assistance during the transition years amounts to 23 per cent of the total amount provided during childhood.⁴⁰ Consequently, youth in lower economic classes face many more challenges than their peers in accessing the post-secondary education and permanent employment that mark adulthood.⁴¹ Their parents are less able to provide the assistance that has now become an accepted factor in the complicated transition to adult independence.⁴² In addition, many young people who have been in care do not have the intangible resources that other young people enjoy, such as a family to visit over the holidays, a place to do their laundry or someone from whom to borrow small amounts of money to cover unexpected costs.

Young people leaving care face a double challenge: less access to the informal resources of family, friends and community and a greater need for support in each of these informal areas of their lives. Furthermore, these youth are situated in a Canadian social policy context that assumes that they have access to these supports, when in reality this is not the case.



The Experiences of Youth in Care

While there is much that is unknown about young people in care, it is clear that many have had significant struggles in their lives as young children and will continue to have these as adults.⁴³ This is to be expected given their life experiences prior to coming into care. For the most part, these young people come from high-risk family and community environments where many adverse experiences negatively influence their social, emotional, cognitive and, sometimes, physical development.⁴⁴ As a result of these experiences, youth in care can fall behind their non-care peers – at least temporarily – on a number of developmental measures.

The negative effects of these early experiences can be compounded by additional adverse experiences while in care. Many young people in care experience numerous placement changes and school disruptions that contribute to a deep sense of loss and instability, as well as other related negative consequences.⁴⁵ A significant number of young people in care struggle with ongoing mental health and behavioural issues.⁴⁶ Young people in care who have the least stability in their lives are more likely to experience difficulties. For example, those young people who move three or more times in a year are more likely to attempt suicide than their peers who move only once.⁴⁷

Case Example

Issue

A young adult who was previously a child in care and was on an Agreement with Young Adults (AYA) needed extensive dental work costing approximately \$1,400. That amount was over and above the yearly dental limit of \$700 that the young adult had already exhausted. The dentist urgently recommended that the young adult have the dental work completed or the result would be increased pain and, inevitably, infection. The young adult had no other means to pay for the dental work. MCFD eventually agreed to an exception of policy and covered the cost of the dental work.

Observation

If the young adult had not been on an AYA at the time of his dental emergency, he may have suffered undue discomfort and pain because he had no means to pay for his medical needs. Youth who transition out of care continue to have medical emergencies with no means to cover extraordinary costs.

Without adequate levels of transitional supports, young people in care are at greater risk experiencing negative outcomes as young adults than their non-care peers.⁴⁸ For example, they are significantly more likely not to graduate from high school and are less likely to attend or complete college or university.⁴⁹ They are more likely to have mental health issues,⁵⁰ become parents at an early age⁵¹ and be unemployed or underemployed.⁵² They

It is worse in the care system. It is like a cycle. It's like people don't get out. They stay on welfare. I'm fighting to get out. It's really hard right? We can only afford to live in areas that don't really take us away from our negative environments. Like the apartment I'm living in right now. There's a drug addict living there. It's like how do you get out? You need the help. You can't do it on your own.

Former youth in care

are also more likely to be involved with the criminal justice system,⁵³ experience homelessness,⁵⁴ receive social assistance,⁵⁵ have substance abuse issues⁵⁶ and have health problems.⁵⁷ They are also less likely to have personal stability in their lives.⁵⁸ As many of these issues are inter-related, young people may experience them concurrently, with an attendant increased risk of poor life outcomes.

Not every young person who has been in care struggles throughout his or her life. In one longitudinal study tracking youth leaving care, some had managed to make progress towards productive independence. A small but still significant portion of young people in the study finished high school, secured stable housing and employment, were not in contact with the criminal justice system and self-reported having good physical and

mental health. A smaller proportion of the young people had either completed post-secondary education or were in the process of doing so. As expected, the young people who do the best tend to have a range of well-developed internal and external resources.

The manner in which young people exit the care system appears to have a significant affect on their life chances. Those young people who leave the system by choice at the earliest possible opportunity and those who age out without later access to additional supports tend to be at the most risk for adverse outcomes.

There's so many of those kids that just want out of the system. And because we haven't supported them in making those connections with family or community, they're out there on their own.

Care provider

Educational attainment is closely associated with positive personal outcomes. And in terms of education, young people who continue to receive support past the age of majority appear to have a higher likelihood of successfully transitioning out of care.



Case Example

Issue

An 18-year-old youth in care applied for funding to take two courses at her local community college. Her social worker was doubtful that funding for the second course would be approved, leaving the young woman unable to plan for her future education. This uncertainty was exacerbated by the lack of a plan for the youth's exit from care and the complete absence of any written information to guide her through transition. She was offered no help and no information that would help her through the next phase of her life.

Observation

Last-minute funding for both college courses was eventually approved and although a good outcome in itself, this uncertainty contributed to this young woman's feeling of insecurity and instability as she approached the age of 19.

This lack of positive support from her social worker, combined with the woeful lack of planning and preparation for her transition out of care, resulted in a missed opportunity to have provided this young woman with the best possible move into her adult years.

It is increasingly obvious that the costs of not helping young people successfully transition to adulthood are far higher than the costs of providing adequate support. When the transition to adult independence is not successful, the social and economic costs of support and treatment can be enormous. An equally important consideration is the loss to society of the positive contributions these young people could have made. A key first step is recognizing that the personal and financial consequences of letting young people leave or age out of the system are significant. Once this has been acknowledged, changes can be identified to make policies and programs more supportive for young people in care, so they can become healthy and productive members of society.

Supports Needed for Successful Transitions

What do youth need for a successful transition to adulthood? While young people in care are different from each other in terms of their cultural, ethnic and class identities, pre-care experiences, individual needs and in-care experiences, they seem to share similar core needs as they transition from child welfare services into independent adulthood. These needs were classified by Reid and Dudding into the seven interdependent categories of relationships, identity, education, housing, emotional healing, life skills and youth engagement.

For each category, youth leaving care need a “pillar” of support, and each of these pillars must be built upon a foundation of adequate financial assistance. Current knowledge suggests that the provision of sufficient supports in these areas will increase the likelihood of a successful transition into adulthood.

Taken together, the seven pillars and a strong financial foundation create a bridge by which youth in care might cross successfully into adulthood. The pillars must be taken together – if one pillar or part of the foundation is neglected, the bridge is likely to collapse. Initiatives undertaken to address shortcomings in one area will only highlight weaknesses in another. It is only when adequate attention is paid to each pillar, and the financial foundation on which it stands, that youth in care will consistently achieve the education, employment, positive relationships and sense of self-worth necessary for productive, self-supporting adult lives.

It is necessary to break down in more detail the pillars of support to understand how each can meet the particular needs of youth in transition from the child welfare system.

1) Relationships

There is no shortage of research showing that relationships are the cornerstone of human development and that all youth need love, affection and reliable support. Like all of us, young people need to turn to those who care about them when they face change. They need the encouragement of their peers and important adults to feel a sense of accomplishment and belonging. They need someone to celebrate or commiserate with them when they move out, end their first relationship, mark important holidays, graduate or find their first job. However, many youth transitioning from care feel they do not have meaningful relationships like this to depend on. They reported mixed feelings about the level of support they received from their social worker—the person who carries primary responsibility for their welfare.

Youth in care can struggle to find long-term, committed relationships for a number of reasons. Being abused or neglected within their families may leave them unwilling to risk further hurt, separation or betrayal by investing in new relationships. Adult survivors of abuse often experience difficulties in maintaining stable relationships, and

describe feeling socially isolated and distrustful. Entry into care can create a physical and emotional distance from family members, especially when the child is placed far from home or family contact is deliberately restricted. It is not uncommon for youth in care to have their placements changed annually, which can often result in a change of school. It is not hard to imagine how moving so frequently undermines children's ability to trust the new adults in their lives and put down new roots.

Research clearly shows that youth in care do better when they have strong social supports and feel connected to their families, schools and communities. Perhaps the greatest change that could support youth in building relationships is decreasing the number of times they are moved. When youth no longer have to worry about when their next move will happen, they can begin to invest in new lasting relationships, to repair existing ones and to engage in activities outside the home.

Sometimes youth just need to talk. They feel alone and they don't want to necessarily talk to their peers or their peers aren't going to help them. They need someone who will offer them some advice or some wisdom or just someone to listen to sometimes. Maybe they are not even looking for anything. They just need someone to vent to in a safe environment. They want to know that people actually care and they're actually being heard.

Former youth in care

However, relationships go beyond simply being connected to a significant person. In order to thrive, people need to feel that they matter to someone and that they have people who matter to them. This sense of mattering is what allows a feeling of connection to other people and to communities. For young people in care or leaving care, it is not simply having a stable living arrangement that makes a difference. Young people also need to feel that they matter and to see proof of this in their lives.

Those who live with their families may get this sense of mattering when their parents help them financially transition to independence. For example, parents often buy household items for their children when they move into their first apartment. It is a concrete statement that the young person matters to his or her parent. Young people in care have this same need, but are less likely to experience such displays of support. This makes the transition to adulthood more difficult

Youth report that they need at least one supportive adult relationship when they transition out of care. Many youth return to their birth parents' home at this time. Those who continue to have relationships with their birth parents and extended families while in care have better outcomes. Some youth also view past or present foster parents as significant supports, although these relationships often end when the youth changes placements or ages out of the system. Where it is in the best interest of the child, supporting their relationships with their birth family and important foster family can have a lasting impact

I was kind of rebellious. It was like I can take care of myself at age 16. I thought I knew it all. I ended up just running away. Eventually, I got into an independent living program where they kind of worked on my terms and they didn't get mad if I missed an appointment. My worker really understood me. She honestly wanted to give me the supports that I needed. I was able to stick it out and make the transition. She didn't give up on me. I'm in college now.

Former youth in care

on their ability to move successfully into adulthood.

Mentoring programs can be another way to connect youth to an adult who will stand by them into independence. Although research on mentoring programs is limited, there is strong evidence to support the benefits of mentoring for the general population of at-risk youth. The National Youth in Care Network supports mentoring and peer programs as an important means for youth in care to develop lasting networks of peer relationships.

In addition, participation in extra-curricular activities can be an important source of

relationships with adult role models. Youth in care who participate in extracurricular activities are more likely to form significant relationships, to complete high school and to have better outcomes, supporting the argument that these activities should be funded as a core need rather than an optional extra. The broader the level in which youth positively engage in their communities, the higher the likelihood that they will have successful outcomes in life.

It really felt overwhelming to have to take care of everything on your own. It was just too hard to keep going through these things over and over.

Former youth in care

2) Education

Graduating from high school increases the likelihood of finding employment and earning a living wage in Canada. Most Canadian youth expect to graduate, and many will go on to a post-secondary education that their parents help fund. Yet youth in care graduate at significantly lower rates and tend to take longer than their peers to complete high school. In addition, very few go on to post-secondary education. When one of the best indicators of future success is the level of education achieved, this pillar deserves significant attention.

Youth in care can struggle in the education system for a number of reasons. Early experiences of abuse and neglect can impair a child's self-esteem and ability to learn, putting them behind in school before they even enter the child welfare system. While in care, placement instability can lead to a revolving and unmanageable sequence of school

changes, leaving children to negotiate making new friends, managing new teachers and learning a new curriculum in a system where they are consistently playing catch-up. For some, the time and attention that would normally be applied to studying is spent dealing with complicated home lives, the consequences of maltreatment and the challenges of living in the system. Teachers cannot always offer the necessary time, psychological and practical services that would help students move from focusing on their emotional and daily living needs to making their educational needs a priority.

As older youth face increasing academic demands, those in care simultaneously face the prospect of losing their child welfare support. It is hard to study for an exam when you are worried about paying bills and finding a cheap enough place to rent. Those sufficiently resilient to graduate often don't have access to the full range of financial support that would make post-secondary education a possibility. Youth in care need financial support to cover accommodation, tuition and supplies if they are to attend post-secondary education. Education is a key factor in successful transition to independent living, and youth in care need more time and financial support to complete it before they are discharged.

It is clear that youth have better educational outcomes when their move into independence is delayed until they have completed their education. One study found that youth in care with their high school equivalent were more than three times as likely as their counterparts no longer in care to be enrolled in a two- to four-year college program.

For some youth in care, education involves a process of restoring the educational deficits associated with a history of maltreatment and attending multiple schools, so they have the same expectations of graduating as their peers. The child welfare and education systems need to collaborate more closely to design and resource individual learning plans that span school and placement, and address a child's educational and emotional needs simultaneously.

3) Housing

Any young person transitioning into independent adulthood needs a place to live. It is estimated that between 150,000 and 300,000 people are homeless in Canada and that nearly a third of them are 16- to 24-years-old. A growing number of youth are living with their parents well into adulthood. In the absence of this kind of family support, a high proportion of youth leaving the child welfare system find themselves homeless or in unstable housing. One study in the U.S. found that 22 per cent of youth were homeless for one or more nights within a year of being officially discharged from care.



It is more difficult for youth leaving care to stay with others during housing crises because they have fewer reliable relationships with adults. It is more difficult to afford rent because they tend to be less educated and less likely to secure stable work with adequate pay. Youth in care may have experienced such instability and exclusion within the care system that they don't expect a permanent home, and describe the fear that misbehaviour will lead to placement change.

What were my fears? Not being able to support myself. What would I do? I think that's – again that goes at your basic needs, you need food, you need shelter and that is your basic need. Where am I going to live?

Former youth in care

For many, the feeling of never knowing where to call home, or how long a place to live will last, can be emotionally damaging. One study found that even those children who had lived in the same foster home for more than three years felt insecure. The experience of placement transience and being excluded from decision-making processes increases the risk to placement stability.

The Child Welfare League of America recommends that youth not be discharged from the foster care system before they secure

They need to have a base until they are 25 where they can screw up and not be kicked out. They need to have someone work with them and to try to figure out how to fix things.

Care provider

stable and sustainable housing. In Canada, these systems are not yet in place. Youth in care consistently identify the need for greater stability while they are in the care system and for stable housing that allows them to leave care. They need more opportunities to participate in placement decisions and to develop the skills needed as adults to decide where and how they live.

4) Life Skills

All youth need practical life skills to make it on their own. Life skills develop over time. They are learned by watching a parent cook dinner, a grandparent pay the bills or a family friend shop for groceries. They are developed through observation and practice within relationships where youth feel able to ask questions and model desired behaviour.

Youth in care are less likely to have the consistent home environment and relationships with caring adults that support the development of life skills. Youth who have left care say

As I was aging out, I received no training of any kind; it was just assumed that I would know.

Former youth in care

they needed more practical skills, like cooking, budgeting and time management. Those who have been traumatized in family relationships talk about the need to learn about personal relationships, parenting and child development to compensate for those areas where they did not have effective role models. To transition to adulthood successfully, they also need skills in job searching, career planning, communicating, finding a home, accessing community services, self-care, work and study habits, and social interaction. It is critical that early training for independence begins young, and is not just a pre-discharge afterthought.

They need someone to teach them those skills on whether it's becoming completely independent or finding resources in adult services to help them. They need someone to help them do that and closing a file at 18 does not give you the opportunity. I have 18-year-olds on my caseload functioning at maybe a 16-year-old level.

Case worker

Research suggests that youth who receive independent living training are more likely to be able to pay all their housing expenses and have higher levels of high school graduation, employment and self-sufficiency. More life skills programs are needed over longer periods of time to allow youth to integrate the lessons into their living situations. It is far more useful for a youth to practice budgeting by going shopping than to learn about it in the classroom. Youth in care develop the tools for independent living when they can practise them and integrate the lessons of their successes and mistakes while still being supported by the child welfare system. It is important that these tools are age and culturally appropriate, and that they are accessible to youth in all circumstances and regions.

5) Identity

One of the most important development tasks of adolescence is identity development. When youth have a strong sense of who they are and where they come from, they are more able to set career and life goals that will determine what kind of adult they want to be. Specifically, a strong sense of cultural identity can help youth feel proud of who they are and more able to pass their cultural knowledge along to future generations.

Healthy development is in part dependent upon young people having a strong sense of their culture. This is true for all young people but particularly the case for Aboriginal youth, given the impact of residential schools upon families and communities. Disconnection from family and community means children in care often have difficulty accessing information about their history and culture. Cultural knowledge tends to be passed on within families and between generations during the normal rhythms of daily life, and it can be hard for out-of-home caregivers to replicate this in a meaningful way.

Youth in care can feel undervalued as they absorb stigmatizing social messages that link involvement in the child welfare system with stereotypes of delinquency or psychological difficulty. If these messages come from peers or people who are important to the youth, they often become incorporated into the youth's self-identity. This inhibits the

developing sense of self during adolescence. It is hard to properly claim your own identity if you feel ashamed or belittled by it. When this is the case, youth are less likely to see themselves as agents of their own lives and work towards positive future goals.

I was scared and I'm still kind of mad. I was mad at the system. I was mad at people who had everything handed to them. I was scared and nervous and I really didn't believe in myself.

Former youth in care

Youth leaving care say they wish more work had been done with them to develop a sense of belonging to their own history and cultural community. They need caregivers and the child welfare system to accept them for who they are, to actively challenge their stigmatization and to support them to explore who they are and what they wish to become.

6) Youth Engagement

When youth feel they own the plan for their lives, they are far more likely to work towards agreed goals than if they are simply told what to do. If supported to make their own decisions, to make mistakes and to deal with the consequences of those mistakes, they build the skills they need to plan, prioritize and manage themselves as they transition into adulthood. It can be hard for youth in care to develop this sense of ownership as they are often less involved in decisions about their lives than are their peers. Not having a sense of control over their lives can create a great deal of fear and worry.

In the care system, decisions are often the responsibility of several adults, some of whom may not know the youth, his or her interests, and how to engage them. When youth in care make decisions that raise issues of risk and liability,

it can be difficult for child welfare agencies to continue to listen to the youth and to maintain ongoing supportive relationships.

I was a puppet and child protection held the strings. I was afraid of what would happen when these strings were cut.

Former youth in care



Youth in care have the right to have their voices heard. They want to be supported to define and work towards their own futures. Over the last 20 years, they have been increasingly recognized as stakeholders in the child welfare system, with a right to be heard in decisions about their own lives. Youth need authentic and full engagement within the system to assist them to develop the self-advocacy, self-awareness and goals they need to see them into adulthood.

Case Example

Issue

An 18-year-old youth has been in care since age four. She has lived in multiple placements and reports that in recent years she has been homeless much of the time. She struggles with substance use and acknowledges that she engages in survival sex work to meet her basic needs for shelter and food. She wants to have a plan for placement and drug and alcohol treatment set up now, as she knows that after her 19th birthday she will be cut off MCFD services.

Observation

This youth has been homeless, engaging in high-risk behaviours and needs assistance to get the supports to help her to transition into adulthood. She requires a carefully developed individualized transition plan developed by professionals who are informed, skilled and empathetic in dealing with a young person who has experienced trauma and abuse. Her planning process needs to take into account the challenge of establishing a trusting relationship with an adult. Her social work team may need to remain engaged to assist her after she ages out of care.

7) Emotional Healing

Risk-taking behaviours such as binge-drinking, unprotected sex, most types of substance use and dangerous driving peak between the ages of 18 and 25. Loneliness and suicidal ideation are particular concerns during adolescence and into the early 20s. Yet the biggest gap in children's health services is for adolescents. Whether they live at home or in care, youth often don't have access to mental health services at the very age when emotional issues create the greatest need for them.

Youth in care are particularly in need of supports to heal from past experiences of separation and trauma. The effects of family-based trauma are often exacerbated by changes in placement, schools and adult relationships over which youth feel little sense of control. When youth act out their feelings of anger, grief and fear, they can be punished for their actions. Much needed treatment services may be unavailable, or youth may feel unprepared to address their difficulties and miss out on a chance to heal. As a result, a significant proportion of youth leaving care face mental health challenges. One U.S. study found that more than 50 per cent had been diagnosed with a psychological disorder at some point in their childhood, and Canadian research found that 24 per cent of youth leaving care were concerned about their own mental health.

Emotional healing comes from having someone to listen, care and help a person rebuild a sense of belonging, acceptance and security. Traumatized youth in care need the support of committed adults who can approach trauma-based behavioural challenges with compassion rather than punishment.

When I look back all I see is darkness, craziness, and drama. I remember that somewhere in there I had a light. There were goals and vision and dreams and somehow, thank God, I had resiliency to make some of that happen later on in life. But how much easier would it have been if I had been supported and I had some grounding and some roots and my desires were understood and I could express them?

Former youth in care

In some situations, youth also

need access to mental health specialists. Mental health services need to be accessible

to youth in the child welfare system, while they are transitioning out of it, and as they establish themselves as independent adults. These youth are likely to face multiple and qualitatively different stressors compared to most of their peers. Unlike many youth who move out for positive, opportunity-oriented reasons, such as attending post-secondary education, youth in care often feel forced into independence by the loss of state support. This can feel like abandonment and re-awaken past experiences of loss and trauma.

It was really helpful that my social worker was saying you are not on your own. It felt really good that it wasn't just "you're all on your own and if you screw up that's it."

Former youth in care

Premature transition to adult roles can have negative long-term consequences for youth. Youth leaving care often have to take on these adult roles not only before their peers, but also before completing key transitions such as finishing high school and finding stable employment and housing. The intersection of historical trauma, system-based stressors such as multiple placements and stigmatization, navigating the normal developmental tasks of adolescence and managing the challenges of premature independence can create enormous stress. In the face of this, youth need ongoing social and emotional support to promote emotional healing and resilience into adulthood.

Housing is a huge barrier, employment is a huge barrier, surviving is a huge barrier, alcohol is a huge barrier, mental health, transitioning from youth services to the adult system for sure. Also all of your support systems drop you. Like everything and good luck. Here's your birth certificate, goodbye.

Former youth in care

The Foundation of Financial Support

What level of financial support is needed to support youth to transition successfully into adulthood? How does the state act as a prudent parent to ensure that the youth for whom it is responsible have the best chance at independence?

It seems the current B.C. policy views youth leaving care as no different from other adults seeking income support. Financial support for youth leaving care is most often linked to social assistance rates, frequently leaving young people unable to afford adequate nutrition, safe housing, transportation and extended health, dental and vision care. The belief is that lower-than-average living conditions are an incentive for people to move into employment. Employable adults are expected to supplement government assistance with personal resources and community supports. But such assumptions simply do not fit for youth leaving care. Their needs are profoundly different from those of the general population of unemployed adults.

Youth leaving care need financial support to help them establish their footing in the world as adults and to prepare for a future as productive, independent citizens. They need broadly-based, accessible and publicly-funded financial programs to replace the patchwork of financial supports currently offered by government, private and non-profit organizations to supplement income assistance.

In order to be effective, these programs need to adopt the principle that the state's obligations to youth leaving care are the same as those of any prudent parent. A prudent parent would recognize the need to invest in and support their child through the critical development period between late adolescence and early adulthood. A prudent parent would show sufficient flexibility in meeting the unique needs of each youth and providing adequate financial support during post-secondary education. Canadian social policy generally accepts that families of children with special needs should receive additional state support to give these children the best opportunity to reach their potential. Government should apply this same standard to meet the special needs of youth leaving care.

Youth in and from care are among the groups most vulnerable to poverty. While the rising cost of post-secondary education is becoming a major issue for all young people, youth in care face additional financial barriers. They do not have the option of choosing to remain at home as a debt-avoidance strategy. Until recently, although the federal government invested in post-secondary education by supplementing parental Registered Education Savings Plan (RESP) contributions, there was no mechanism in B.C. that allowed the state as parent to make RESP contributions for children in care. In March 2014, the B.C. government introduced legislation that will allow for contributions to a fund for youth who have been in care to attend post-secondary education.

However, many of those who do receive some financial support for their post-secondary education lose it before they finish their studies due to arbitrary cut-off points based on

age rather than need. The available financial support rarely takes into account that youth from care usually complete post-secondary education later than their peers.

They don't have the supports our own children, our own kids do. Often they are trying to figure out where they are going to sleep at night and where their next meal will come from and [it is] hard for them to think about getting up in the morning and going to school every day when they are just trying to meet their basic needs.

Case worker

Ensuring that young people in care receive the preparation and support necessary to become self-sufficient, fully participating citizens is an important public policy objective. There is overwhelming evidence that such support can prevent significant future problems in physical and mental health, social relations and finances. Supporting youth through the short-term transitional crisis into adulthood can prevent them from becoming trapped in poverty and unemployment and possibly requiring lifetime assistance. The longer-term benefits of support are seen in increased high school graduation rates, more stable housing, healthier relationships and outcomes that are similar for the general youth population.

Every young person is a little bit different in terms of what issues they are struggling with. Often once they turn 18 they still don't know how to live independently let alone find a job, keep a job or go to school or get funding. All these things are complicated. Many of them have suffered huge amounts of trauma and abuse in their lifetime.

Case worker

Providing the necessary supports makes solid economic sense. The Conference Board of Canada recently determined that a young person now leaving care will earn about \$326,000 less over his or her lifetime than peers who have not been in care. The Conference Board further estimated that the average former young person in care will cost governments more than \$126,000 in lower tax revenues and higher social assistance payments.

As Canada's birth rate decreases, making the time-limited investment to support youth leaving care to become educated, productive and engaged adults becomes a social and economic necessity, as well as the right thing to do.



Direct Provincial Support for Youth Leaving Care

Young people in B.C. are considered adults when they turn 19. This means they are no longer eligible for protection under the *CFCS Act*. With the exception of one clause, this Act, which gives MCFD responsibility for the care and/or guardianship of youth in care until their 19th birthday, no longer applies.

Between 16 and 18, youth may be eligible for a Youth Agreement if they experience a significant adverse condition such as homelessness, behavioural or mental disorders, severe substance abuse or sexual exploitation *and* they cannot live with their family *and* government care is not the best option.

Under a Youth Agreement, youth may receive financial and other support in return for their commitment to work with service providers on a plan for independence. Funding may cover accommodation, daily living and other one-time-only costs such as start-up expenses, damage deposits and training course fees. Services might include regular support and monitoring from a social worker, a one-to-one support worker, life skills programming and connection to appropriate treatment, education, job readiness or employment programs. Youth may live in one of a range of residential options, from substance abuse or other treatment centres, to supported room and board, to accommodation with an independent landlord.

Participating youth sign a three-month legal agreement with their social worker that can be renewed for up to six months at a time until they turn 19. Non-compliance with the agreement may lead to its termination. This leaves these youth little room to fail in their attempts at independence. It does not necessarily allow for the multiple attempts at independence which are needed by many “boomerang kids” outside the care system. No youth can be on a Youth Agreement beyond his or her 19th birthday.

The *CFCS Act* contains one provision that allows some youth to continue to be supported between the ages of 19 and 24 – through the Agreements with Young Adults program. Youth may be eligible for this program if, on their 19th birthday, they were on a Youth Agreement or in

Youth Agreement (YAG)

A Youth Agreement is a legal agreement between MCFD and youth ages 16-18. The purpose of the agreement is to help youth gain independence, return to school, or gain work experience and life skills.

Agreements with Young Adults (AYA)

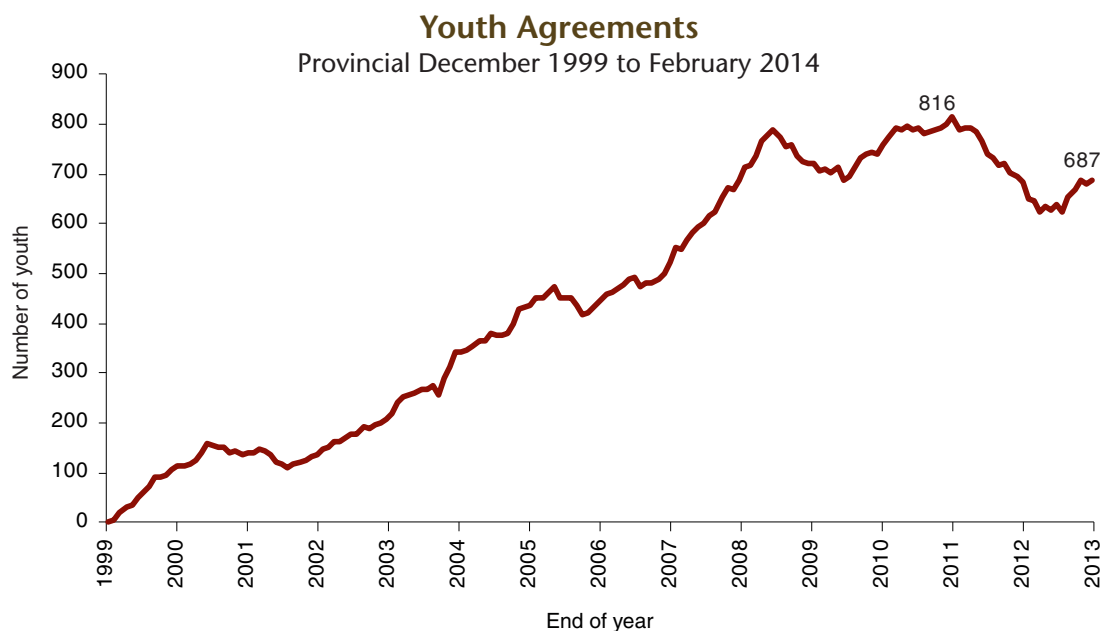
Agreements with Young Adults is a program offered by MCFD that supports young people ages 19 to 24 who are transitioning out of government care and into adulthood. The program provides financial assistance and support services to young adults, helping them to finish high school, learn job and life skills, attend college or university or complete a rehabilitation program.

Financial assistance may include living expenses, child care expenses, health care expenses or tuition fees.

the permanent legal custody or guardianship of the ministry. Youth in care subject to a temporary legal order are not eligible.

The intent of this program is to financially support youth so they can complete educational, vocational or rehabilitation options. Youth must attend these programs, which can include high school completion and treatment programs, at least 15 hours per week. Youth in education or vocational programs must carry a minimum 60 per cent of a full-time course load (40 per cent if they have a permanent disability). The money is intended to cover food, shelter and daily basic living and medical expenses. It may also pay for tuition and program supplies if these cannot be covered another way. Youth receive guidance and support from a social worker who remains involved throughout the term of the agreement. Agreements with Young Adults last for up to six months. The total of all agreements cannot be more than 24 months and they cannot extend beyond the youth's 24th birthday.

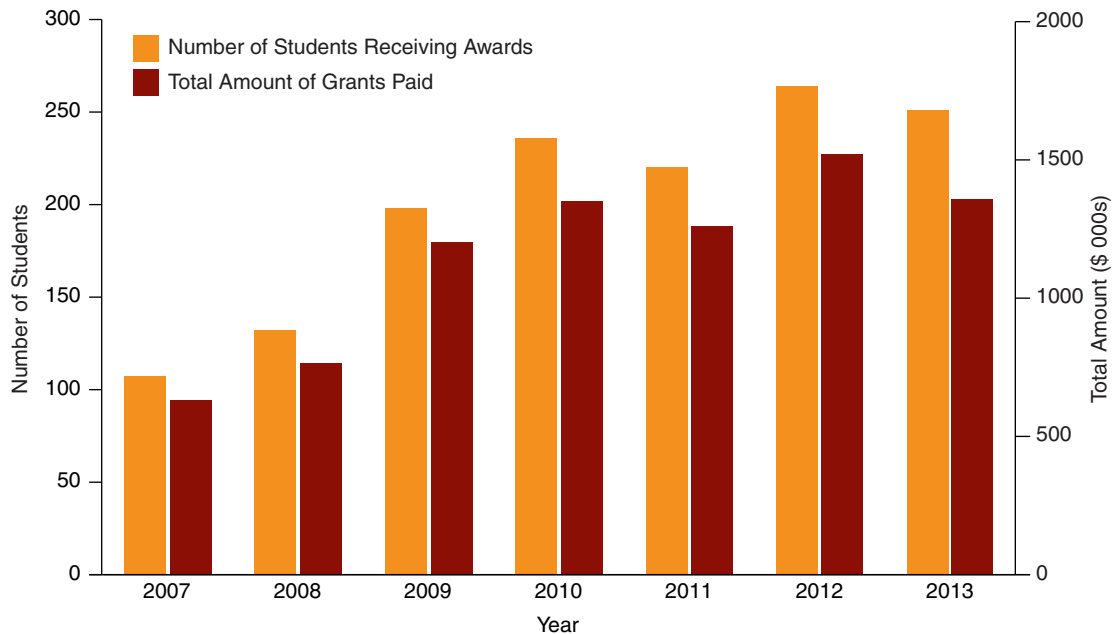
The number of young people under Youth Agreements has increased significantly since the fiscal year 2000/01, although there has been a decrease in recent years. The number of young people with Youth Agreements peaked in February 2012 at 816. As of February 2014 687 youth, of whom 25 per cent were Aboriginal, were on Youth Agreements.



Two provincial government funds also offer bursaries for former youth in care to attend post-secondary education. These are the Youth Education Assistance Fund (YEOF) and the Public Guardian and Trustee Educational Assistance Fund. However, these funds are only available to youth over the age of 18 who have been in the permanent legal custody of the ministry. They are not available to youth for whom the ministry has assumed legal guardianship on a temporary basis or those on a Youth Agreement.

YEOF is for young adults ages 19 to 24, who are in post-secondary education or vocational training and were formerly in the permanent care of the ministry, with taxable grants of up to \$5,500 towards cost of living expenses, tuition and books. These youth may apply annually for a maximum of four years for bursaries that can extend until their 24th year. For each bursary, their program must be at least 12 weeks long at a designated post-secondary institution, although the program does not have to be in the province. Students without disabilities must carry a minimum 60 per cent of a full-time course load. Students with disabilities must carry a minimum 40 per cent of a full-time course load. Funding is provided by MCFD and administered through a partnership between the Ministry of Advanced Education and the Victoria Foundation.

YEOF – Students Receiving Bursaries and Amount of Trust Funds Grants Awarded by Year



Total number of students who have received a YEOF award since its inception in 2002: **1,890**

The Public Guardian and Trustee Educational Assistance Fund offers annual bursaries of up to \$4,000 for youth who were formerly in the permanent care of the ministry to attend post-secondary education. According to the trust, applicants are assessed on their grades, financial needs, career goals and other considerations. Funds available are dependent on rates of investment return. A total of \$129,500 has been awarded to 112 applicants since 2007/08. A total of \$16,600 was awarded to 13 applicants in 2013/14.

In addition, a fund was established in early 2014 at the Vancouver Foundation to help former youth in care offset living costs while they are attending post-secondary institutions. Coast Capital Savings contributed \$200,000 to launch the new fund. Efforts are underway to solicit additional donations to this fund from private sector businesses and individuals.

MCFD has designated a provincial lead for Young Adult Services who will focus on improving outcomes for young people ages 19 to 24 who were in care or on youth agreements. MCFD has also set up working groups to try to improve youth input in decision-making processes and to increase staff knowledge regarding transition policies and services. MCFD has also recently updated the transition manual first published in 1999.

MCFD's new care plan for youth provides detailed guidance for developing a transition plan, including the setting of educational goals for youth. The ministry has also stabilized its funding to YEAF, with \$1.4 million now provided on an annual basis. In addition, a Cross-Ministry Transition Planning Protocol for Youth with Special Needs is in place. The focus is on young people between the ages of 14 and 25 who require significant additional educational, medical and social support to transition to adulthood.

While MCFD has recently made improvements to transition supports, they do not measure up to initiatives in Ontario. For example, Ontario provides after-care benefits to former youth in care up to age 24. These include prescription drug, dental and extended health benefits. (See Appendix 1)

Federal Sources of Financial Support for Young People Leaving Care

The federal government provides Canadian families with benefits and tax measures to assist with the costs of raising children. Since 1998, the federal government has provided direct financial assistance to families through the Canada Child Tax Benefit (CCTB), a non-taxable monthly payment determined by the family's net income and number of children.

Generally, all families with children under the age of 18 are eligible to receive the CCTB. It consists of two components: the base benefit, which is paid to low- and middle-income families, and the National Child Benefit Supplement (NCBS), an additional benefit paid to low-income families. The NCBS is needs-based, with a ceiling that is determined annually. It is a joint initiative of the federal, provincial and territorial governments. Most provinces and territories offset the NCBS by reducing social assistance payments to low-income families equal to the amount of the supplement.

The federal government also provides a Universal Child Care Benefit (UCCB) to families. The UCCB is a taxable benefit paid to all families for each child under age six to help cover the cost of child care. Eligible families can also apply for the Child Disability Benefit (CDB). This is a tax-free payment to families who care for a disabled child under age 18. For a family to receive the CDB, the child must have a severe and prolonged impairment in mental or physical function.

All CCTB benefits are indexed annually. The basic monthly benefit for 2013-2014 is \$119.41. The NCBS monthly benefit is \$185.08. These two amounts are directed to families on a decreasing scale for subsequent children. The 2013-2014 UCCB rate is \$100 per month per child under age six. The current monthly CDB benefit is up to \$218.83, depending upon parental income.

Under the *Children's Special Allowances Act*, the federal government pays provincial and territorial child welfare authorities the Children's Special Allowance (CSA) for each child who comes into care. The amount is equivalent to the maximum CCTB payments, including the base benefit and NCBS. The CSA also includes the UCCB for children under age six.

In most jurisdictions, when a child comes into care, the provincial or territorial government applies for CSA. In B.C., these benefits are paid into the government's general revenue fund. The allowance is not directed to foster families or young people. This contrasts with Ontario where, since 2008, Children's Aid Societies have been required to deposit the payments into an RESP if the child has been in care for at least six consecutive months.

In addition to these benefit programs, the federal government provides grants to families to pay for the future care or education of their children. The Registered Disability Savings Plan (RDSP) helps families save money for the future of their children who have disabilities. Earnings accumulate tax-free within the plan until money is taken out. The federal government contributes to the RDSP through the Canada Disability Savings Grant (CDSG) and Canada Disability Savings Bond (CDSB). Through the CDSG, the federal government provides matching grants of up to 300 per cent, depending on the amount contributed to an RDSP and the beneficiary's family income. There is a \$200,000 lifetime contribution limit. The maximum grant is \$3,500 each year, with a lifetime limit of \$70,000. In addition, the government contributes up to \$1,000 a year to the CDSB, depending upon family income, to a lifetime maximum of \$20,000.

There is no policy in B.C. requiring child welfare authorities to open RDSPs for eligible children in their permanent care and custody, and these children often don't benefit from this important future financial support.

The federal government has also established an RESP program to help families save for their children's post-secondary education. Every child under the age of 17 in Canada who has a social insurance number is eligible to have an RESP set up in his or her name. The contribution ceiling is \$50,000. The federal government has established a Canada Education Savings Grant (CESG) to help families save by adding to the amount of money accumulated in a child's RESP. The CESG matches parental contributions to a maximum lifetime grant of \$7,200. The Canada Learning Bond program contributes up to \$2,000 to RESPs opened by families who receive the NCBS under the CCTB program. These programs were intended to help low-income families save towards their children's post-secondary education by adding federal contributions to existing RESPs. There have been no clear policy or practice efforts to ensure that youth aging out of care receive support from federal social programs.



Recommendations

Recommendation 1

That the Ministry of Children and Family Development immediately take steps to establish a Youth Secretariat to provide a defined youth focus across all of the ministry's service areas and to coordinate cross-ministerial efforts to ensure successful transitions to adulthood for youth leaving care and out-of-home placements. The Secretariat should work to ensure that youth are provided the same or better access to supports and services as their non-care peers. It should include strong Aboriginal participation and leadership and work to ensure effective coordination and leadership on transition issues affecting young people in care and those in out-of-care placements.

Details:

The Secretariat should:

- Lead collaboration among MCFD and the ministries of Health, Education, Advanced Education, Social Development and Social Innovation and Justice, co-ordinating a cross-ministry effort to examine how to best anchor transition services for youth in care and out-of-home placements to make them more accessible and effective.
- Form an effective partnership with the B.C. Federation of Youth in Care to establish local youth committees in each of the MCFD service areas. Youth in care should serve on these committees, which would act as advisory bodies to MCFD and associated service providers.
- Ensure that program evaluations are completed on transitional support services to measure impacts and outcomes and contribute to evidence-based program development and work to ensure greater accountability for ministry contracts and engagement with service providers and the public.
- Oversee the gathering and analyzing of baseline and longitudinal data of education, health and employment outcomes for former youth in care up to age 25.
- Ensure that MCFD reports annually on the transition of youth in care, as well as those on Youth Agreements, Independent Living Arrangements and out-of-home placements, beginning at age 18 until the expiration of such agreements and services.
- Work with the Ministry of Social Development and Social Innovation to establish minimum income support levels for extended care and maintenance programs to ensure young people leaving care receive a reasonable standard of living that exceeds the Low Income Cut-Off for B.C.
- Work to ensure access to health, dental and vision care assistance for former youth in care up to age 25.
- Provide preferential access for former youth in care to ongoing counselling or other emotional support services up to age 25.
- Work with and support the ministry and the Provincial Guardian and Trustee to conduct financial literacy training for youth in care.
- Promote civic engagement of youth in care and out-of-home placements so they can be supported to be active and engaged members of their communities.

continued

Recommendation 1

continued

- Provide youth in care, their caregivers and the staff working with them with easy to access, centralized information on transition through web-based advice as well as other supports on financial, educational, employment, housing, health and mental health issues.
- Encourage the development, adoption and implementation of a robust social media and engagement policy so that young people can make and maintain relationships with ministry staff and contracted agencies in a manner that is relevant to them, therefore increasing the capacity of the ministry and its agencies to work effectively with these youth.
- Develop recommendations on the potential introduction of specialized transition navigators, youth workers with expertise in the various aspects and processes of transition who would be available to young people, care providers and staff for consultation, information and mentoring on the necessary steps and tasks in the transition process.

Secretariat should be in place by Sept. 1, 2014.

Preliminary work plan should be shared with the Representative by Nov. 1, 2014.

First progress report to the Representative by March 31, 2015.

First public report on transition outcomes for youth by March 31, 2016.

Recommendation 2

That the Ministry of Education begin a targeted initiative in all B.C. school districts to ensure that every youth in care or in an out-of-care placement has a clear education plan and skills training pathway to guide them as they progress in school and transition out of government care and high school.

Details:

- Minister of Education to issue a special order under the *School Act*, requiring implementation in all school districts in B.C., and assign accountability for implementing the recommendation to Superintendents with a stand-alone annual report required on the work undertaken.
- Requirements for these plans for every youth in care in B.C. should be built in to the annual accountability contract with school districts, and meaningfully addressed by Superintendent's Reports on an annual or more regular basis.
- Minister of Education to take steps to ensure that independent schools also participate in this dedicated planning and reporting for children in care and direct the Inspector of Independent Schools to use the authority in the *Independent School Act* to report on an annual basis.
- Minister of Education to identify planning steps taken for children in care who are not in school for any extended period of more than 20 school days in a given year.
- Planning should begin for each child in Grade 6 and escalate through each middle and high school year through to high school graduation.
- Plans should identify remedial needs, and how they will be addressed and reassessed.
- MCFD to take these requirements into account, and ensure that these plans are incorporated into plans of care for youth in care, and that school personnel are actively involved in care planning and coordinate out-of-school supports with in-school efforts.

First report on strategy to achieve this recommendation to the Representative by Sept. 1, 2014.

First report of progress and outcomes to the Representative by May 31, 2015.

Recommendation 3

That MCFD build a durable policy foundation for youth programs and services in British Columbia to ensure that vulnerable youth, such as those in care and out-of-home placements, are provided guaranteed access to training, skills and other programs as well as adequate social supports, and are not transitioning to dependence with poor opportunities.

Details:

- In the short-term, MCFD to consider amending the *Child, Family and Community Service Act* to permit, on a case-by-case basis, the extension of foster care up to age 25 for young people who are attending post-secondary institutions or apprenticeship programs.
- MCFD to prepare a discussion paper on legislative options for a more durable, stable policy framework to close the gap for transitioning vulnerable youth.
- MCFD to promote discussion and consideration of a *Youth Leaving Care Act*, similar to that in force in the U.K., to provide a stable, long-term commitment to helping youth in care and out-of-home placements make the transition to adulthood and to anchor programs, services and a systemic approach to accountability.

Progress report and plan to Representative by March 31, 2015.

Recommendation 4

That the Select Standing Committee on Children and Youth consider holding public hearings on youth leaving care and out-of-home placements to better inform legislators and the public of the need for a solid, durable program of services and supports for these youth.

Conclusion

While there have been some improvements in recent years in the supports available to transition young people out of care and into independence, there is still much to be done to help young people who have been in care become full, contributing members of society. The failure to provide the necessary supports carries a high collective price. The manner in which young people leave care has a significant influence on how well they move into independence. Those who leave prematurely, or who simply age out, are likely to experience immediate and longer-term difficulties in their lives. They are more likely to be unemployed or underemployed, more likely to come in contact with the criminal justice, mental health and substance use systems, more likely to have poor health outcomes, more likely to experience homelessness, and less likely to attend post-secondary institutions.

These outcomes carry steep economic and social costs. The costs of not helping young people in care successfully transition into adulthood are significantly higher than the costs of providing adequate support. The loss to society of the positive contributions these young people could make if they had the needed supports for a successful transition is equally important.

In order to make a successful transition to adulthood, all young people need to receive support in the areas of relationships, education, housing, life skills, identity, engagement and emotional healing. There needs to be an adequate level of financial support for these areas to be properly attended. Young people who receive support past the age of majority have a higher likelihood of educational achievement, which is closely associated with other positive personal outcomes. Young people who have been in care and receive financial support to go to school are more likely to be stable and successful in other parts of their lives. There is a need to increase the levels and types of support available to ensure that more young people can attend post-secondary education or find stable employment.

It is as if magically somehow they've developed into a whole different person overnight on their birthday and the things they weren't able to do a week before are now expectations that they have to do in order to either stay in care or continue to receive funding, so there's still a whole realm of problems there associated with – it's like staying in care is not a right. It's perceived as something you have to earn. Children that live at home don't have to earn the right to live with their families.

Care provider

It is important to remember young people in care are not a homogeneous group. In order to provide the best possible supports for young people, their unique needs must be considered. Generic supports will not have the same positive influence as those that target a young person's specific needs, however, the ability to target specific needs is handicapped by a general lack of knowledge about the young people in care. Much is still unknown about these youth and the effectiveness of the current transitional programming. One of the difficulties in Canada, as with many other countries, is a lack of longitudinal research about what happens to young people once they leave care. A stronger research base is needed in B.C. and Canada on all aspects of transitioning young people out of care.

Conclusion

A number of assumptions must be challenged to develop a truly effective transitional process. The first, and perhaps the biggest, is the assumption that young people in care are the same as their peers who have not been in care. Young people in care are different from their peers because of their experiences prior to coming into care and their experiences in care. The response to their transitional needs must take these differences into account. It cannot be assumed that they will take the same transitional paths as their non-care peers, nor that the timelines for transition will be the same. As well, the assumption that young people in care match their peers in every developmental aspect based simply upon chronological age is incorrect.

Holding youth in care to a higher standard than those who have not been in care, and approaching policy and program planning from this belief, is not acceptable. It is a false assumption that young people who have been in care will automatically return to their families of origin and be able to draw on a built-in support system. The reasons why young people come into care in the first place can still be there when they leave care. Many young people do not want to re-establish contact with their families and, even if they do, there is no guarantee that their families can provide support.

My mother wants to have a relationship with me, but too much happened in the past. I can't do it.

Former youth in care

Successful transition requires that plans be developed that acknowledge the individual needs and dreams of the young person. This process needs to begin in early adolescence and be flexible enough to change as needs and desires of the youth change. It means actively ensuring that they are experiencing educational success while in care, in addition to the development of the types of living and job skills all young people need to be successful in life. It means meeting their basic permanency, belonging, health and social needs while they are in care and that the provision of support continues until they have successfully transitioned into adulthood.

If we want productive citizens, if we want citizens that are going to give back to the country and be part of the country they are not going to do it if they are turfed at 18... Some are ready at 18 but the majority aren't, so if all we are doing is moving them from one system to another because they are not able to support themselves, then it doesn't make any sense to me.

Care provider

If it is believed that once young people come into care the state becomes their parent, then the state as a prudent parent must be willing to take on longer-term responsibility for these young people, just as a family would do. Right now, some youth have access to supports past the age of majority while those with higher needs – who arguably need greater support – are left with little or no help. Their new parent becomes the criminal justice, mental health or substance use systems. Do well and you can stay. Fail and you have to leave. This has to change. If parents treated

their children the way many of the young people who have been in care have been treated, there would be serious questions about their competency and commitment.

Glossary

Agreements with Young Adults – Agreements with Young Adults (AYA) is a program offered by the British Columbia Ministry of Children and Family Development (MCFD) that supports young people aged 19 to 24 who are transitioning out of government care and into adulthood. The program provides financial assistance and support services to young adults, helping them to finish high school, learn job and life skills, attend college or university or complete a rehabilitation program. Financial assistance may include living expenses, child care expenses, health care expenses or tuition fees.

Canada Child Tax Benefit – The Canada Child Tax Benefit (CCTB) is a non-taxable monthly payment made to families to help them with the cost of raising children under age 18. The amount of the CCTB is based on the family's net income. The CCTB may include the National Child Benefit Supplement and Child disability benefit.

Child Disability Benefit – The Child Disability Benefit (CDB) is a monthly non-taxable benefit providing financial assistance for qualified families caring for children under 18 with severe and prolonged mental or physical impairments.

Canada Disability Savings Grant – The Canada Disability Savings Grant is a grant program offered by the Government of Canada that matches parental contributions to a Registered Disability Savings Plan (RDSP). The government provides matching grants of up to 300 per cent, depending on the amount contributed and the beneficiary's family income. The maximum grant is \$3,500 each year, with a limit of \$70,000 over a lifetime.

Canada Education Savings Grant – The Canada Education Savings Grant (CESG) is a Government of Canada program that pays a contribution to a child's RESP, acting as an incentive for parents, family and friends to save for a child's post-secondary education. The basic grant amount is 20 per cent of the annual contribution to each RESP beneficiary, to a maximum annual amount of \$500 and a maximum lifetime amount of \$7,200.

Child, Family and Community Service Act (CFCS Act) – Legislation enacted in 1996 that governs child protection in British Columbia.

Canada Learning Bond – The Canada Learning Bond (CLB) is a Government of Canada program that helps modest-income families start saving early for their child's post-secondary education. The CLB is available to families that qualify for the National Child Benefit Supplement (NCBS) and is capped at a lifetime maximum amount of \$2,000.

Children's Special Allowance Act – Legislation enacted in 1992 by the Government of Canada that provides for the payment of special allowances for the care and maintenance of children and youth in the custody of provincial child welfare authorities.

Children's Special Allowance – The Children's Special Allowances (CSA) program provides payments to federal and provincial agencies and institutions (e.g., children's aid societies) that care for children. The monthly CSA payment is equal to the maximum CCTB payment plus the National Child Benefit Supplement (NCBS) plus the Disability Benefit (CDB) plus the Universal Child Care Benefit (UCCB) if applicable.

Delegated Aboriginal Agency (DAA) – Through delegation agreements, the Provincial Director of Child Protection (the Director) gives authority to Aboriginal agencies, and their employees, to undertake administration of all or parts of the *CFCS Act*. The amount of responsibility undertaken by each agency is the result of negotiations between the ministry and the Aboriginal community served by the agency, and the level of delegation provided by the Director.

Director of Child Protection – A person designated by the Minister of Children and Family Development under the *CFCS Act*. The Director may delegate any or all of his or her powers, duties and responsibilities under the Act.

Former youth-in-care – A young person who is no longer living under the care of the ministry.

National Child Benefit Supplement – The National Child Benefit Supplement (NCBS) is the Government of Canada's contribution to the national child benefit. It is a joint initiative of federal, provincial, and territorial governments, and First Nations that provides a monthly financial benefit for low-income families with children.

Registered Disability Savings Plan – A Registered Disability Savings Plan (RDSP) is a savings plan to help parents and others save for the long-term financial security of a person who is eligible for the disability tax credit. Contributions to an RDSP are not tax deductible and can be made until the end of the year in which the beneficiary turns 59.

Registered Education Savings Plan – A Registered Education Savings Plan (RESP) is a special savings account for parents who want to save for their child's education after high school. Under an RESP, parents set aside contributions towards their children's education. Contributions are invested by a third party and paid to the children in the form of Educational Assistance Payments (EAPs) when they enter a post-secondary education program.

Universal Child Care Benefit – The Universal Child Care Benefit (UCCB) supports Canadian families by providing direct financial assistance for child care. The UCCB is for children under the age of six years and is paid in installments of \$100 per month per child.

Youth Agreement – A Youth Agreement is a legal agreement between the British Columbia Ministry of Children and Family Development (MCFD) and youth aged 16 to 18. The purpose of the agreement is to help youth gain independence, return to school, or gain work experience and life skills.

Youth Education Assistance Fund – The Youth Education Assistance Fund (YEAF) is administered by British Columbia Ministry of Children and Family Development (MCFD), in partnership with the Victoria Foundation and the Ministry of Advanced Education. YEAF provides bursaries for former youth in permanent care between 19 and 23 years of age who are attending university, college, a university-college, an institute, or designated private school. The maximum annual YEAF bursary amount is \$5,500, to primarily assist with the costs for tuition, books and fees.

Youth – A person who is 16 years of age or over, but under 19 years of age.

Youth-in-care – A young person who is under the care of the ministry.

Appendix 1: Financial Supports Available to Youth Leaving Care in Ontario

The following is a chart outlining the financial supports available for youth in and leaving the care of Ontario's child welfare system.¹³⁴ In addition to the financial supports outlined below, the Ministry of Children and Youth Services and its partner ministries fund programs to support youth as they transition to adulthood, such as the Youth-in-Transition Worker Program and Crown Ward Education Championship Teams.

Name of Support	Who is Eligible	Program Description	How it supports youth leaving care
Ontario Child Benefit Equivalent (OCBE)	For all youth in care up to and inclusive of age 17.	The Ontario Child Benefit Equivalent (OCBE) provides increased access to educational, social, cultural and recreational opportunities for all youth up to and inclusive of age 17. In addition, youth ages 15, 16 and 17 who have been in the care of a children's aid society (CAS) or a Formal Customary Care agreement for 12 consecutive months or more are eligible to participate in a savings program.	At age 18, eligible youth can access OCBE savings, which can support their transition to adulthood (e.g., funds can be used for post-secondary education). As part of accessing OCBE savings, youth must participate in a Financial Literacy Program, which supports them to acquire financial skills and develop financial competency. The OCBE program currently contributes \$100.83 a month to each savings account.
Registered Education Savings Plan (RESP) Program	Children in care ages 0-6.	Launched in 2008, the Registered Education Savings Plan (RESP) Program supports increased educational attainment for youth who have been in the care of the Children Aid Society (CAS). Through the program, CASs are required to establish RESPs for eligible children in care using funds from the Universal Child Care Benefit (UCCB). When a youth in or leaving care enrolls in an eligible post-secondary education or vocational training program, he or she can access the RESP funds to support education-related expenses.	The first redemptions of UCCB-funded RESPs are expected to occur beginning in 2020, when the eldest youth who were eligible for UCCB funds when the policy came into effect will be able to enter post-secondary education or training. Youth eligible to receive the maximum amount are expected to begin enrolling in post-secondary education in 2025.
Renewed Youth Supports (RYS)	Youth whose court-ordered society care or Formal Customary Care was terminated at age 16 or 17.	The Renewed Youth Supports (RYS) Program allows eligible youth to voluntarily enter into an agreement with a CAS to receive supports up to age 18. Through the RYS program, youth become eligible for further supports once they turn 18, including Continued Care and Support for Youth (CCSY).	Eligible youth can return to a CAS and access financial and case support until age 21, through CCSY.

Name of Support	Who is Eligible	Program Description	How it supports youth leaving care
Continued Care and Support for Youth (CCSY)	<p>A youth who is 18 to 20 years old and;</p> <p>a. Was subject to a Crown wardship or legal custody order (s. 65.2) immediately prior to the youth's 18th birthday;</p> <p>b. Was subject to a Crown wardship or legal custody order (s. 65.2) immediately before the youth's marriage if the marriage occurred before the youth's 18th birthday;</p> <p>c. Was the subject of a customary care agreement for which the society paid a subsidy immediately prior to the youth's 18th birthday; or</p> <p>d. Was eligible to receive Renewed Youth Supports (RYS) at ages 16 and/or 17, whether or not the youth actually received RYS.</p>	<p>The Continued Care and Support for Youth (CCSY) policy came into effect in May, 2013 and replaced the former Extended Care and Maintenance (ECM) policy, for youth 18 to 20 (inclusive).</p> <p>It provides eligible youth with financial (\$850/month) and other supports based on their individual needs and aspirations to enable them to transition smoothly to adulthood. CCSY sets out a youth-centred, strength-based program that empowers youth to be more actively involved in decisions that impact them.</p>	<p>Eligible youth receive financial support of \$850/month, as well as non-financial supports, to help them meet their goals during their transition into adulthood.</p>
Ontario Access Grants for Crown Wards	<p>Youth who are Crown wards or were previously Crown wards (at any age), or who are receiving or were eligible to receive <i>Continued Care and Support for Youth</i>.</p>	<p>Youth in OSAP eligible programs that are two or more years in length may receive Ontario Access Grants for Crown Wards for 50% of tuition fees to a maximum of \$3,000/year for up to four years.</p> <p>Students in a one year program may receive an Ontario Access Grant for Crown Wards for 100% of tuition costs to a maximum of \$3,000.</p>	<p>Eligible youth receive up to \$3,000 a year to cover the costs of 50% of their tuition fees.</p>

Name of Support	Who is Eligible	Program Description	How it supports youth leaving care
100% Tuition Aid for Youth Leaving Care	Youth who are eligible to receive the <i>Ontario Access Grant for Crown Wards</i> .	Participating colleges and universities in Ontario provide funding to cover the remaining 50% of tuition fees up to \$3,000 (for a total of \$6,000) for students who are eligible for the Ontario Access Grant for Crown Wards. <ul style="list-style-type: none"> The tuition aid provided by the school does not reduce the amount of OSAP full-time funding that a student is eligible to receive. 	Eligible youth receive up to \$3,000 a year to cover the remaining 50% of their tuition fees, from participating colleges and universities.
Ontario Crown Ward Postsecondary Application Fee Reimbursement Program	Current and former Crown wards.	This program covers the cost of college and university application fees for Crown wards and former Crown wards applying for their first college or university program.	Eligible youth receive reimbursements up to the maximums listed below and only in up to two of the following institutional categories: <ul style="list-style-type: none"> Ontario Universities' Application Centre (OUAC): All application fees for up to five first entry university/program choices* Ontario Colleges Application Service (OCAS): All application fees for up to five college/program choices OSAP approved programs offered by Ontario private postsecondary institutions: Up to \$100 in application fees OSAP approved programs offered by out-of-province postsecondary institutions: Up to \$100 in application fees*
Living and Learning Grant (LLG)	Youth ages 21 to 24 (inclusive) who received, or were eligible to receive CCSY, and who are enrolled full-time in OSAP-eligible post-secondary education and training programs.	The Living and Learning Grant (LLG), provides \$500 a month during the school year to eligible youth.	Eligible youth receive \$500 a month/ \$2,000 a semester (up to \$4,000 a year), to use towards their living expenses. This grant does not reduce the amount of OSAP loan and grant funding a student is eligible to receive (i.e., a youth may receive the LLG in addition to the 100% Tuition Aid).

Name of Support	Who is Eligible	Program Description	How it supports youth leaving care
Aftercare Benefits Initiative (ABI)	<p>Youth ages 21 to 24 (inclusive) who had Crown ward status that expired at the age of 18; who were subject to a formal Customary Care agreement or a protection custody order at age 18; or who were eligible for the Renewed Youth Support program.</p> <p>Youth who are eligible to participate in another benefits program, for example with their post-secondary institution, through social assistance or through their employer, are not eligible to participate in this program.</p>	Beginning the summer of 2014, the ABI will be administered by the Ontario Association of Children's Aid Societies (OACAS) and will provide prescription drug, dental and extended health benefits to eligible youth.	The ABI will help eligible youth to transition to adulthood, increase their resiliency and improve their self-care.

* Participating Colleges: Collège Boréal; Cambrian College; Canadore College; Humber College; La Cité Collégiale; Northern College; Sault College; Sheridan College. Participating Universities: Algoma University; Brock University; Carleton University; Lakehead University; Laurentian University; McMaster University; Nipissing University; OCAD University; University of Ontario Institute of Technology; University of Ottawa; Queen's University; Ryerson University; Saint Paul University; Trent University; University of Guelph; University of Toronto; University of Waterloo; University of Windsor; Western University; Wilfrid Laurier University; York University.

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Appendix 1: Financial Supports Available to Youth Leaving Care in Ontario

134. Information was provided by the Ontario Ministry of Children and Youth Services.

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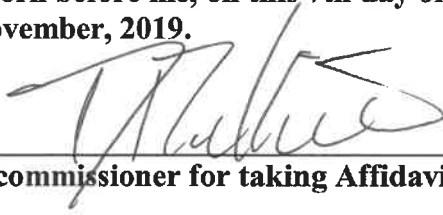
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**This is Exhibit "M" referred to in the
Affidavit of Mary Ellen Turpel-Lafond,
sworn before me, on this 7th day of
November, 2019.**

A handwritten signature in dark ink, appearing to be "T. Turpel-Lafond", written over a horizontal line.

A commissioner for taking Affidavits



REPRESENTATIVE FOR
CHILDREN AND YOUTH

Not Fully Invested
*A Follow-up Report on the
Representative's Past Recommendations
to Help Vulnerable Children in B.C.*

October 9, 2014



REPRESENTATIVE FOR
CHILDREN AND YOUTH

October 9, 2014

The Honourable Linda Reid
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Ms. Speaker:

I have the honour of submitting the report *Not Fully Invested: A Follow-up Report on the Representative's Past Recommendations to Help Vulnerable Children in B.C.* to the Legislative Assembly of British Columbia. This report is prepared in accordance with Section 6(b) of the *Representative for Children and Youth Act*.

Yours sincerely,

Mary Ellen Turpel-Lafond
Representative for Children and Youth
Province of British Columbia

pc: Mr. Craig James
Clerk of the Legislative Assembly

Ms. Jane Thornthwaite, MLA
Chair, Select Standing Committee on Children and Youth



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Executive Summary

In the six-year period covered by this review, the Representative for Children and Youth, an independent Office of the B.C. Legislature, has made a total of 148 recommendations – carefully considered prescriptions for how the lives of vulnerable children in British Columbia can be improved.

The Representative has made these recommendations to the bodies that carry the responsibility to protect and provide services to children in this province. As such, the vast majority have been made to the B.C. government and its designates.

Recommendations have been made after completing detailed investigations into individual incidents of death and injury to B.C. children – the kinds of cases from which it is essential to learn. Recommendations have also come as a result of aggregate reviews of such incidents and through careful examination of issues and trends that affect the safety, health and well-being of vulnerable youth in this province. Recommendations have been shaped and advanced strategically by the Representative's Office as we address sectors of the child and youth population that continue to be inadequately served.

This report – the first to track progress made toward fulfilling the Representative's cumulative recommendations – shows that 72 per cent of all recommendations have been substantially or fully implemented.

At a superficial glance, that might seem like encouraging progress. But it is not. We are talking about the lives of children and youth – impressionable, needy and vulnerable youngsters who each deserve the full help, protection and commitment of their government. And in that context, a progress rate of less than 75 per cent is just not good enough.

The Representative does not make recommendations lightly. The 148 recommendations she has made were the result of a total of 22 reports from 2008 to 2013. Each of the Representative's reports require months and sometimes years of research, file reviews, data analysis, interviews with staff and professionals working in the child- and youth-serving field, as well as interviews with family members and young people themselves.

It is critical to know the status of recommendations stemming from these reports, and whether outcomes and long-term prospects are getting better for B.C.'s most vulnerable children and youth. This is not only important for the Representative's Office but for all British Columbians so they are kept informed about how well their government is serving and protecting its most needy citizens.

The need for a critical eye to be placed on B.C.'s child welfare system came into focus with the 1995 *Gove Inquiry into Child Protection in British Columbia* following the death of five-year-old Matthew Vaudreuil. The focus intensified a decade later with the Hon. Ted Hughes' *B.C. Children and Youth Review* in 2006, following the death of toddler Sherry Charlie.



The Office of the Representative for Children and Youth was created in 2007 following the Hughes Review, which re-confirmed the need for oversight that was identified in the Gove Inquiry. The genesis of the Representative's Office lies in these critical investigations into the tragic deaths of children – circumstances similar to those we continue to encounter and investigate and report out on.

Hughes recommended that the Representative should assume an oversight role to *"monitor and report on government's services to children and families, and on the Ministry's responses to child deaths and critical injuries."*

Hughes wrote: *"There is also a need for an external body to push for change to the system from time to time. The Representative will have the authority, the expertise and the resources to study the child welfare system from an informed but external perspective and recommend change where needed."*

The *Representative for Children and Youth Act (RCY Act)*, gives the Office the authority to publicly report on designated services for children and youth and offer recommendations for change.

The vast majority of those recommendations have been made to the Ministry of Children and Family Development (MCFD) and its designates, including delegated Aboriginal Agencies (DAA), with others going to a number of other provincial ministries, the government of B.C. as a whole, and public bodies such as policing services, Aboriginal organizations and other independent offices of the Legislature. Recommendations have been made with careful consideration of the experiences of children and youth and their families and also of the experiences and knowledge of the staff who work in the field.

A close look at the status of the Representative's recommendations since 2008 shows that public bodies, including MCFD, have generally been willing to follow through on recommendations that addressed needed changes to policy, standards or procedures, or compliance in these areas – vital changes required to improve service systems and their delivery.

However, it is important to look at the recommendations that government has not implemented and to ask why not. What has been the impact of government decisions to ignore important recommendations?

The answer to this question is troubling to the Representative. Of the nine recommendations made to the B.C. government as a whole – the ones that require the greatest cross-ministry involvement and organization – seven have been largely disregarded. These include several significant recommendations that are central to improving the lives of B.C.'s vulnerable children and youth.

These are the recommendations that require overarching accountability, leadership and commitment from the provincial government and the fact they have been ignored is both deeply disappointing and the most striking finding of this report. It has been too easy for government to use the notion that child welfare "is difficult work" as an excuse for not tackling it with the determination and resources required. Difficult work is done willingly by those on the front lines of the system. Organizational leadership and



the adequate deployment of resources – things that have too often been lacking on government's part – demand the same level of commitment.

Unaddressed recommendations include a call for a provincial strategy and action to reduce child poverty. It is unacceptable that B.C. has consistently had one of Canada's highest child poverty rates and yet there has been no concrete, over-arching action plan to address this glaring problem in our province. Living in poverty deeply affects long-term outcomes for children, both physical and mental. Leadership is desperately needed in B.C. to tackle this problem with the urgency it requires.

Similarly, the B.C. government has failed to act on a recommendation for a comprehensive plan to tackle the complex issue of youth mental health. Most British Columbians know someone who is affected by a mental health problem. In a number of reports, the Representative has identified the inability of B.C.'s mental health services to respond appropriately and effectively to the needs of children and youth and yet the problem persists. In *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.*, the Representative's top recommendation was for government to provide the necessary leadership and accountability on this file by creating a Minister of State for Youth Mental Health. Government has ignored that recommendation and failed to address this area as a whole in any meaningful way.

Children living in situations of domestic violence are dramatically affected by what they see and hear, yet the government's response to recommendations on domestic violence has been weak, lacking clear outcomes, time frames and measurements of success. In addition, poverty and unemployment are clear risk factors for domestic violence, but the government's three-year domestic violence plan, which is long on generalities and short on resources, ignores these risks.

It has long been known that Aboriginal children and youth are grossly over-represented in the B.C. child welfare system. Despite comprising just eight per cent of the total B.C. child population, more than 50 per cent of the children in government care are Aboriginal.

The Representative has issued a number of reports that have identified concerns about the well-being of Aboriginal children and youth, but subsequent recommendations have resulted in slow response and little commitment to a dedicated focus on this issue – from either the federal or provincial government.

A major focus of the Representative's recommendations since 2008 has been on quality assurance and outcomes reporting. The Representative believes that it is essential for MCFD and other government bodies to track performance in serving children and youth and to be able to say, with certainty, that performance is improving.



Disappointingly, this report finds that it is still not possible to say with certainty whether things are getting better for B.C.'s vulnerable children and youth. The demand for RCY advocacy services and reports of injuries and deaths remain consistently high. MCFD's ability to measure performance and publicly report on whether it is achieving results has remained inconsistent and inadequate. The lack of quality assurance and outcomes reporting is yet another sign of a gap in overall government leadership in this area.

The Representative's work as an oversight body for child welfare in B.C. is grounded in the concept of government serving as the prudent parent of all children in its care. The test is: What would a prudent parent do for his or her child? Government has a duty, at a minimum, to meet that standard for the children and youth in its care.

A big part of that duty is to step up and fill the gaps identified by the Representative, an expert independent body that carefully considers the B.C. child-serving system and determines what is missing and what is required. Those careful considerations result in report recommendations. While the B.C. government is not compelled by legislation to follow our recommendations, to do so shows commitment and makes good sense – for the good of children, youth and families in our province.

Considering what is at stake, government can and should do better.



Introduction

The Representative issues public reports for two main reasons: to improve services for children, youth and their families; and to learn from children's experiences in order to better support all vulnerable children. The Representative's reports often contain recommendations to assist government, public bodies and service providers in improving services and outcomes for children and youth in B.C.

Section 6(b) of the *RCY Act* makes the Representative responsible for monitoring, reviewing, auditing and conducting research on the provision of designated services, making recommendations to improve the effectiveness and responsiveness of these services, and commenting publicly on any of these functions.

This report is the first comprehensive review of progress on these recommendations and includes the Representative's assessment of how government and other public bodies have responded to the recommendations contained in reports released between Jan. 1, 2008 and Dec. 31, 2013.

It is the Representative's role to monitor and report on the child- and youth-serving system and to make recommendations for improvement. It is the government's responsibility to respond to those recommendations. This report enables the public to hold government accountable for its performance in operating the system and provides an important reminder to the public and the government about critical deficiencies that are yet to be addressed. Have MCFD and other ministries changed their policies and practices as a result of recommendations? Can government speak with confidence about improvements it has made and whether children, youth and their families are better served as a result? These are the questions this report seeks to answer.

During the six-year period ending Dec. 31, 2013, the Representative issued 22 reports containing 148 recommendations. These recommendations have strategically addressed the services provided to our most vulnerable children and youth and have been directed to several different government ministries and other public bodies. They have targeted a number of key areas identified through the Representative's work, including services to Aboriginal children and youth, domestic violence, mental health and planning for children in care.



The Representative is concerned that several key recommendations to government have not been implemented, or even accepted. This report reviews those recommendations and identifies why some remain unaddressed.

While implementation of recommendations is a measure of government responsiveness to oversight, the most important measure for assessing services for children and youth is whether or not services and outcomes are getting better. This report summarizes the types of service quality and child outcomes data available, recognizing that there remain serious weaknesses in MCFD's ability to assess whether services for children and youth are improving.

This report enables the Representative and the public to determine to what extent government has listened to and acted upon advice provided by the Representative's Office.



The Representative's Independent Oversight

There is an inherent power imbalance between children and youth and the systems in place to serve them. There are many interests at play in the management and delivery of services, and in some cases the best interests of children and youth do not receive adequate attention. The independent oversight of the Representative is intended to focus the attention of service systems, elected representatives and the public on what is most important – how well vulnerable children, youth and their families are supported.

In his 2006 independent review of B.C.'s child protection services, Hughes stressed the need for external oversight to restore public confidence in child welfare services and recommended external oversight of those services through the creation of the Office of the Representative for Children and Youth. Government implemented this recommendation in 2007 with the passing of the *RCY Act* which established the Representative's mandate.

The Representative is independent from the governing party of the day, appointed by and accountable to the B.C. Legislature and reports to the Speaker. The Representative appears regularly before the Select Standing Committee on Children and Youth (SSCCY) to present and engage in dialogue on the Representative's activities and findings. SSCCY meetings provide a public forum in which the Representative can promote greater awareness of the performance of the child-serving system and highlight areas of particular concern.

The Representative's oversight mandate extends to reviewable and designated services identified in the *RCY Act*, including but not limited to:

- family support
- child protection
- foster care
- adoption
- guardianship
- children and youth with special needs
- early childhood development and child care services
- mental health and addiction services for children
- youth justice
- services for youth and young adults during their transition to adulthood
- CLBC services for young adults between their 19th and 24th birthdays.



Oversight Activities

Children, youth and families receiving services often face multiple challenges and are among the most vulnerable members of our society. They often do not have a voice or means to share their service experiences or comment on how well services are supporting them. The Representative undertakes a variety of oversight activities that help to refocus service-delivery systems on the best interests of vulnerable children and youth and how to respond appropriately to them.

Advocacy

In some cases, children, youth and their families require support in order to receive services as they should and ensure that they are treated fairly. From April 1, 2007 to March 31, 2014, the Representative's Office opened 11,761 advocacy case files. Oversight in the form of advocacy for individual children and youth helps ensure that they, and those who care for them, have the information and support required to interact as successfully as possible with services. RCY advocates work to ensure that services meet expectations outlined in government policies and standards. In this way, advocates provide on-the-ground oversight on a daily basis.

When advocacy is provided for many children and youth over a period of time, analysis of their challenges with services can bring to light systemic issues that need to be addressed. This window into system-wide challenges assists the Representative in determining the service-delivery monitoring activities to undertake to ensure that government services are meeting the needs of those they serve.

Monitoring the Service System

Service systems and those responsible for them should be accountable for the quality of services and the outcomes they achieve. The Representative provides independent oversight to track and assess changes in the overall service system that affect service quality and outcomes for children and youth. The Representative also carries out reviews, audits and research activities on specific services and performs on-going monitoring of government approaches to delivering and improving services for children and youth, in areas such as:

- governance and leadership
- organizational and service-delivery structures
- policy, program development and service delivery
- quality assurance and accountability
- other identified areas of concern as required, such as the impact of the Integrated Case Management (ICM) system on child protection services.

The Representative's monitoring activities result in public reports identifying challenges within the child-serving system and making recommendations for improvement. The Representative strategically targets these



monitoring activities to pressing issues with services based on input from the public, systemic issues identified through advocacy and investigation activities and expert advisers.

Reviews and Investigations of Critical Injuries and Deaths

The Representative has a mandate to review and investigate critical injuries and deaths of children who have received services or programs under the *Child, Family and Community Service Act (CFCS Act)* and *Youth Criminal Justice Act* as well as mental health and addictions services for children.

The Representative receives reports of injuries and deaths from MCFD and DAAs, and reviews all incidents of particular concern. Between June 1, 2007 and Jan. 31, 2014, RCY received 1,555 critical injury reports and 628 death reports. Some reviewed incidents go on to full investigations that include interviews of witnesses. When children and youth receiving public services suffer injury or death, independent review and investigation provides unbiased reporting on what happened, why, and what can be done to prevent similar tragedies in the future, both for individual cases and in aggregate.

The Representative publishes reports and recommendations based on individual investigations of critical injury and death as well as aggregate reports on a number of cases with similar characteristics. Similar to the advocacy function, results of an aggregate review or individual investigation can highlight a concern that requires further analysis of the wider service system's responsiveness and effectiveness.

Reports and Recommendations

The Hughes Review recommended that "*the Representative provide advice and recommendations ... through annual reports and special reports.*" While annual reports provide summaries of the Representative's activities, special reports are presented to the Legislature, the leaders of ministries and other public bodies and the public with findings of oversight activities.

In developing reports and recommendations, the Representative takes into account input from children, youth and families as well as from professionals working with them on the front lines. These reports assess how well services are addressing the needs for children, youth and their families, draw attention to the experiences of those receiving and delivering services, and make recommendations with the intent to foster real improvements in the child- and youth-serving system.

Following the release of a report, the Representative presents the report's findings and recommendations to the SSCCY. The Representative also tracks the implementation of recommendations and reports on their status in annual reports to the Speaker. The Representative informs the SSCCY of concerns regarding lack of implementation and reports on the overall implementation status of recommendations in annual reports.

In some cases, the same concern appears in multiple reports over time, pointing to weak links in the service system as well as to demographic groups such as Aboriginal children and youth who are chronically underserved. The Representative has strategically referred to or repeated previous recommendations in current reports when government has failed to act on those issues.

The Representative's oversight activities, including reports and recommendations, hold government accountable, promote public accountability and both spark and influence fundamental change and improvement in the system of services for children and youth.

Lessons from Other Jurisdictions

While focused on oversight activities here in B.C., the Representative takes into account lessons from oversight activities elsewhere. For example, an emerging body of literature from other countries speaks to the risk of oversight processes having unintended consequences. Implementation of recommendations focused on standardizing practice can result in an overburdening of front-line staff with "check-box" procedures that get in the way of genuine connections and the use of professional judgement with children, youth and families.¹ The Representative recognizes that it is critical to be aware of what is happening on the ground and to connect recommendations with the realities experienced by front-line staff and the children, youth and families they serve.

A number of studies have also found that focusing on recommendations that are relatively easy to implement can mean that the underlying systemic issues that are important to more fundamental change can get sidelined.² The Representative has found that government is more likely to act on recommendations regarding policy, procedure and standards than on those that require collaborative change across government.

Oversight Environment

As MCFD receives the majority of the Representative's recommendations, it is important to understand the relationship between MCFD and the Representative's Office during the time frame of this report. Leadership sets the tone for any organization, and has been highly influential in how MCFD has responded to the Representative's oversight activities.

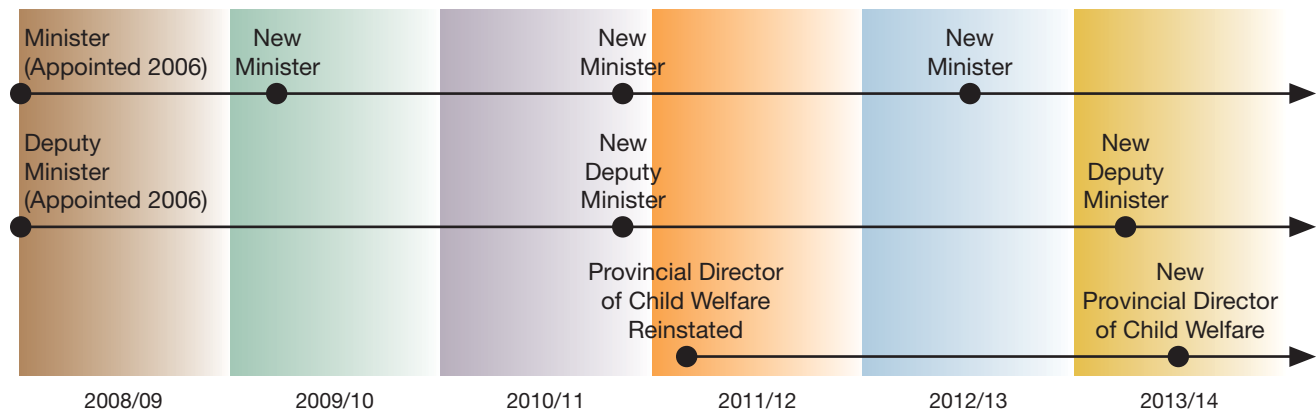
Between 2008 and 2011, MCFD had three different ministers. One deputy minister led the organization throughout this period. A new premier took office in 2011, and another minister and two deputy ministers have been appointed between the beginning of the new premiership and the end of 2013. In total, MCFD has had four different ministers and three different deputy ministers since the Representative's Office was established.

¹ Munro, E. (2011). *The Munro Review of Child Protection: Final Report*. London: Department of Education.

² Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C., & Megson, M. (2013). *New learning from serious case reviews: a two year report for 2009-2011*. Department of Education.



Figure 1: Changes in MCFD Leadership 2008/09 to 2013/14



The period between 2008 and 2011 was marked by the ministry's general disregard for the Representative's oversight. MCFD was also slow to respond to the recommendations of the 2006 Hughes Review on B.C.'s child welfare system. In 2010, the Representative's final report on the implementation of the Hughes Review recommendations found that *"the ministry's lack of overall success in meeting the aim of the review remains a major concern."*

During this period, discussions with MCFD regarding report findings and approaches to acting on recommendations were limited. MCFD's focus during this time appeared to be on transforming its service-delivery system, with minimal consideration of the role and potential benefits of external oversight.

The time period under this deputy minister was marked by a move by MCFD to decentralize to more autonomous regional structures and a blending of previously distinct service lines. Both of these actions eroded the accountability of MCFD at the provincial level. It was also a period without a provincial director of child welfare – a key leadership role that had previously been accountable for the provision of services under the *CFCS Act* and for ensuring consistent, quality practice throughout the province.

The years from 2006 to early 2011 were, for the most part, a lost opportunity to address issues raised by external oversight, first by the Hughes Review and later by the Representative.

In addition to the general disinterest in oversight described above, in 2010 MCFD and the Office of the Premier failed to comply with their statutory duty under the *RCY Act* to provide the Representative with Cabinet submissions associated with the Child in the Home of a Relative (CIHR) program and its replacement, the Extended Family Program. In this case, MCFD and the Office of the Premier failed to comply with their duty to provide all information necessary for oversight to be exercised by the Representative's Office. The Supreme Court of B.C. ordered the Province to comply, and information has since been appropriately shared.

In 2011, a new minister and deputy minister were appointed. The deputy minister soon announced a direction of incremental change and a departure from the "transformation" approach of the previous leadership that had consumed significant resources, caused instability, and eliminated the internal oversight mechanisms that were in place to ensure quality service delivery. Service lines were clarified and a process of rebuilding MCFD began.

The deputy minister also announced that MCFD would review all of the Representative's reports and recommendations from 2007 through 2010 and discuss with the Representative the findings, themes and status of the recommendations. Moving forward, the position of a provincial director of child welfare was re-instated and played a central role in responding to recommendations from the Representative.

The ministry produced an *Operational and Strategic Directional Plan* for the years 2012/13 to 2014/15, which has since been updated annually. In 2012, MCFD began issuing policies and practice directives to address a wide variety of service issues. While the Representative continues to have many concerns about the quality of MCFD's services, leadership since 2011 has set a much clearer course for the ministry and has been much more responsive to recommendations from the Representative.

The contrast in MCFD's attitude toward external oversight in the two periods described above underlines the importance of the context in which the Representative carries out mandated oversight activities. Government and its ministries must respect and see the value of oversight if meaningful change is to be achieved.

Government and oversight bodies must each maintain their independent mandate but, as the Hughes Review indicated, they must also work in a "*spirit of cooperation and collaboration*." Had MCFD been responsive to oversight and consistent in addressing issues raised beginning in 2006, it could have achieved significant progress and children and youth could now be experiencing the benefits of improved services as a result.

MCFD Budget

No one ministry alone dictates government priorities. Government as a whole must commit focus and dedicate the resources needed to make services for children and youth better in relevant ministries.

MCFD's annual budget was reduced by more than \$37 million between 2008/09 and 2013/14 – this amounts to a nearly \$100-million reduction in its budget³ when accounting for inflation. It is difficult to improve services on a shrinking budget.

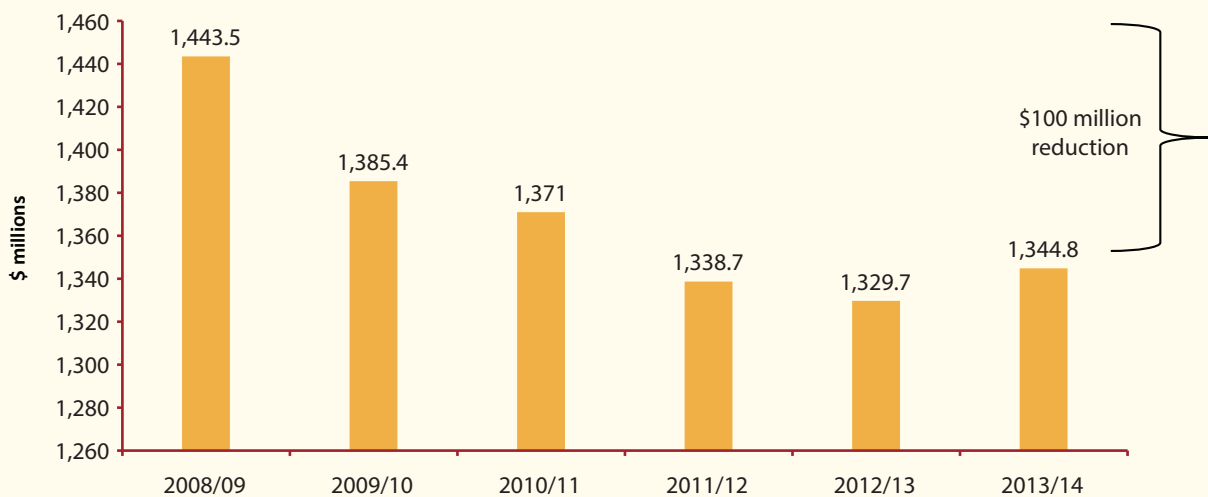
While a willingness to accept oversight and act on recommendations is crucial to service-delivery improvement for B.C.'s most vulnerable children, government's lack of financial commitment since 2008 has also no doubt played a major role in its failure to meet key recommendations by the Representative.

³ Calculations based on the restated estimates for MCFD's budget from MCFD Service Plans (BC Budgets 2009 to 2014) and adjusted for inflation (2013/2014 fiscal year dollars) using the Consumer Price Index for B.C. by Fiscal Year (Statistics Canada).



The Representative observes that this failure to implement key recommendations presented between 2008 and 2013 occurred during a time of budget restrictions and staffing freezes. The Representative believes there has been a deterioration in MCFD's five core areas of service during this period due to these staffing and budget shortfalls.

Figure 2: MCFD Budget Adjusted for Inflation (2008/09 to 2013/14)



Note:

1. Figures are based on MCFD Service Plans, Restated Estimates (BC Budget 2009-2013)
2. Adjusted budget are based on BC Stats, Consumer Price Index (CPI) for BC (2008/09 to 2013/14)
3. Figures are adjusted based on 2013/14 base dollars

Reports and Recommendations

Representative's Reports

The 22 reports reviewed in this document are comprised of investigations into individual cases of critical injury or death or audits and reviews of service systems. These reports have centred on aspects of MCFD's six service lines and focussed on specific topics that include child safety, domestic violence, mental health, service coordination and planning for children in care.

The Representative weighs a variety of factors to determine whether a report is warranted, and what kind of report is appropriate in the specific circumstances.

An investigation into an individual case of injury or death may proceed if the case illustrates an issue the Representative believes should be scrutinized to help prevent similar injuries or deaths in the future. Aggregate reports on injuries and deaths enable the Representative to review and make recommendations on issues that appear across multiple cases.

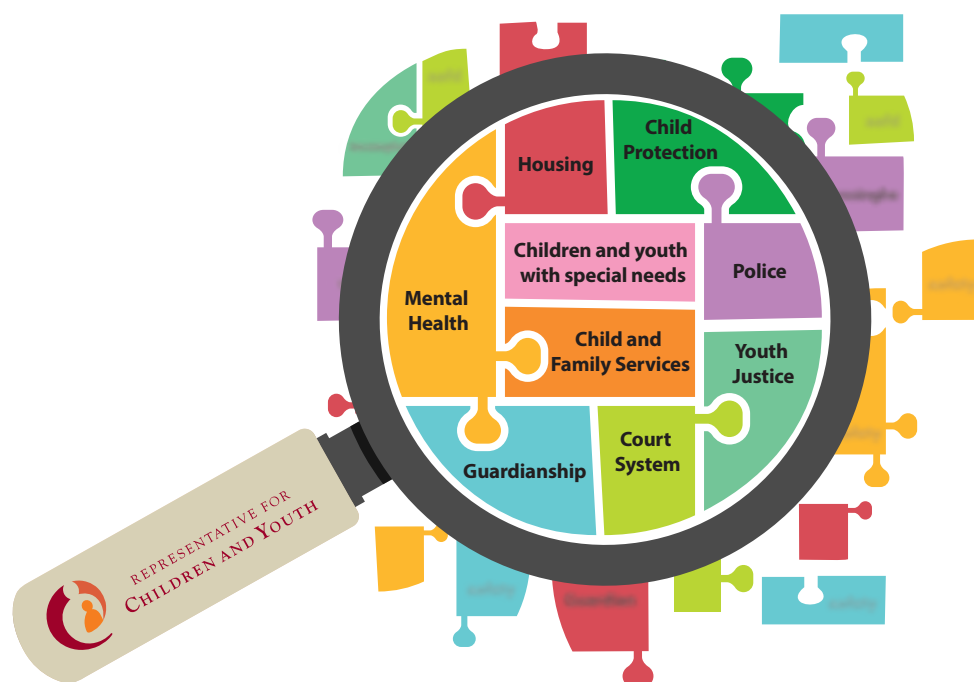
Reports on reviews and audits into an aspect of the child- and youth-serving system result when an issue has been identified. Such concerns can come from a variety of sources, including members of the public, through analysis of issues that present in the Representative's advocacy services and through recurring systemic issues identified in reviews and investigations of injuries and deaths.

The Representative also releases research reports that focus on vulnerable children and youths' long-term interaction with services such as youth justice, education, health and income assistance. The intent of these reports is to bring attention to how the experiences and outcomes of vulnerable children and youth differ from those children and youth in B.C.'s general population. Research reports highlight areas where government should be focusing its attention to improve the health and well-being of vulnerable populations overall.

About three-quarters of the Representative's reports between 2008 and 2013 focused specifically on children and youth in government care or children, youth and their families who had been involved with MCFD and DAA child protection services, including related family support services. This focus on children and youth involved with MCFD and DAAs stems from the Representative's mandate and the fact that all of the critical injury and death reports involve children (or their parents) who have received services from MCFD or DAAs. While many reports addressed issues related to Aboriginal children and youth – this population has been strategically targeted for oversight by the Representative's Office because it has been poorly served – two reports specifically focussed on this group.

Reports from the Representative have looked at nine over-arching service areas. They have focused primarily on child protection, guardianship, child and youth mental health services and services to children and youth with special needs. Other service areas addressed include youth justice services, the court system and housing. A number of reports covered multiple service areas.

Figure 3: Service Areas Addressed by RCY Reports



Recommendations – What did we find?

In the period covered by this review, the Representative's reports included 148 recommendations to address concerns about services to children and youth (a full list of reports and status of recommendations appears in Appendix 1). About half of the reports contained recommendations related to the following issues:

- a lack of appropriate policy, standards and procedures required to guide services and practice
- the need to change practice by shifting the culture or focus of an organization or service
- gaps in services.



About one-third of the reports contain recommendations addressing:

- poor collaboration and coordination among services
- governance concerns
- inadequate quality assurance
- service quality not meeting expectations, including lack of compliance with existing policies, protocols and standards.

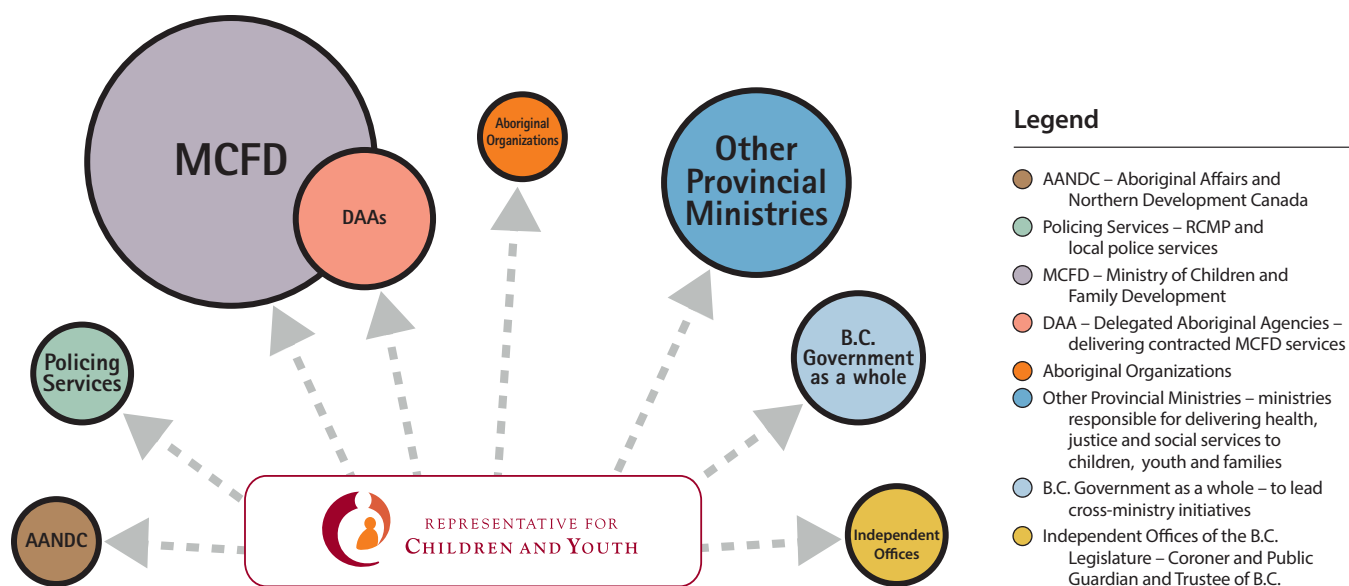
Over time, two concerns were consistently raised in the Representative's reports – the need for new or improved policy, procedures and/or standards to guide practice, and the lack of compliance with existing policy standards.

The Representative's reports have also recommended a range of actions that public bodies can take to improve services and outcomes for children and youth. More than one-third of recommendations called for actions to better collect and report data on services or to improve quality assurance activities. The ability to collect, analyze and report on service and client data is essential for managing, improving and being accountable for services to children and youth.

One-third of recommendations called for actions to improve guidance to staff and service systems through the creation or refinement of policy, procedures or standards. About one in seven recommendations called for employee training to increase capacity within the child- and youth-serving system.

Responsibility for child and youth well-being goes beyond that of a single organization or ministry. Reports by the Representative have made recommendations to 15 different organizations. While about 75 per cent of the Representative's recommendations have been made to individual organizations, 25 per cent called for coordinated action from two or more organizations. This speaks to the fact that public bodies often share responsibility and need to work collaboratively if positive change is to occur.

Figure 4: Organizations that Received Representative's Recommendations



By far the majority of recommendations – more than 80 per cent – were made to MCFD, either as the sole recipient or in conjunction with one or more other organizations. This is in part due to the Representative's mandate and in part because MCFD has responsibility for the majority of community-based child and family services identified in the *RCY Act*.

Importantly, nine recommendations were made to the government of B.C. as a whole, rather than to an individual ministry or public body. These sought system-wide improvements in services to children and youth that required leadership and commitment at the highest level.

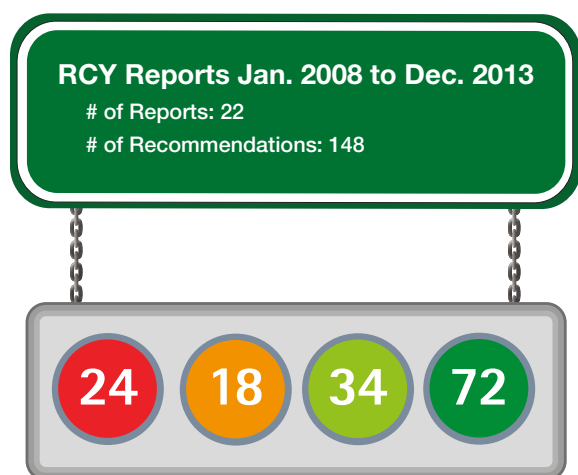
Responsiveness to Recommendations

Implementation of Recommendations

As of the end of March 2014, public bodies (provincial government ministries and other public organizations such as the BC Coroners Service, police, the Public Guardian and Trustee of BC and Aboriginal Affairs and Northern Development Canada) had made substantial progress on or fully implemented about two-thirds of the 148 recommendations covered in this report. On the other hand, no progress at all was made on 24 of these recommendations (see Figure 5).

Specifically, government has not been responsive to recommendations that have called for significant system change that cuts across ministry mandates and requires inter-ministerial coordination and commitment. Of the nine recommendations made to the B.C. government as a whole, seven have been largely ignored (see Figure 6). These include the call for a plan to reduce child poverty in B.C., much needed improvements to services for Aboriginal children and families, the need for government accountability and the lack of a comprehensive system of services for youth with mental health challenges.

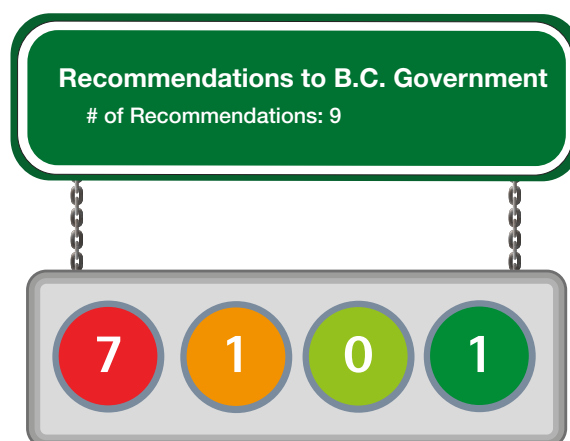
Figure 5: Status of RCY Recommendations



Note:

- No progress on recommendation
- Some progress on recommendation
- Substantial progress on recommendation
- Recommendation fully implemented

Figure 6: Status of Recommendations to B.C. Government





The only recommendation made to government as a whole that has been fully implemented is the expansion of RCY's advocacy services to include children and youth with neurodevelopmental disorders and their families from birth to age 24. While some progress has been made on recommendations regarding domestic violence, progress is not good enough. The Representative is extremely concerned about this lack of action from the highest levels of public leadership in B.C.

Government Response Example

GOOD

Report Title: *Kids, Crime and Care – Health and Well-being of Children in Care: Youth Justice Experiences and Outcomes*

Recommendation #5: That every school in British Columbia assign a single staff person to oversee education planning, monitoring and attainments of the children in care that attend their school. This function should be in place and functioning by September 2009.

FEB 2009

Report Released

MAR 2009

Ministry of Education (MOE) states intent to partner with MCFD to implement recommendation.

JUNE 2009

MOE advises Superintendents of Schools of recommendation and ministry's support to implement it.

SEPT 2009

MOE and MCFD distribute information to school districts about children in continuing care.

FEB 2010

All districts have a person in each school to monitor success of children in care and promote appropriate interventions.

AUG 2012

Recommendation is fully implemented.

MCFD and other government ministries and public bodies have generally been responsive to recommendations that addressed inadequate policy, standards or procedures or compliance in these areas, but the record has been poor on recommendations addressing concerns related to gaps in services for children and youth. Only seven of 15 recommendations that identified such gaps have been substantially or fully implemented, while just three of seven recommendations on the governance of services for children and youth have been substantially or fully implemented.

Implementation of recommendations addressing collaboration and cooperation among service providers has also been relatively weak, with just over half of such recommendations seeing substantial progress or full implementation.

Of the 89 recommendations made solely to MCFD, the ministry made good progress on or fully implemented more than three-quarters (69) of them. More than two-thirds of the recommendations made jointly to MCFD and one or more other public bodies were

substantially or fully implemented. Just over half of the recommendations made to public bodies other than MCFD were substantially or fully implemented.



Key Recommendations that Remain Unaddressed

The Representative is concerned about the risks posed to children and youth by the lack of progress on a number of important recommendations involving domestic violence, poverty, mental health and vulnerable Aboriginal children and youth. These recommendations, in particular, have been strategically advanced because they represent significant shortcomings in service to vulnerable children and youth.

Recommendations that require the coordination of more than one ministry or other public body cannot simply be ignored. These recommendations are a key to changing systems of services that impact the present and future well-being of children and youth.

Committed and concerted action in these areas is necessary if we are to prevent children and youth from falling behind their peers, falling into or being stuck in poverty, being left at risk in homes with domestic violence, or suffering from mental health challenges without proper support. Failing to address the gross over-representation of Aboriginal children in care of the government in a meaningful way will also ensure that this vulnerable population continues to suffer significantly poorer outcomes than other B.C. children.

Government Response Example

INADEQUATE

Report Title: *Honouring Christian Lee – No Private Matter: Protecting Children Living with Domestic Violence*

Recommendation #3: That the Ministry of Attorney General undertake a review and enact necessary changes to improve the administration of justice in criminal matters involving domestic violence, including establishment of domestic violence courts, to better protect the safety of children and their mothers.

SEPT 2009

Report Released

APR 2010

Representative requests update on implementation of report recommendations.

MAY 2010

Ministry of Public Safety and Solicitor General indicates that specialized domestic violence courts will not be created.

MAR 2012

Representative releases *Honouring Kaitlynne, Max and Cordon: Make Their Voices Heard Now*, another report on a domestic violence tragedy, and renews call for specialized domestic violence courts.

FEB 2014

British Columbia's Provincial Domestic Violence Plan commits to "working with the judiciary and other justice system partners to explore the development of a framework for domestic violence courts."



Children in Situations of Domestic Violence

The Representative investigated the deaths of children in situations of domestic violence: *Honouring Christian Lee – No Private Matter: Protecting Children Living with Domestic Violence* (2009) and *Honouring Kaitlynn, Max and Cordon: Make Their Voices Heard Now* (2012).

Both of these reports called for co-ordinated, effective and responsive systems that meet the safety needs of children involved in situations of domestic violence (see Figure 7).

Government did create a Provincial Office on Domestic Violence, although the Office is under-resourced and cannot compel the inter-ministerial cooperation necessary to advance this important work.

The government's three-year domestic violence plan launched in February 2014 does not address the role of key risk factors for domestic violence such as poverty and unemployment. It also lacks clear outcomes, concrete time frames, and measurements of success, and there has been no real progress on the creation of specialized domestic violence courts that were first recommended by the Representative in 2008.

Two years after the release of *Honouring Kaitlynn, Max and Cordon*, there had been "some progress" on half of the report's recommendations. However, a solid foundation is not yet in place for implementing them. Given the risk associated to children witnessing domestic violence, "some progress" is not good enough.

Research shows that, compared with Alberta and Ontario, B.C.'s response to the needs of children in situations of domestic violence is underfunded and limited in scope. For example, the Ontario Coroner has a Domestic Violence Death Review Committee (DVDRC) that has been conducting annual reviews on domestic violence deaths for 10 years.

Figure 7: Key Recommendations from *Honouring Christian Lee – No Private Matter: Protecting Children Living with Domestic Violence* (2009), and *Honouring Kaitlynn, Max and Cordon: Make Their Voices Heard Now* (2012)

Recommendation:	No Progress	Some Progress	Substantial Progress	Implemented
<p>That the government of British Columbia take the following actions to demonstrate a renewed and serious commitment to protect children who are exposed to or are living in circumstances of domestic violence:</p> <ul style="list-style-type: none">• Adequate additional funding• Appointment of a permanent lead or agency of government with sufficient authority across government to be accountable for delivering on a comprehensive approach• Continuous evaluation and regular public reporting of outcomes.				



Children and Youth Experiencing Mental Health Challenges

Prior to the April 2013 release of *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.*, the Representative had identified in a number of reports concerns about the capacity of the Province's mental health services to meet the needs of children and youth:

- *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm (2012)*
- *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children (2013)* and,
- *Much More than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care (2013)*.

These reports speak to a population of children in care that is experiencing varying degrees of mental health challenges, and also of a child protection system that is struggling to meet their needs.

The Representative raised concerns about the ability of these systems to understand the needs of children and youth with mental health concerns and provide the needed support. The reports' recommendations to the ministry focused on bolstering services and practice for children and youth in care struggling with mental health or complex behavioural concerns.

Government Response Example

NO ACTION

Report Title: *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.*

Recommendations: A Minister of State for Youth Mental Health as a single point of accountability to address the needs of transition-age youth with mental health problems.

A three-year operational plan to improve service delivery to youth from acute care needs through to self-care supports, including immediate improvements to emergency, acute and community-based intensive intermediate care as well as youth-friendly service delivery models.

A robust system of quality assurance, including performance measures and outcomes, and regular plain-language reporting to the public, decision-makers and service providers.

An assessment of hospital acute care beds for transition-age youth in B.C. including a plan to address unmet service needs.

APR 2013

Report Released

MAR 2014

No response received from government. No progress on implementation of recommendations*

*This report considers progress on recommendations as of March 31, 2014. Initial correspondence regarding the report in this example was received in April 2014 from the Ministry of Health and MCFD. The correspondence indicated that the ministries would work together, with Ministry of Health taking the lead, to create an action plan responding to the findings of the *Still Waiting* report. Further correspondence received in July 2014 provided information on planned activities and stated that a *Still Waiting Action Plan* would be provided to the RCY by Dec.15, 2014. This information did not change the Representative's assessment of progress on *Still Waiting* recommendations.



In 2012, the Representative undertook a review of youth mental health services in B.C. Based on input from more than 850 people with first-hand experience, *Still Waiting* describes a mental health system that is fragmented, frustrating to navigate and remains plagued by serious gaps in the continuum of services. Findings from the report emphasize the lack of leadership and overall accountability as a major contributor to the failings in the system.

The provincial government has made no progress on four recommendations from the *Still Waiting* report in the year following its release (see Figure 8).

Figure 8: Recommendations from *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.* (2013)

Recommendation:	No Progress	Some Progress	Substantial Progress	Implemented
• A Minister of State for Youth Mental Health as a single point of accountability to address the needs of transition-age youth with mental health problems				
• A three-year operational plan to improve service delivery to youth from acute care needs through to self-care supports, including immediate improvements to emergency, acute and community-based intensive intermediate care as well as youth-friendly service delivery models				
• A robust system of quality assurance, including performance measures and outcomes, and regular plain-language reporting to the public, decision-makers and service providers				
• An assessment of hospital acute care beds for transition-age youth in B.C. including a plan to address unmet service needs.				

Some children and youth have complex needs involving multiple co-existing problems that can involve physical and/or mental health challenges, developmental disabilities, significant life trauma, and environmental stressors such as poverty. The 2013 report *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children* documented how the system failed to provide support or protection to just such a child with complex needs. In this report, the Representative recommended:

"that MCFD urgently create a comprehensive plan to develop a continuum of residential services for children and youth in B.C. with complex needs that cannot be met in traditional foster home or group home settings, and fully fund and support that plan to ensure that these vulnerable children have access to residential care to support their optimal development."

MCFD has made very little progress on creating these much-needed services.



Given that a conservative estimate of the chances of a Canadian having a mental illness in his or her lifetime is one in five,⁴ and that about half of all lifetime cases of mental disorders start by age 14 and three-quarters by age 24,⁵ the provincial government's lack of response to the Representative's recommendation is both surprising and discouraging.

Child Poverty

The issue of child poverty has been a recurring theme across several reports by the Representative since 2008.⁶ Children who live in poverty are at a higher risk of developing health problems, and have a higher likelihood of experiencing more behavioural and developmental issues, achieving lower levels of education, and living in life-long poverty.⁷ B.C. is one of only two provinces without a poverty reduction plan.

B.C. has become known as the province with the highest child poverty rate in Canada. In 2011, the provincial child poverty rate was 11.3 per cent (based on the Low Income Cut-off, Income after Tax LICO-IAT), well above the national rate estimated at 8.5 per cent. About 93,000 children live in poverty in B.C.⁸

Poverty Measurement

The low income cut-off (LICO) is the income threshold below which a family will spend a larger share of its income on food, shelter and clothing than an average family would in similar circumstances. The measure used in this report is the LICO-IAT (Low Income Cut-off, Income After Tax), which is based on after-tax income – the most precise measure of the total income resources available to a family.

This issue has been of concern to others besides the Representative. A recent report by the Conference Board of Canada also highlighted the risks to children who grow up in poverty, noting that *"failure to address poverty may place a heavy burden on a country's economy."*⁹ In addition, a 2011 cross-Canada status report on child and youth health by the Canadian Paediatric Society rated B.C. *"poor"* in addressing child poverty reduction. A *"poor"* rating means a province has neither legislation nor a strategy to reduce child poverty.¹⁰

⁴ Kirby, M. J., & Keon, W. J. (2004). *Report 1. Mental Health, Mental Illness, and Addiction: Overview of Policies and Programs in Canada*. Standing Senate Committee on Social Affairs, Science and Technology. Government of Canada.

⁵ Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593-602.

⁶ *Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Infants (January 2011), Housing, Help and Hope: A Better Path for Struggling Families (July 2009), Kids, Crime and Care: Health and Well-Being of Children in Care: Youth Justice Experiences and Outcomes (February 2009), Amanda, Savannah, Rowen and Serena: From Loss to Learning (April 2008)*.

⁷ Canadian Paediatric Society. (2012). *Are We Doing Enough?: A status report on Canadian public policy and child and youth health*.

⁸ Statistics Canada. (2013). *2011 Census of Canada. Persons in low income families*. CANSIM, table 202-0802. Retrieved from <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&tid=2020802&paSer=&pattern=&stByVal=1&p1=1&p2=37&tabMode=dataTable&csid=>


⁹ Conference Board of Canada (2014, August 11). *Child Poverty*. Retrieved from <http://www.conferenceboard.ca/hcp/details/society/child-poverty.aspx>.

¹⁰ Canadian Paediatric Society. (2012). *Are We Doing Enough?: A status report on Canadian public policy and child and youth health*.

In January 2011, the Representative released *Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Infants – Aggregate Review of 21 Infant Deaths*. This report looked into the lives of 21 infants who died before age two between June 1, 2007 and May 1, 2009. All of the infants' families had been involved with MCFD. Families in this review, particularly the Aboriginal families, were often stuck in chronic, deep poverty that was found to be the single largest risk factor in their environment.

The Representative's first recommendation in this report addressed the issue of poverty head on (see Figure 9).

Figure 9: Recommendation from *Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Infants – Aggregate Review of 21 Infant Deaths* (2011)

Recommendation:	No Progress	Some Progress	Substantial Progress	Implemented
<ul style="list-style-type: none"> That B.C. develop a non-partisan child poverty plan, with leadership from the Premier's Office, through a special initiative that identifies strategies to address all aspects of child poverty in the province, including specific strategies to address poverty affecting Aboriginal children and families. 				

However, rather than developing a province-wide child poverty plan, the B.C. government chose to address poverty by focusing on a job-creation plan designed to strengthen the economy and by developing community poverty reduction strategies in selected communities.

In 2012, government announced a community poverty pilot project, in partnership with the Union of British Columbia Municipalities, to be implemented in seven B.C. communities. The project was designed to connect families directly to existing services in their communities, address the key challenges that low-income families face and develop community action plans. No new funding was provided for the initiative.

According to the project's May 2014 progress report, the pilots assisted just 72 families – a poor response for a province with a population approaching 4.7 million and 93,000 children living in poverty. It is discouraging that the progress report identified already well-known barriers for families living in poverty as “*key findings*,” including basic food security, housing, health and education/skills training. Report findings also identified a need for an “*inter-ministerial, cross-sector*” approach to supporting low-income families.

It is clear that the B.C. government still has not made a meaningful impact on the issues facing families struggling with poverty. There are no plans to expand the community poverty pilot projects to other communities and the province has yet to create a comprehensive province-wide plan to reduce poverty.



Vulnerable Aboriginal Children and Youth

Aboriginal children and youth are significantly over-represented in the B.C. child welfare system and under-represented in many supportive services. More than 8,000 B.C. children are in government care, and more than half of these children are Aboriginal, despite the fact only about eight per cent of the province's entire child population is Aboriginal. The high rate of Aboriginal children in care is of specific concern to the Representative, especially given the evidence showing poorer outcomes related to education, health and safety for Aboriginal children and youth compared to other children and youth in B.C.

Over the years, a significant number of initiatives between government and communities and leadership (i.e. memoranda, accords, agreements and plans) have committed to improving the lives of Aboriginal children, youth and families in an effort to close the social and economic gaps between Aboriginal people and other British Columbians. These initiatives brought a focus to the issue of Aboriginal child welfare and highlighted the need to take action and engage Aboriginal communities in the search for solutions.

Has anything changed in the lives of Aboriginal children, youth and families as a result of these initiatives? Has measurable progress been made in achieving these goals? What outcomes have resulted?

Hughes commented specifically about the circumstances of Aboriginal people, Aboriginal child welfare service delivery and the over-representation of Aboriginal children in care in his 2006 *BC Children and Youth Review*. The Representative has issued 13 reports since 2008 that have explored some issue of well-being for Aboriginal children and youth, with two reports focusing solely on the delivery of services to Aboriginal children and youth.

The Representative continues to advocate for the B.C. government, the government of Canada and Aboriginal leadership to develop stronger policies for Aboriginal children, youth and families and to ensure a real effort to improve outcomes. But response has been slow and there is still much more work to be done in measuring outcomes for this vulnerable population that continues to be ignored (see Figure 10).

To date, the B.C. government has not worked effectively with the federal government and First Nations leadership to develop a poverty reduction plan, just as it has not developed a province-wide plan to address poverty for all children and youth in B.C.



Figure 10: Key Recommendations to close the outcomes gap for Aboriginal children and youth

Recommendation:	No Progress	Some Progress	Substantial Progress	Implemented
<ul style="list-style-type: none"> That the government of B.C. engage the federal government and First Nations leadership and communities to develop a plan to reduce Aboriginal child and family poverty in B.C. (<i>Housing, Help and Hope: A Better Path for Struggling Families</i>, 2009) 				
<ul style="list-style-type: none"> That B.C. develop a non-partisan child poverty plan, with leadership from the Premier's Office, through a special initiative that identifies strategies to address all aspects of child poverty in the province, including specific strategies to address poverty affecting Aboriginal children and families (<i>Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Infants</i>, 2011) 				
<ul style="list-style-type: none"> That MCFD take the lead in developing a clear plan for B.C. to close the outcomes gap for Aboriginal children and youth across government ministries including Education and Health as well as other service-delivery organizations, with clear targeted outcomes and performance measures that would be applicable on- and off-reserve, and encompass all Aboriginal children and youth regardless of where they reside (<i>When Talk Trumped Service: A Decade of Lost Opportunity for Aboriginal Children and Youth in B.C.</i>, 2013) 				

Given the lack of response by government to address issues facing Aboriginal peoples, child welfare service delivery to Aboriginal children, youth and families continues to be a significant focus of the Representative's work. In her 2013 report, *When Talk Trumped Service: A Decade of Lost Opportunity for Aboriginal Children and Youth in B.C.*, the Representative described a lost decade when more than \$66 million was spent by MCFD on Aboriginal governance endeavours that produced very little real benefit for Aboriginal children, youth and families.



The Representative concluded that MCFD failed in its mandate to set out effective, responsive and culturally appropriate child welfare services to Aboriginal children, youth and families. There have been no measurable outcomes and demonstrated improvements for Aboriginal children and youth and evidence-based strategies and practices have not been adopted.

In June 2014, Hughes reiterated his concerns and recommended national action on the “*gross disproportion*” of Aboriginal children in government care across Canada, calling the situation “*a national embarrassment*.”¹¹ He said a national action plan should tackle the effects of colonization including poverty, inadequate housing and unsafe drinking water – conditions, he said, that underlie the over-representation of Aboriginals in the child welfare system, as well as in rates of suicide and incarceration. Hughes said other benefits would include improved educational achievement, employment and economic opportunity. Such leadership and coordinated, sustained action needed to close the outcomes gap for Aboriginal children and youth are long overdue.

Each of the reports referred to in this section called for significant changes to how government addresses issues of domestic violence, mental health services, poverty and Aboriginal inequity. Most of the unfulfilled recommendations in these reports require the involvement of more than one ministry, allocation of adequate resources and leadership from the highest levels of government.

These changes are not easy, but they are necessary if we are to prevent children and youth from falling behind their peers, falling into or being stuck in poverty, being left at risk in homes with domestic violence, or suffering from mental health challenges without proper support.

The cost of not mending our services to provide adequate support to vulnerable children is huge. The human cost of suffering and despair is immeasurable. The economic costs of preventable long-term use of public services, unfulfilled human resources and drain on productivity are very clear. There are many more reasons to act than not.

¹¹ Hughes, T. (2014, June). *Speech by Ted Hughes, June 5, 2014 to the staff of the Office of the Representative for Children and Youth, Victoria, B.C.*



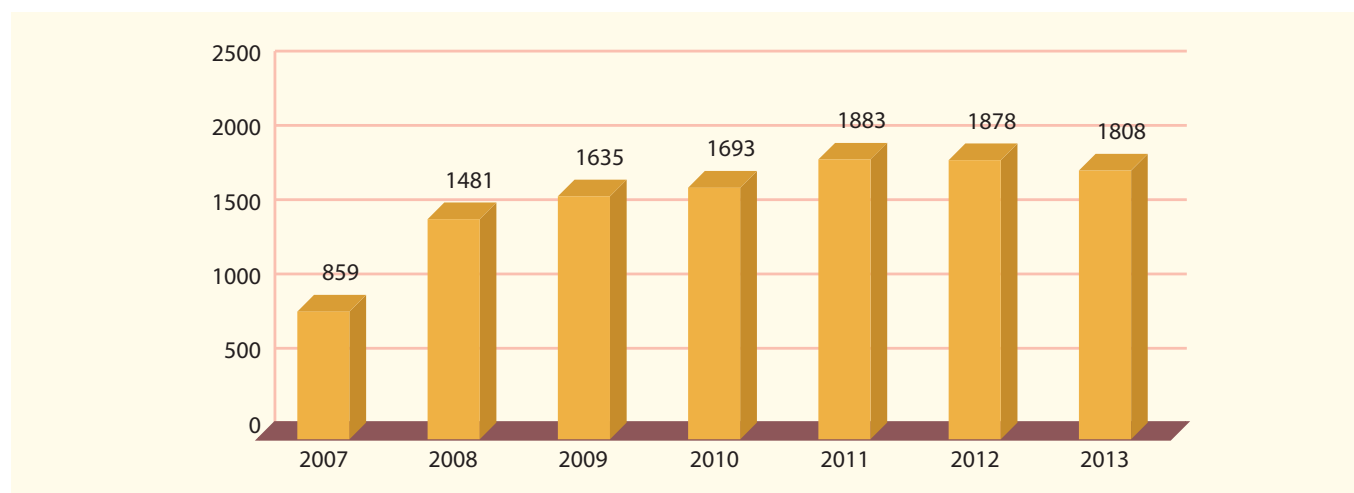
The Need for Service Quality and Outcomes Measurement

The intent of the Representative's recommendations is to improve the quality of services that contribute to the well-being of children and youth, and to identify gaps in those services. Well-being is all about a child's social, educational, physical and developmental progress. Public services are among the many factors that can affect this well-being. Government must be accountable to the public for what and how services are provided, and whether those services are achieving their intended results.

After 22 Representative's reports containing 148 recommendations, are government services achieving better outcomes for B.C.'s children and youth?

It is the Representative's view that this key question remains unanswerable, due mainly to a lack of data on service quality and outcomes. While more – not fewer – concerns are being brought forward to the Representative's Office via requests for advocacy services, and reports of injuries and deaths have not changed, it is impossible to say whether this is a result of greater awareness of the Representative's services and mandate, or from ongoing and increasing challenges in MCFD service delivery experienced by children and youth.

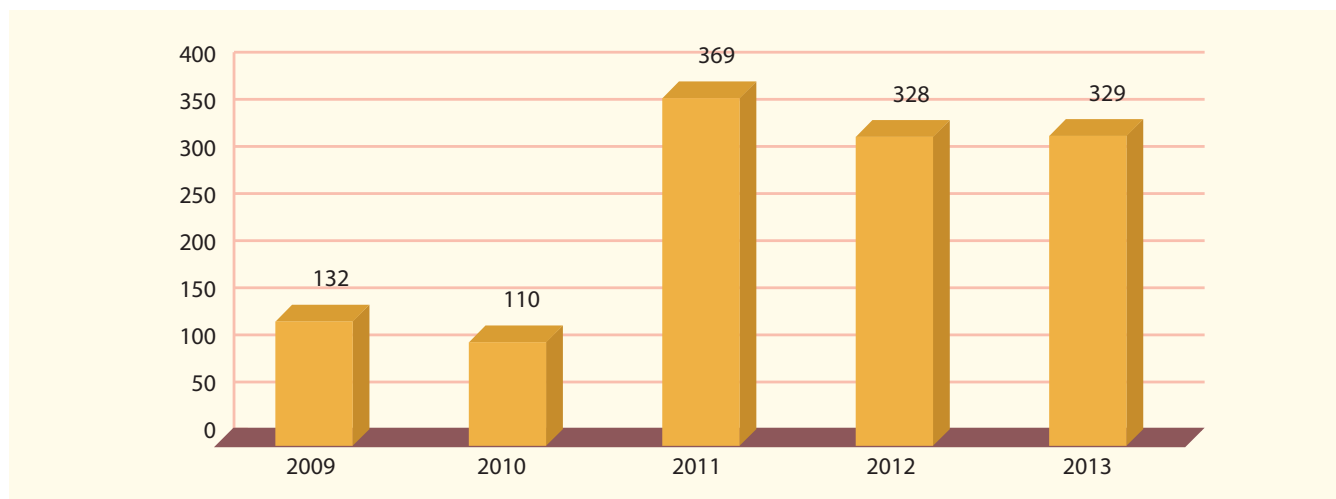
Figure 11: Total RCY Advocacy Cases Opened by Calendar Year 2007 to 2013



Notes:

1. Figures are reported for January to December.
2. RCY Advocacy program began in April 2007. Figures for 2007 only include data from April to December 2007.

Figure 12: Number of Critical Injuries Received by RCY Calendar Year 2009 to 2013



Notes:

1. Figures are reported for January to December
- * Prior to 2011, MCFD was not reporting all critical injuries to the Representative that should have been reported as outlined in the *RCY Act*. MCFD changed its reporting after the Representative cited her concerns in a December 2010 special report. Effective March 1, 2011, the number of critical injuries reported to RCY increased substantially.

It is critical for government to publicly report on service quality and how effectively services are meeting the needs of children and youth. But this information is, for the most part, not available in B.C. In the areas of quality assurance, performance measurement, and public reporting – activities that can demonstrate how well services are delivered and whether expected results are achieved – MCFD has much more work to do.

Quality Assurance

Quality assurance is about complying with standards and policies that govern service expectations and it requires a process to measure and track this compliance. The ministry must know whether or not services meet agreed-upon standards of delivery and publicly demonstrate commitment to maintaining quality service delivery for children, youth and families.

Director's case reviews and case practice audits are two key quality assurance activities that measure MCFD's compliance to practice standards.



Director's Case Reviews

MCFD can conduct director's case reviews after the death or critical injury of a child or youth who has received services within the 12 months prior to the incident. The most important reason for these reviews is to prevent similar deaths and injuries from occurring. Reviews focus on the ministry's decisions, actions, and provision of services and determine whether practice was consistent with legislation, policy and standards and if practice contributed in any way to the death or injury in question.

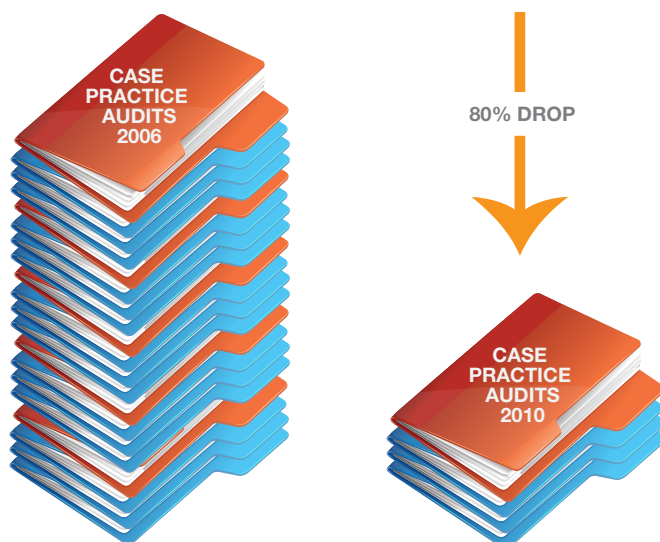
The Hughes Review recommended that MCFD produce an aggregate analysis of recommendations that stem from case reviews as a way to educate staff, policy-makers and the public about key risk factors and opportunities for child death and injury prevention. Such a report has not been done since 2007, although the ministry continues to conduct individual case reviews on an annual basis.

Without these aggregate analysis reports, it is impossible to know whether there are any significant risk factors or patterns that require provincial strategies for child death and injury prevention. For a half-dozen years, there has been no public accountability from MCFD in this crucial area.



Case Practice Audits

MCFD case practice audits are meant to measure whether practice standards are being followed and identify areas in practice that should be strengthened. Historically, the ministry's internal audits have shown low compliance in areas that include planning for children in care, internal reporting on child deaths, injuries and serious incidents, and completing child protection investigations in a timely manner.



The Representative's *Much More than Paperwork* report (2013) found that the number of MCFD case practice audits declined significantly between 2006 and 2010 – from about 500 audited files to fewer than 100. It is clear that by 2010 MCFD had discontinued case practice audits, leaving a void in the systemic monitoring of the quality of child protection practice.



In 2012, the ministry re-instated the case audit program as a pilot project for the first year using new audit tools and methodology. In 2013/14, family service practice audits were completed in four geographic service delivery areas (SDA).

The provincial pilot and two completed SDA audit results for family services have been shared with the Representative. These results show low compliance across several critical measures. The implementation of the new audit program occurred at the same time as social workers were transitioning to using new child protection response policies as well as using the ICM system – a system that has been fraught with technical issues since April 2012 and could potentially impact audit results.

Given these other issues impacting social workers at the time of the audit pilot, the Representative is concerned that the audit results are inconclusive and do not accurately determine whether the ministry is meeting its own standards and whether good practice outcomes are being achieved. Rather, the audit results identify that substantial work is required by the ministry to improve its understanding of how practice decisions are being made and whether they actually comply with policies and standards.

Measuring Performance and Public Reporting

The Hughes Review stated: *"When programs and policies are introduced, the ministry and the public need to understand the expected results for children; and after implementation, they need to be able to tell whether those results are being achieved."*¹²

Measuring organizational performance and publicly reporting out on progress communicates to the public the ministry's priorities, how well the ministry is carrying out its responsibilities and the ministry's accountability to the public for its performance.

The ability of the ministry to measure and report publicly on outcomes for the children and youth in its care is a necessary pre-condition for determining if the actions taken are having the desired result.

From 2008 to 2010, MCFD's work was guided by its policy document, *Strong, Safe and Supported: A Commitment to B.C.'s Children and Youth* (MCFD, 2008). Performance measurement reporting on this document was communicated through the *Integrated Framework for Children and Youth*, which outlined government's expectations for children and youth in B.C. No public reporting on identified indicators ever occurred so it was not possible to assess whether or not completed activities contributed to achieving desired outcomes.

In its 2010/11 service plan, the ministry committed to developing an array of performance measures that reflect practice change and to increase public reporting on those measures. From 2010 to 2012, the ministry released three reports that expanded to 30 measures across an array of areas such as early years,

¹² Hughes, T. (2006). *BC Children and Youth Review: An Independent Review of BC's Child Protection System*.



child protection, education and fatalities. These reports indicated a positive direction by MCFD, although work still needed to be done to understand client outcomes and how the information was being used to improve services.

In 2012, MCFD moved towards a performance management framework to focus on improving outcomes for children, youth and families with more meaningful analysis of programs and services to develop measurable actions on improvement. This led to the release of two Operational Performance and Strategic Management (OPSM) reports that provided information on several aspects of MCFD service delivery, including a few measures of service quality and a number of outcome measures.

In the September 2013 OPSM report, MCFD's own assessment of its operational data was that it was *"clearly inadequate in the short term to support effective progress in a number of strategic key actions."* Another challenge with these reports is that they do not provide enough comparative data to identify whether the ministry is achieving the intended progress.

The Representative agrees with the ministry's own assessment and concludes the reports lack context to understand progress towards improving service-delivery and client outcomes. More meaningful analysis is required to understand how the measures are to be interpreted, what the results mean and how the ministry intends to use the information to inform decision-making. Targets are required so that the organization and the public understand the ministry's performance expectations and the gaps that exist between actual and targeted performance.

There continues to be a gap in available data, including a lack of data from service providers who deliver contracted services to children, youth and families. In addition, there is inadequate data collected for services other than child protection services, such as child and youth mental health services and services for children and youth with special needs. These gaps include basic client information, wait times, the number of children and youth served, prevalence rates and the outcomes for children and youth receiving service. Having this information would provide more accountability to the public to judge whether government-funded services are adequate and whether outcomes for children and youth are improving. The Representative is disappointed that there hasn't been an improvement to these gaps during the seven-year oversight period of her Office to date.

The Representative's own reports go some way to filling the gap in understanding the experiences and outcomes of vulnerable children and youth. However, the Representative's Office does not have the capacity to conduct on-going data collection and on-going assessment of service quality for the many diverse services responsible for supporting children, youth and their families.

Individual ministries need to be accountable for publicly stating service quality and client outcomes expectations and reporting out on whether they are achieving their desired goals. Certainly, much more needs to be done so that the public knows whether services and outcomes are getting better for children and youth.

Conclusion

The Representative is committed to making worthwhile and valuable recommendations to help improve the child- and youth-serving system in B.C., recognizing that it is critical to be in tune with what is happening on the ground and to connect recommendations with the realities experienced by front-line staff and the children, youth and families they serve.

However, the Representative does not have the authority to carry out these recommendations. That is up to government, which means that government leadership is extremely important to improving services for B.C.'s vulnerable children and youth.

This report concludes that government as a whole must exhibit better leadership and commitment when it comes to addressing the needs of children and families in this province.

Commitment means providing adequate resources to deliver those services. More money is not the answer to every question, but it is difficult to understand how a provincial government can reduce its budget in constant dollars to children and families at a time when B.C. leads the nation in child poverty rates and at a time when Aboriginal children continue to experience poorer outcomes and receive poorer services than their contemporaries.

Since 2007/08, MCFD's annual budget has been reduced by more than \$37 million, which equates to a nearly \$100-million reduction in real dollars when inflation is taken into account. This has happened during a period when vulnerable B.C. families have also been dealing with the effects of a severe economic downturn.

The Representative is also troubled about front-line staffing resources. Accounts of staff shortages within some MCFD offices have come to the attention of the Representative through a number of ways, including advocacy cases. The Representative is concerned about the potential impacts these shortages may have on children and youth and the Office plans to conduct a review of MCFD staffing levels in the coming months.

Adequate resources and staffing are necessary for MCFD and other child-serving ministries. But just as important is a willingness by B.C. government leaders to listen to and act on recommendations by the Representative's Office. And that doesn't mean acting only on the easier recommendations while claiming that a 72 per cent implementation rate is good enough. It is not.

Government leadership must drive B.C. to fulfill the tougher recommendations from this Office, the ones that require cross-ministry participation, change and commitment – to implement a strategy to address child poverty, for example; or to provide a consistent and equitable system of services to address child and youth mental health problems. Government leadership must act to address the key areas of deficiency in the system that the Representative has strategically emphasized over the years – services to Aboriginal children and youth, domestic violence prevention and child and youth mental health services.







Government leadership must also drive competent and consistent evaluation of the job it is doing for children and youth in this province. In 2006, the Hughes Review recommended that MCFD establish a strong quality assurance function, track and report on a comprehensive list of outcomes for children, youth and their families and develop shared data sets with other ministries. Pockets of progress have been made in this regard, such as reporting of education outcomes of children in care. But on the whole, MCFD and other ministries have fallen far short of the mark set by Hughes. Large gaps exist in understanding who is receiving what types of services and what service experiences and outcomes are for clients. On the surface, it seems simple – in order to improve, you have to know what kind of a job you are doing now.

The Representative's mandate provides for valuable oversight that can influence public services for children and youth. However, it is up to government to deliver these services, ensure that they are of high quality and that they are making desired contributions to the well-being of children and youth. The scope of the Representative's reports and recommendations make it clear that this responsibility is shared across government ministries and at the highest level of government leadership.

MCFD, the lead ministry for many aspects of services to children, youth and families, has taken some steps in the right direction, particularly since 2011, to respond to oversight recommendations, develop quality assurance mechanisms and report on performance. Leadership at MCFD must build on the foundation that is now being laid, and government must ensure that progress at MCFD continues. There remains a long way to go.

Appendix 1

Recommendation Status Categories

Status	Description
 No Progress	<p>No substantial action has been taken to implement the recommendation. The intent to do something or the development of a high level plan is not considered substantial action.</p> <p>OR</p> <p>Action that has been reported to RCY does not meet the intent of the recommendation.</p>
 Some Progress	<p>Implementation has begun. Action to date has not produced the foundation that will be required for full implementation.</p>
 Substantial Progress	<p>Implementation is well underway. A solid foundation has been built and full implementation is expected if action continues as planned.</p>
 Implemented	<p>The recommendation has been fully implemented.</p>



Appendix 2

Status of all RCY Recommendations: 2008 to 2013

Reports by Year (January 1, 2008 to December 31, 2013)	Number of Recommendations	Implemented	Substantial Progress	Some Progress	No Progress
2013					
<i>When Talk Trumped Service: A Decade of Lost Opportunity for Aboriginal Children and Youth in B.C. – Nov. 2013</i>	5				
<i>Out of Sight: How One Aboriginal Child's Best Interests Were Lost Between Two Provinces – Sept. 2013</i>	4				
<i>Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C. – April 2013</i>	4				
<i>Much More than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care – March 2013</i>	10				
<i>Who Protected Him? How B.C.'s Child Welfare System Failed One of its Most Vulnerable Children – Feb. 2013</i>	4				
2012					
<i>Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm – Nov. 2012</i>	1				
<i>Special Report: The Impact of Criminal Justice Funding Decision on Children of B.C. – March 2012</i>	3				
<i>Honouring Kaitlynn, Max and Cordon: Make Their Voices Heard Now – March 2012</i>	8				



Reports by Year

(January 1, 2008 to
December 31, 2013)

Number of
Recommendations

Implemented

Substantial
Progress

Some
Progress

No
Progress



2011

*So Many Plans, So Little Stability: A Child's Need
for Security – Sept. 2011*

3



*Isolated and Invisible: When Children with Special
Needs are Seen but Not Seen – June 2011*

4



*Issue Report: Phallometric Testing and B.C.'s Youth
Justice System – April 2011*

4



*Fragile Lives, Fragmented Systems: Strengthening
Supports for Vulnerable Infants – Aggregate Review
of 21 Infant Deaths – Jan. 2011*

7



2010

*Special Report: Reporting of Critical Injuries and
Deaths to the Representation for Children and
Youth – Dec. 2010*

1



*Issue Report: Sexual Abuse Intervention Program –
Sept. 2010*

6



*No Shortcuts to Safety: Doing Better for Children
Living with Extended Family – June 2010*

10



*Hearing the Voices of Children and Youth:
A Child-Centred Approach to Complaint
Resolution – Jan. 2010*

7





Reports by Year

(January 1, 2008 to
December 31, 2013)

Number of
Recommendations

Implemented

Substantial
Progress

Some
Progress

No
Progress



2009

*Honouring Christian Lee - No Private Matter:
Protecting Children Living with Domestic
Violence – Sept. 2009*

7



*Housing, Help and Hope: A Better Path for
Struggling Families – July 2009*

5



*Kids, Crime and Care: Youth Justice Experiences
and Outcomes – Feb. 2009*

7



2008

*Issue Report: Medical Assessments in B.C.'s Youth
Justice System – Sept. 2008*

4



*Amanda, Savannah, Rowen and Serena: From
Loss to Learning – April 2008*

32



*Monitoring Brief – System of Services for Children
and Youth with Special Needs – Feb. 2008**

12*



Recommendation Status as of March 31, 2014

*Outstanding issues will be addressed through appropriate responses to the recommendations provided in the *Isolated and Invisible: When Children with Special Needs are Seen but Not Seen* report.

Glossary

Aboriginal – a broad term which, according to the *Constitution Act* of 1982, includes the Indian, Inuit and Métis people of Canada. However, the term "Aboriginal" is generally more broadly interpreted as including people who are registered status Indians, non-registered Indians, Inuit and Métis. Non-registered Indians are generally people who self-identify as having Aboriginal heritage, but who are not eligible to be registered under the *Indian Act*.

Child, Family and Community Service Act (CFCS Act) – legislation enacted in 1996 that governs child protection in British Columbia.

Child or youth in government care – any child under 19 years of age living under the custody, care or guardianship of a Director under the *Child, Family and Community Service Act*.

Child protection services – services delivered under the *Child, Family and Community Service Act* in response to reports of child abuse or neglect. Child protection services can include investigation, providing or arranging for support services to families, supervising the care of children in their homes, and protecting children through removal from their families and placement with relatives, foster families or specialized residential resources.

CLBC services – services to adults with developmental disabilities that are funded by the Crown agency Community Living B.C.

Delegated Aboriginal Agency (DAA) – through delegation agreements, the Provincial Director of Child Protection (the Director) gives authority to Aboriginal agencies, and their employees, to undertake administration of all or parts of the *CFCS Act*. The amount of responsibility undertaken by each agency is the result of negotiations between the ministry and the Aboriginal community served by the agency, and the level of delegation provided by the Director.

Domestic violence courts – courts that are dedicated to domestic violence cases and have the underlying principles of increased safety for victims, early intervention for low-risk offenders, vigorous prosecution for serious and/or repeat offenders, commitment to rehabilitation and treatment, and coordinated systems response.

Family support services – services provided to families by MCFD, delegated Aboriginal Agencies or contracted service providers to support and assist families to care for their children. Services may include services for children and youth, counselling, in-home support, respite care, parenting programs and services to support children who witness domestic violence.



First Nation(s) – a term that became more common during the 1970s to replace the term "Indian." While there is no legal definition for term "First Nation(s)," it is meant to describe those persons who are registered as "Indians" under the federal *Indian Act*.

Foster care – a family or persons approved by and funded by the Director, to care for children who are in the care, custody and guardianship of the Director. Family care services are provided from private homes lived in and maintained by the foster parents. Foster care includes Restricted, Regular, Level 1, Level 2, and Level 3 Family Care Homes. Persons who provide family care services are referred to as family care parents, foster parents or as a foster family.

Guardianship services – services provided by MCFD or delegated Aboriginal Agencies to children and youth who are in long-term or continuing care as a result of a child custody order granted under the *Child, Family and Community Service Act*, or an order under the *Family Relations Act* when a child has no parent or guardian. Guardianship services have parental duties and responsibilities towards children and youth and are responsible for their care, custody and guardianship.

Hughes Review (The BC Children and Youth Review) – the 2006 independent review of British Columbia's child protection system by the Hon. Ted Hughes, QC. It was a review that recommended the appointment of an independent Representative for Children and Youth.

Public bodies – provincial government ministries and other organizations that serve the public such as the Coroners Service of BC, RCMP, Public Guardian and Trustee of BC and Aboriginal Affairs and Northern Development Canada.

Select Standing Committee on Children and Youth (SSCCY) – an all-party committee of the B.C. Legislature responsible for fostering awareness and understanding among legislators and the public about the B.C. child welfare system. The Representative reports at least annually to the SSCCY, and the committee receives and reviews the Representative's service plan and annual report, receives and considers all reports of the Representative and may refer a critical injury or death of a child to the Representative for investigation.

Youth justice services – services for youth who have been accused or found guilty of a criminal offence and were aged 12 to 17 at the time of the offence. A youth may be subject to community-based services (such as probation), youth custody, or a combination of both.



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