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,

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

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.

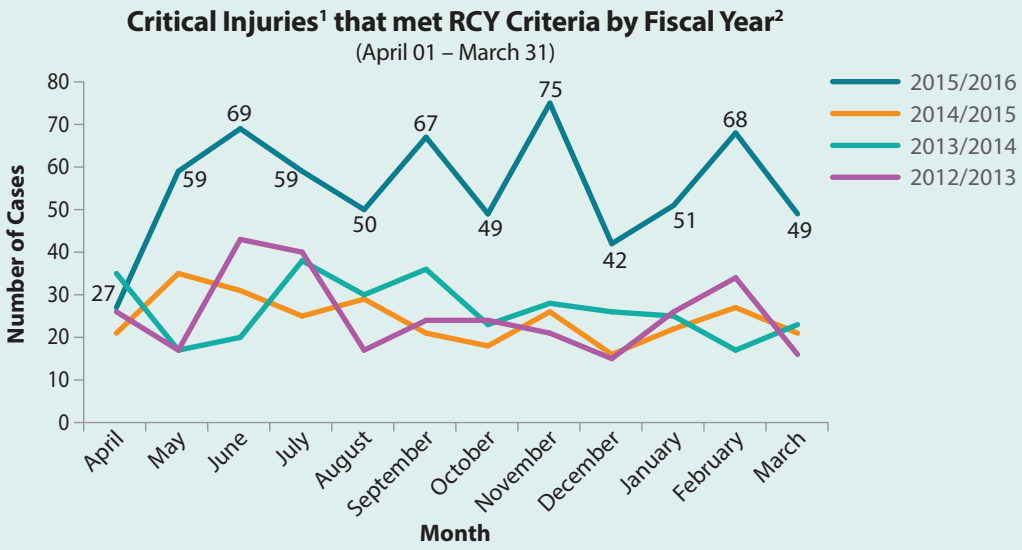
What follows is a description of RCY's investigation that satisfies the *RCY Act* in terms of the Office's duty to report out on investigations it has conducted but offers far less detail than is typically provided. However, the Representative has provided the Ministry of Children and Family Development (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.

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.



[1] RCY Critical Injuries can include both MCFD Serious Incident and MCFD Critical Injury classifications.
[2] This graphic shows fiscal years 2012/2013 to 2015/2016. An updated policy was introduced in June 2015 and training was completed on the updated Reportable Circumstances Policy in the same month. Subsequently, the number of Reportable Circumstances received by the RCY in 2015/2016 has increased.

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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