



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

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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 "melturpellafond". The signature is written in a cursive, lowercase 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/el/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 COPH 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 COPH 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 COPH 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 COPH 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’ COPH 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 COPH 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 COPH application being denied.
- On June 13, the grandparents phoned the social worker, who confirmed the decision that the COPH 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’ Copenhaven (COPH) 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 COPH 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 COPH 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 COPH 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 COPH funding, which was her continued presence in the grandparents' home. With that plan in place, the COPH 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.bcgeu.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 COPH 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 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.

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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