15-YEAR-OLD NETASINIM

An Investigative Review

OCTOBER 2016

ocya OFFICE OF THE CHILD AND YOUTH ADVOCATE ALBERTA

Under my authority and duty as identified in the *Child and Youth Advocate Act (CYAA)*, I am providing the following Investigative Review about the accidental death of a 15-year-old First Nation youth who was, at the time, receiving services from the Government of Alberta.

This is a public report that contains detailed information about children and families. Although my office has taken great care to protect the privacy of the youth and his family, I cannot guarantee that interested parties will not be able to identify them. Accordingly, I would request that readers and interested parties, including the media, respect this privacy and not focus on identifying the individuals and locations involved in this matter.

In accordance with the *CYAA*, Investigative Reviews must be non-identifying. Therefore, the names used in this report are pseudonyms (false names). Finding an appropriate pseudonym can be difficult, however, it is a requirement that my office takes seriously and respectfully. His mother requested that we call this young man, Netasinim, a Cree word meaning "my child" or "my own".

We met with some of Netasinim's family members, caregivers and service providers who helped us understand his circumstances. It was a privilege to also meet with Elders from his First Nation. They shared their personal stories, along with the story of their community. They involved us in ceremony and helped us gain understanding through teachings.

Netasinim died in a tragic drowning accident. Although, potential systemic issues were identified at the outset of the review process, they were not confirmed. Services and supports provided to Netasinim and his family were appropriate.

My office has completed over 20 Investigative Reviews and this is the first instance in which I am not making any recommendations. This does not mean that there are not challenges that face young people and their families in similar circumstances to those reviewed. It does mean that our review of the systemic issues arising from the circumstances of Netasinim and his family were not confirmed in our Investigative Review.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

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EXECUTIVE SUMMARY

Alberta's Child and Youth Advocate ("the Advocate") is an independent officer reporting directly to the Legislature of Alberta, deriving his authority from the *Child and Youth Advocate Act (CYAA)*. The Advocate has the authority to conduct investigations into systemic issues related to the death of a child receiving designated services.

Fifteen-year-old Netasinim, a First Nation youth, was swimming with friends when a strong current pulled him under and he drowned. He was the subject of a Permanent Guardianship Order (PGO) and living in a group home when he died.

The primary objective identified in the Terms of Reference that guided this Investigative Review was related to "examining the services and supports provided to Netasinim and his family specifically related to capacity within the community." Through the review process, no systemic issues were found and the Advocate is not making any recommendations.

Netasinim's death was a tragic accident. Services and supports were appropriate when his circumstances were brought to the attention of Child Intervention Services staff.

INTRODUCTION

The Office of the Child and Youth Advocate

Alberta's Child and Youth Advocate ("the Advocate") is an independent officer reporting directly to the Legislature of Alberta. The Advocate derives his authority from the *Child and Youth Advocate Act (CYAA),*[1] which came into force April 1, 2012.

The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act*[2] (the *Enhancement Act*), the *Protection of Sexually Exploited Children Act*[3] (*PSECA*), or from the youth justice system.

Investigative Reviews

Section 9(2)(d) of the *CYAA* provides the Advocate with the authority to conduct Investigative Reviews. The Advocate may investigate systemic issues arising from the death of a child who was receiving a designated service at the time of the death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Upon completion of an investigation under this section of the *CYAA*, the Advocate must release a public Investigative Review report. The purpose is to make findings regarding the services that were provided to the young person and make recommendations that may help prevent similar incidents from occurring in the future.

An Investigative Review does not assign legal responsibilities, nor does it replace other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an Investigative Review is not to find fault with specific individuals, but to identify key issues along with meaningful recommendations. Fundamentally, an Investigative Review is about learning lessons, rather than assigning blame.

1 *Child and Youth Advocate Act*, S.A. 2011, c. C-11.5.

2 *Child, Youth and Family Enhancement Act*, RSA 2000, c. C-12.

3 *Protection of Sexually Exploited Children Act*, RSA 2000, c. P-30.3.

ABOUT THIS REVIEW

The Advocate received a report that 15-year-old Netasinim (not his real name)[4] passed away in a drowning accident. At the time of his death, he was receiving Child Intervention Services from a Delegated First Nation Agency (DFNA).[5] He was the subject of a Permanent Guardianship Order[6] and living in a group home.

Netasinim's child intervention record was thoroughly reviewed by investigative staff from the Office of the Child and Youth Advocate (OCYA). The Advocate determined that an Investigative Review was required and the Ministry of Human Services was subsequently advised.

Terms of Reference were established and are provided in Appendix 1. A team gathered information and conducted an analysis of Netasinim's circumstances through a review of relevant documentation, interviews and research. Netasinim's family members met with the investigative team and shared their experiences. There were also a number of meetings with community members, service providers and Elders.

The primary objective (potential systemic issue) identified in the Terms of Reference that guided this review, was related to providing services for children in their communities.

About Netasinim and his Family

Those who knew Netasinim well, said that he was most comfortable spending time on his own; he liked being outdoors, watching movies and playing on his computer. Sometimes, he had trouble controlling his emotions, particularly his anger. He was close to his foster mother.

Netasinim was the oldest of a large sibling group. His parents, Tayla and Albert, struggled with addictions and their relationship was marred by violence. They often relied on family and friends to help care for their children.

4 All names throughout this report are pseudonyms to ensure the privacy of the child and family.

5 An agency that delivers on-reserve child intervention services to a First Nation community. DFNAs operate under provincial legislation but are federally funded.

6 An Order in which the court awards guardianship to the Director on a permanent basis. The child is in the care of the Director and remains in an approved placement.

SUMMARY OF CHILD INTERVENTION SERVICES INVOLVEMENT

Netasinim from Birth to 5 Years Old

When Netasinim was six months old, Child Intervention Services became involved with his family because he was significantly underweight. Tayla had recently separated from Albert because of domestic violence and alcohol abuse. She was open about her drinking, stating that everyone in her family drank so she did too. Tayla entered into a three-month Support Agreement[7] and agreed to access supports and medical services for Netasinim.

A month after the agreement ended, Child Intervention Services received concerns that Tayla continued to abuse alcohol, was not taking Netasinim to medical appointments and the family home had mold. Child intervention involvement ended six months later.

Netasinim was two years old when Tayla had her second child, Tom. Tayla asked her sister to care for him. Ten months later, Tom was apprehended because he was underweight, dehydrated and his caregivers were intoxicated. He was removed from the community to receive urgent medical care.[8]

When Netasinim was three years old, concerns were received that he did not have a sober caregiver. Tayla was struggling with an addiction to alcohol and was a victim of domestic violence. Child Intervention Services helped Tayla and Netasinim move to a women's shelter where she could get counselling and have support.

Approximately six months later, Tayla had her third child, who was born suffering from alcohol withdrawal. All three children were brought into care because of Tayla's ongoing addictions. They were placed together in a foster home in a neighbouring community. Their foster parents, Mona and Karl, were also of First Nations heritage. Over the 18 months the children were in their care, Mona and Karl became very attached to them.

Tayla and Albert saw a counsellor and went to treatment; the children were subsequently returned to their care. Child Intervention Services continued to be involved for about six months after the children's return. During this time, Tayla had another child, who was placed with relatives.

7 Also known as a Family Enhancement Agreement, a voluntary agreement between Child Intervention Services and a child's guardian intended to address protection concerns while the child remains in the guardian's care.

8 Tom was diagnosed with failure to thrive and severe dehydration. He was subsequently returned to Tayla's care.

Netasinim from 6 to 12 Years Old

Child Intervention Services was not involved for almost six years; however, the family continued to struggle with issues of neglect, lack of housing, alcohol abuse and domestic violence. During this time, Netasinim and his siblings moved between caregivers within their family. Tayla had another child who was placed with a relative.

The children spent summers and holidays with their former foster parents, Mona and Karl. Once, they stayed there for about eight months. Their involvement temporarily ended when family members did not want the children going there. Netasinim continued to call Mona and Karl when things were not going well at home and asked them to take him back. They wanted to help, but without the relatives' support they were unable to.

Netasinim from 12 to 15 Years Old

When Netasinim was 12 years old, concerns were received about his younger brother. Eleven-year-old Tom was found intoxicated. Tom was apprehended and placed in an emergency foster home because no sober family member could be located. He returned to a relative's care the following day.

Five months later, Child Intervention Services received information that Netasinim and Tom had been living in a garbage dump for approximately two weeks. Netasinim was not willing to return home because of his family's drinking and physical abuse. He was emotional when he explained that he preferred to live in the dump because it was safer. The police investigated and charged his mother with assaulting Netasinim and his younger sister.

The children were apprehended and returned to Mona and Karl's foster home. Initially, they had difficulty with basic daily routines, did not want to shower or change their clothes and often left the home at night. The first three months were challenging for their foster parents and it took almost a year for the children to settle in.

Shortly before Netasinim's 15th birthday, his behaviours began to change. He was increasingly angry and physically aggressive with his siblings and foster parents. He began to talk about the physical abuse he had endured at home. The children became subjects of Permanent Guardianship Orders.

After approximately two years with Mona and Karl, Netasinim was moved to a group home in the city so that he would have access to more supports. He was settling in and went on outings with the other boys in the home. Group home staff described him as quiet and very polite.

Circumstance of Netasinim's Death

Approximately three weeks after his move, Netasinim returned to his First Nation to attend an annual cultural event. He went swimming with friends, a strong current pulled him under and he drowned.

DISCUSSION AND FINDINGS

The objectives (potential systemic issues), identified in the Terms of Reference that guided this review were to examine the services and supports provided to Netasinim's family related to capacity within the community; and, to comment upon relevant protocols, policies and procedures, standards and legislation. Through the Investigative Review process, the Advocate found that although there are challenges in his community, there are also strengths. The potential systemic issue was not confirmed.

Netasinim's First Nation is remote; the nearest city is some distance away. Unemployment, poverty, inadequate housing and alcohol abuse are issues that members struggle with. However, the Nation is strong in its traditions and heritage. Many in the community have maintained their native language and ceremonies. Hunting and fishing continue to sustain families. Elders are present to guide young people and want them to be healthy and grow strong.

Child Intervention Services had extensive involvement with the family during Netasinim's first six years. The children were brought into care and placed in a foster home. They were kept together in a First Nation community, close to their home, with caregivers who became very attached to them. The children were subsequently returned to their parents' care.

Child Intervention Services did not receive any concerns for the following six years. While it appears that the children continued to be exposed to addictions, neglect, physical abuse and violence, community and family members provided support and child welfare was unaware; and therefore, could not intervene.

When Netasinim was 12 years old, concerns were received that he and his younger brother were living in the community garbage dump. They were apprehended, along with their younger sibling, and placed with their former foster parents who had maintained a significant relationship with them. Netasinim settled in and was able to stay there for almost two years. He was subsequently moved to a group home because his behaviours changed and his foster parents were no longer able to provide the care he needed. Although he was moved some distance away, he maintained connections to his family and community.

Netasinim died while on a visit to his First Nation for an annual cultural event. His death was the result of a tragic drowning accident.

The Advocate did not confirm the potential systemic issue that was identified at the outset of this Investigative Review related to community capacity and is not making any recommendations. However, the Advocate recently completed a special report

on Aboriginal child welfare in Alberta, "Voices for Change"[9] and many of the findings and recommendations are relevant in Netasinim's circumstances. As noted in that report, "Many Aboriginal communities face challenges that will require significant resources and support to overcome…action must be taken in strengthening Aboriginal communities' capacity to provide care for their children."

It is critical that the recommendations contained in the "Voices for Change report" are acted upon so that the experiences of young people, their families and communities, in circumstances similar to those of Netasinim, are improved.

9 Office of the Child and Youth Advocate, July 2016.

APPENDICES

APPENDIX 1: TERMS OF REFERENCE

Authority

Alberta's Child and Youth Advocate ("the Advocate") is an independent officer reporting directly to the Legislature of Alberta, deriving his authority from the *Child and Youth Advocate Act* (*CYAA*). The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act*, the *Protection of Sexually Exploited Children Act* or from the youth justice system.

Section 9(2)(d) of the *CYAA* provides the Advocate with the authority to investigate systemic issues arising from the death of a child who was receiving designated services at the time if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Incident Description

The Advocate received a Report of Death regarding 15-year-old Netasinim who drowned while swimming with friends. He was receiving Child Intervention Services at the time.

The decision to conduct an investigation was made by Del Graff, Child and Youth Advocate.

Objectives of the Investigative Review

- To review and examine service and supports provided to Netasinim and his family specifically related to capacity within the community
- To comment upon relevant protocols, policies and procedures, standards and legislation

Scope/Limitations

An Investigative Review does not assign legal responsibilities, nor does it replace other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an Investigative Review is not to find fault with specific individuals, but to identify and advocate for system improvements that will enhance the overall safety and well-being of children who are receiving designated services.

Methodology

The investigative process will include:

- Examination of critical issues
- Review of documentation and reports
- Review of Enhancement Policy and casework practice
- Review of case history
- Personal interviews
- Consultation with experts
- Other factors that may arise for consideration during the investigation process

Investigative Review Committee

The membership of the committee will be determined by the Advocate and the OCYA Director of Investigations. The purpose of convening this committee is to review the preliminary investigative review report and to provide advice regarding findings and recommendations.

Chair: Del Graff, Child and Youth Advocate

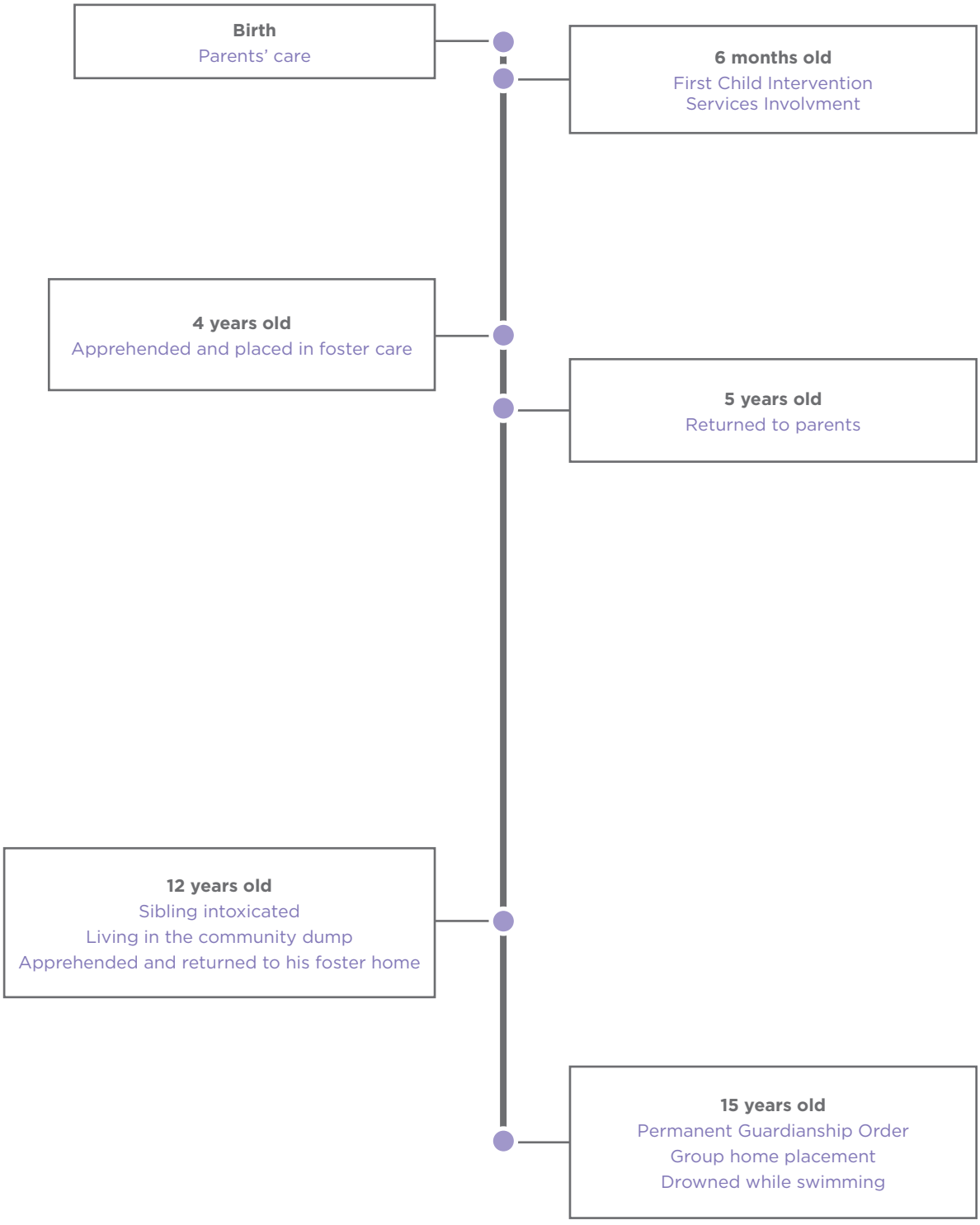
Members: To be determined but may include:

- An expert in the area of service provision to remote First Nation communities
- An expert in the area of addictions
- A specialist in the area of child welfare best practices
- An Elder

Reporting Requirement

The Child and Youth Advocate will release a report when the Investigative Review has been completed.

APPENDIX 2: SUMMARY OF SIGNIFICANT EVENTS



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AN INVESTIGATIVE REVIEW

NORTH OFFICE

#600, 9925 109 Street NW
Edmonton AB T5K 2J8

SOUTH OFFICE

#2420, 801 6 Avenue SW
Calgary AB T2P 3W3

www.ocya.alberta.ca
1 800 661 3446