

Broken Promises

Alex's Story



REPRESENTATIVE FOR
CHILDREN AND YOUTH

February 2017

Feb. 6, 2017

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 *Broken Promises: Alex's Story* 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 blue ink, appearing to read "B. Richard", is placed above the typed name.

Bernard Richard
Acting 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

Acknowledgement

The Acting Representative recognizes the profound loss suffered by Alex's family and friends and thanks them for their assistance and understanding in the preparation and release of this report.

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Executive Summary

On a mid-September morning in 2015, in an act of obvious desperation, an 18-year-old Métis youth named Alex took his own life by smashing through the window of his fourth-storey Abbotsford hotel room and plunging to the ground below.

Through an in-depth investigation into the life and death of this troubled youth, the Representative for Children and Youth has developed an understanding of what led to such a tragic outcome. It is hoped that this report and its recommendations will help prevent other children and youth from experiencing a similar fate.

Alex lived a life that none of us would wish on our own children, or any child. He experienced repeated abuse while in the care of his biological parents, both of whom were dealing with significant mental illness. Although child welfare authorities in two provinces were involved with Alex early on, his subsequent journey through the child welfare system was marked by constant instability, repeated missed opportunities for permanency, and trauma.

When a child is taken into care for his own protection, it is the responsibility of government to fulfill the role of the “prudent parent” – to ensure that the child’s needs are met, that he has a stable home, nurturing relationships and experiences, enough food and suitable clothing, education, medical care and a meaningful connection to his culture. In Alex’s case, the services he actually received fell far short of the care we expect from any parent in British Columbia.

Instead, he was left to drift through the care of the provincial Ministry of Children and Family Development (MCFD), living in 17 different placements and under the watch of a total of 23 different social workers and caregivers after being removed from his birth family. At the very end, Alex was alone. The final caregiver who was being well paid to oversee him was absent from the hotel that Alex had reluctantly been forced to consider “home” for 49 straight days.

Permanency is supposed to be a top priority for children and youth in care. It is specifically called for by the *Child, Family and Community Service Act (CFCS Act)* that governs the work of MCFD and Delegated Aboriginal Agencies (DAAs). The ministry itself defines permanency in policy as “*a permanent connection to a significant person or persons who can provide children with the stability and continuity they need to develop into healthy, secure adults.*”

For Alex, however, permanency was a concept that didn’t actually exist. Instead, he was left in the hands of paid caregivers rather than those to whom he had a meaningful personal connection. The ministry’s own internal review of his death stated that a lack of any collaborative approach to permanency planning – or even toward creating a permanent care arrangement for him – contributed to a life of “*profound instability and neglect.*”

Sadly, the Representative has discovered through the course of this investigation that Alex might well have found that much-needed permanency had the ministry taken its responsibility seriously instead of deciding, for all intents and purposes, at a very early stage that the fate of this boy would be to “age out” of care at 19.

Opportunities for Alex to be permanently placed with his stepmother in B.C., or with an aunt and her family in Québec, were missed by MCFD, in favour, ultimately, of placing him in the long-term care of a contracted residential agency. Both these family members expressed considerable interest in having Alex live with them permanently and RCY investigators could find no concrete reasons why either of those family placement options would not have worked for Alex. In fact, this investigation finds that the ministry and its delegates failed to adequately explore either option.

For reasons unknown to RCY investigators, MCFD refused to provide the modest support that Alex’s stepmother requested to facilitate his placement with her – a fraction of what his previous foster placement had cost. Instead, the ministry, and later its Delegated Aboriginal Agency (DAA), opted to pay far more for the boy to be placed with a contracted residential agency for the next seven years. At the very end, the DAA contracted with a former respite worker – at an exorbitant rate more than 11 times what MCFD had offered to the stepmother years earlier – to provide ‘care’ to Alex in a hotel. This worker collected money from the DAA but, according to witnesses, left Alex largely alone, without adequate food or clothing or support.

The effects of early and continual trauma in Alex’s life due to abuse, instability and constantly changing placements were noted in a psychiatric assessment completed in 2007. The psychiatrist who conducted that assessment noted that 10-year-old Alex was a child with “*significant anxiety and oppositional behaviour*” which she attributed to an unstable upbringing, exposure to abuse and “*chaotic home situations*”. The psychiatrist emphasized that, because of his attachment issues, MCFD should do its utmost to create stability in Alex’s current foster placement for the sake of his “*mental health and well-being*”.

This advice was ignored. The stability called for by the psychiatrist never materialized, with the ministry often citing Alex’s “*challenging behaviours*” as it continued to shuttle him through a multitude of placements and caregivers that only served to further traumatize him. Alex never received adequate support for his mental health needs. Despite five separate referrals to Child and Youth Mental Health services while in care, and despite overwhelming evidence that Alex desperately needed robust and effective mental health interventions to cope with the repeated traumatization, he was never connected to appropriate services.

This report also finds that the child welfare system failed to connect Alex to his Métis culture, despite the fact MCFD identified him as being Métis shortly after bringing him into care at age seven. The ministry consistently ignored its duty under the *CFCS Act* as did the DAA under its own Aboriginal Operational and Practice Standards and Indicators (AOPSI) to connect him with his culture, often using the excuse that he wasn’t interested in learning about his heritage or embracing it. MCFD and the DAA

thus put the onus on a young boy to realize how much of a protective factor his culture might have provided and to act on that. Essentially, they abdicated their responsibility and Alex paid the price.

In addition to Alex's cited lack of interest in his Métis culture, social workers told investigators that their caseloads were too high and too complex for them to conduct the detailed cultural work called for under standards. While the Representative appreciates that these workers were struggling with caseloads, he does not accept this as justification for the ministry denying Alex the right to know his culture and to be meaningfully connected to it. It is troubling that legislation and standards to protect Indigenous cultural connections are in place but often ignored or merely given lip service. If caseloads are too large or difficult, then certainly it is up to the ministry and government to make the necessary changes in order to ensure that these requirements can be met. Otherwise, why do such standards and legislation exist?

RCY investigators could find no evidence that Alex's documented lack of interest in his Métis culture was ever addressed by a social worker. With a few small exceptions, his cultural identity was ignored by his eight social workers and 15 caregivers during the 11 years that he was in the care of the provincial government.

There is little wonder, then, that Alex, lacking permanent family connections and mental health support and cut off from his culture, also developed substance use issues and extremely challenging behaviours in his teen years.

While constant instability, a lack of connection to his culture and insufficient mental health supports were all factors in Alex's path, so was the quality of care he received, particularly during the final seven years of his life when he was in the care of the contracted residential agency and, during the final 49 days, when he was supposed to be cared for in the hotel by the privately contracted caregiver.

MCFD eventually terminated all of its contracts with the residential agency that had cared for Alex. But not before Alex and others were subject to highly questionable care and, likely, much worse. At various times when under care of the residential agency, Alex complained of being sexually assaulted – once by a female caregiver he said had first given him cocaine. He also complained about a lack of food in his residence and about not being provided enough money to buy clothing. Other evidence collected by RCY investigators and the ministry before it cancelled its contracts with the residential agency pointed to a serious lack of supervision in the house and of workers being hired and retained despite dubious backgrounds and highly questionable conduct on the job.

RCY investigators, with the assistance of an accountant, found that there was almost no quality control for care provided through this arrangement with the residential agency. Neither was there any meaningful financial oversight of the agency to verify how it was spending ministry or DAA contract dollars.

After it had terminated all contracts with the residential agency, MCFD enlisted a national accounting firm to carry out an initial assessment of the agency's internal control, financial reporting and contract compliance practices. The subsequent report

identified several areas of high risk and proposed a more detailed follow-up review that could quantify the amount, if any, of overpayment and determine the actual costs of delivering the specified services by examining all the agreements that were in place. MCFD opted not to do this deeper financial review, as it believed it would not be cost-effective. However, the Representative believes the ministry should have considered the deterrent effect that such a review might have had on other contracted residential agencies adopting similar practices in the future.

Termination of the residential agency's contracts left the DAA with little choice in where to place Alex in the summer of 2015. It was in this context that Alex's final placement was made, with his former respite caregiver, in a hotel.

Under the arrangement, the caregiver was paid more than \$8,000 a month to care for Alex. In addition, the DAA paid costs for him to live in an adjoining room to Alex's in the hotel. But this caregiver was rarely on site – in fact, witnesses told RCY investigators he hadn't been there at all in the 10 days before Alex's death – and Alex complained bitterly that the caregiver was pocketing the money meant for him to purchase food and clothing.

In the hours before his death, Alex was using cocaine heavily and stressing about what would happen to him once he aged out of care in just eight months. The BC Coroners Service ruled his death, caused by blunt force injuries, to be a suicide.

This report recommends that MCFD provide necessary support for children and youth in care who are unable to return to their birth families to help them achieve permanency with extended family or another adult with whom they have a positive connection. This should include providing supports such as respite and child care to families to help ensure success of such placements and also ensuring that social workers have the time necessary to pursue such placements.

The Representative also calls on MCFD to fulfill recommendations made by both the previous Representative for Children and Youth and Grand Chief Ed John to bring Care Plans into compliance with standards already called for in legislation and policy. Priority should be placed on ensuring that permanency is being actively pursued for every child or youth who is in continuing care and that all Indigenous children and youth in care have a robust cultural plan connecting them to their Indigenous heritage.

The Representative also recommends that MCFD take immediate steps to ensure that children and youth in care who have been identified with mental health needs receive timely and uninterrupted mental health services, regardless of any changing circumstances in their lives, including changes in placements.

Finally, this report calls on the ministry to significantly enhance the provision of quality assurance oversight and financial accountability for all contracted residential agencies. The highest priority should be given to the monitoring of service delivery quality and outcomes for children and youth receiving care from these agencies.

When tragedy occurs, it is our responsibility as a society to learn lessons and make the changes required to prevent similar occurrences. The Representative expects government to learn from Alex's story and to take these necessary steps.

Methodology

The *Representative for Children and Youth Act (RCY Act)* 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.

Alex's death was reported to the Representative by MCFD on Sept. 21, 2015. After completing a review of ministry and DAA files on April 28, 2016, the Representative determined that a reviewable service or the policies or practices of a public body may have contributed to his death and a full investigation was begun.

The investigation examined Alex's life from his birth on May 23, 1997, until his death on Sept. 18, 2015. A particular focus was the final year of his life and the services and supports that were available to him during that period.

Numerous files and documents were reviewed in the course of this investigation. Records were obtained from multiple sources, including MCFD, police, the DAA, schools, provincial health authorities and the B.C. Coroners Service witnesses told RCY investigators (see Appendix B).

Interviews with MCFD staff, DAA staff, health care professionals, school staff, executive and contractors with the contracted residential service provider and Alex's friends and family 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. Sixty-eight interviews were conducted (see Appendix A).

A draft report was provided to the Representative's Multidisciplinary Team (see Appendix C), 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 individual and collective expertise of the team members. Additional experts in financial accountability and the provision of contracted residential services were also consulted.

Agencies and individuals that provided evidence to this investigation, including Alex's family, were also given an opportunity to review the draft report and provide feedback on the facts presented.

Chronology

Birth to Age Seven: Parental Mental Health Concerns and Judicial Intervention

Alex was a Métis child, born in Gatineau, Que., on May 23, 1997. Alex's father has Cree heritage and was connected with the Temiskaming Métis Community Council in Ontario. His mother was adopted and, while her heritage is unclear, her family believes she may be Indigenous. Her adoptive mother had an Algonquin grandparent. Both of Alex's parents had extensive histories of mental illness and they began an on-again, off-again relationship after they met in hospital nine years before Alex's birth.



The family quickly came to the attention of child welfare authorities. Alex was apprehended by Québec's Child Protection Services when he was two-months-old after his mother began experiencing postpartum psychosis.¹ He was placed in the custody of his father four months later, but his mother continued to have periodic visits with Alex. These visits were terminated when she was hospitalized long-term due to paranoid psychosis, the beginning of a pattern of loss and abandonment that would follow Alex for the rest of his life. Alex's father retained custody from September 1997 until January 2002. During this time, Alex and his father moved frequently between different small towns in Québec and Ontario.

Several child protection incidents occurred during this period. Investigations into these incidents by child welfare authorities resulted in findings that Alex's father was an "adequate" caregiver. Ontario Children's Aid Societies (CAS) reports indicate that the family's frequent moves were intended, at least in part, to avoid the scrutiny of various child welfare authorities. Concerns documented during this time included Alex having no lunch at school, his father's disruptive behaviour in Alex's classroom, and a general decline in his father's mental health associated with increasing substance use. In January 2002, at the age of 4½, Alex was taken into care after his father was arrested and charged with assaulting Alex during an event at a local hockey arena in a small Ontario town. While accounts of the incident vary, multiple sources confirm that Alex's father kicked his son in the back, causing Alex to fall down a flight of stairs. His father ultimately pled guilty to the assault charges and Alex remained in care in Ontario on a six-month wardship order.

1 Postpartum psychosis is relatively rare and occurs in about one to two per cent of births when the mother suddenly experiences many or all of these symptoms: delusions or strange beliefs, hallucinations, significant irritability, hyperactivity, inability to sleep or lack of need for sleep, paranoia or suspiciousness, rapid mood swings and difficulty communicating.

At about the same time, Alex's father was hospitalized after experiencing psychotic symptoms. As a result of this hospitalization, in February 2003, an Ontario Superior Court ordered that a parental capacity assessment be conducted on both of Alex's parents. The court-ordered report concluded that Alex should be made a permanent ward with neither of his parents being allowed access.

The impact of Alex's chaotic early life was detailed in the psychologist's report, which described the five-year-old as "*emotionally undeveloped*", "*anxious*", and showing signs of depression. At the time, according to the report, Alex was exhibiting "*behaviours, which are typical of children who are withdrawn, aggressive and who have thought problems.*" Alex was described as "*quite delayed [academically], even though his intellectual potential appear[s] to be at least average.*" Further, the report noted that Alex displayed inappropriate sexualized behaviour toward other children which, in the writer's opinion, "*strongly*" suggested that Alex had been the victim of some form of sexual abuse or interference. This evidence of sexual abuse was never followed up or investigated any further.

Several months after the assessment of Alex was ordered, his father reconnected by telephone with his former long-term partner, a correctional officer who was living in British Columbia with her two sons. While court proceedings in Ontario to permanently remove Alex from his parents were still underway, Alex's father moved to B.C. and married his former long-term partner on the same day he arrived in the province. Due to this sudden change in the father's circumstances, the Ontario court ordered a fresh parental capacity assessment to be undertaken in B.C.

Supervision Order

A Supervision Order (SO) is a court-ordered plan designed to keep a child or children safe. The plan includes terms and conditions and gives the ministry the authority to monitor the child or children's progress and needs. In Alex's case, one term of his SO was that his stepmother had to be involved in his care and that any change in marital status was to be reported to the Ontario child welfare authorities.*

* Section 7.4 *Interprovincial Child Protection Referrals* and Section 7.5 *Repatriation Services of the Provincial/Territorial Protocol on Children and Families Between Provinces and Territories* set out the provisions for which a child under a Supervision Order from Ontario and being enforced in B.C. could be repatriated back to the home province due to terms of the Supervision Order being violated in B.C.

The B.C. assessment was received in July 2004 by the Ontario court. It recommended that Alex's father and his new wife be given the opportunity to parent Alex. The B.C. report concluded that Alex's new stepmother was a stable and dependable person, and that her ability to provide structure and order would be beneficial to Alex. The assessment also attributed the father's mental breakdown to the stress of having his son taken away from him.

As a result of the findings in the B.C. report, the Ontario court ordered that Alex be returned to his father and new stepmother by August 2004. The judge's decision made it clear that significant concerns still remained and placed stringent conditions on the placement. A six-month Supervision Order (SO) commenced on Aug. 15, 2004, with responsibility for Alex's case transferred to MCFD in B.C.

Age Seven to Nine: Move to B.C., Removal from Family and Nine Foster Placements

Alex was now seven-years-old, living in a new province with his father – with whom he had not lived for more than two years – as well as his father’s new partner. He was also about to start attending school.

Intake/Incident

When an individual calls MCFD with a report about a child or youth, a social worker gathers as much pertinent information from the caller as possible. Reports of suspected child abuse and neglect are assessed on a case-by-case basis and, depending on the circumstances, will warrant different types of responses. Social workers choose the response that is least disruptive to the child or youth, and will keep the child or youth safe. After the assessment process is complete, if the child or youth is not at immediate risk of harm, the social worker may:

- Offer the family support services;
- Refer the child, youth and/or family to a community agency; or
- Take no further action, if no further action is needed.

<http://www2.gov.bc.ca/gov/content/safety/public-safety/protecting-children/reporting-child-abuse>

As per the terms of the Ontario SO, MCFD was in regular contact with the family. On Sept. 29, 2004, within two months of Alex returning to his father’s care, MCFD received its first report on the family. This was a report from police who had attended the family’s apartment after a noise complaint by a neighbour. Police found that there had been a verbal dispute between the father and stepmother, but that no physical violence had occurred. MCFD’s intake file noted that Alex’s stepmother was finding it difficult to cope with Alex’s behaviour and that his father’s mental health was declining following his decision to stop taking prescribed medication. In response to this incident, MCFD arranged for counselling for the parents through a local community agency.

MCFD received two more calls regarding the family during the next three months. On Nov. 9, 2004, the child care worker from

Alex’s school called the ministry to report that Alex was left unsupervised during out-of-school hours, and that several dangerous situations had resulted. The caller described two incidents when the adult uncle of another student had physically assaulted Alex after Alex and the man’s nephew had been fighting. The caller told MCFD that the school had alerted Alex’s father about these incidents, but he appeared unconcerned. As a result of this call, a risk assessment was completed and an investigation by MCFD commenced. During the investigation, MCFD spoke to Alex’s stepmother, who said that she was just beginning a parental leave which would allow her to provide more supervision to Alex. Satisfied that this, along with the counselling services already in place, would address the risks to Alex, MCFD closed the intake.

Less than a month later, on Dec. 2, the ministry began a third intake on the family when Alex’s father attended an MCFD office and complained that he was being physically and emotionally abused by his wife and that she was physically violent with both him and Alex. During the subsequent investigation, Alex’s stepmother confirmed to social workers that she was often frustrated with both her husband and Alex, had been physically aggressive with Alex’s father and had herself grabbed Alex on one occasion.

Voluntary Care Agreement (VCA)

A Voluntary Care Agreement is a short-term agreement with MCFD or a DAA to cover a period of time when a child or youth's parents are unable to provide care. The parent(s) retain custody of their child under this agreement. This means that parents generally hold decision-making rights as well as access to their child while giving some responsibilities to the Director. The overall goal of a VCA is to return the child to the family home.

Alex corroborated her version of these events. These incidents, combined with MCFD's concerns about the father's mental health, resulted in the ministry offering a Voluntary Care Agreement to Alex's father and stepmother. They consented to the temporary placement of Alex in foster care on Dec. 3, 2004.

Between that day, when Alex first came into care under the VCA, and May 2006, he was moved between nine different foster homes. There was no planning for any of these moves between foster placements, which included his first hotel stay at the age of eight – a two-week stint in a Best Western

Hotel with a revolving door of child care workers looking after him. Often Alex was told, without any advance notice, that he was moving to a new placement. Case notes document the reasons for his many moves as being related to his “*challenging*” behaviours, which included destruction of his personal belongings, angry outbursts and aggression directed at other children. Ironically, case notes prepared in January 2005 contained the observation that: “*Behavioural difficulties tend to be reduced with a stable living environment.*” However, when interviewed about the rationale for Alex's high number of placements, social workers said that permanency for Alex was not a priority because his VCA status meant that he would eventually be returned to his father and stepmother.

After Alex had spent nine months in foster care, his father attempted to have him returned to the family by withdrawing his consent to the VCA. MCFD responded by removing Alex from his father and stepmother's care on the basis that the original child-protection concerns remained unaddressed. In particular, social workers noted a further decline in the father's mental health, and the risk to Alex posed by his father's unwillingness to seek psychiatric treatment. Despite the family volatility, social workers consistently documented that Alex's stepmother was a stable, positive and loving person in his life but they felt that as long as she was involved with Alex's father, Alex was at risk of harm.

Social workers often told Alex that it was his behaviours that caused him to have to move so frequently rather than perceiving his actions as the predictable result of his repeated traumatization. As a result of Alex's “*challenging behaviours,*”

CYMH and ACYMH

MCFD offers a range of mental health services for children, youth and their families, including assessment, treatment, consultation and education through its Child and Youth Mental Health (CYMH) offices. These services are provided based on the urgency of need with acute mental health conditions and suicidal behaviours having the highest priority. Aboriginal Child and Youth Mental Health is a component of the Child and Youth Mental Health service stream focused on providing culturally appropriate services to meet the unique needs of Indigenous children and youth. Alex received service from neither of these streams.

in May 2006, Alex's social worker put in a referral for him to receive counselling from Child and Youth Mental Health Services (CYMH). This would be the first of five CYMH referrals that were made for Alex, none of which ever resulted in him receiving CYMH services. In this particular case, the referral was rejected because Alex had moved out of the service area in which his CYMH referral was made.

After finding out that Alex had been brought into care in B.C., Alex's biological mother, who was still living in Québec, retained a lawyer and requested that MCFD consider giving her custody of Alex. In a letter dated July 31, 2006, MCFD requested that the Ontario Children's Aid Society undertake a home study on Alex's mother to determine whether she would be an appropriate caregiver for him. Five months later, MCFD received the report, which concluded that Alex's mother would not be able to care for

Alex due to her fragile mental health and unstable living situation.

Family Care Homes

Five types of Family Care Homes exist in B.C. – restricted, regular, and three levels of specialized family care homes:

Restricted homes care for children related to or known to the caregivers. The agreement with MCFD is specifically for the children or youth and ends when they leave the home or are no longer in care.

Regular homes care for children who are not usually known to the foster parents.

Specialized homes care for children with *"moderately to extremely challenging behavioural/emotional issues or significant developmental delay"* and are categorized by MCFD as level 1, 2 or 3. The maximum number of children per specialized family care home is restricted to: six children for level 1, including the caregiver's own children; three children for level 2; and two children for level 3. Exceptions to the rules are considered and made based on specific criteria including the placement of sibling groups and previous residence in the home with consideration to the ages of children in the home.

Basic payment for each child in the home in the form of a per-diem is intended to cover all the costs of the children's everyday needs. Specialized homes receive extra payment that recognizes greater responsibility and expectations and includes money for respite. For a comprehensive explanation of the types of foster homes and the basic allowance paid to these homes please see:

<http://www2.gov.bc.ca/gov/content/family-social-supports/fostering/for-current-foster-parents/foster-care-payment>

Age Nine to 10: Return to Stepmother, Québec Family Ties, and Placement in Assessment Centre

In mid-2006, MCFD began to consider placing Alex with his stepmother. When Alex arrived in B.C., the earliest documentation shows that his stepmother wanted to adopt him. Additionally, since his removal, Alex's stepmother had made it clear to MCFD on numerous occasions that she was willing and able to take Alex into her home as long as sufficient supports were provided. In advocating to have Alex placed in her care, his stepmother told MCFD that she would be separating from Alex's father and would care for Alex on her own. From the time of his initial removal, Alex had expressed a desire to return to live with his stepmother and file notes document her regular visits with him. Alex also retained a strong attachment to his two stepbrothers.

Although both Alex and his stepmother clearly wanted Alex returned to her care, that didn't happen. Instead, in April 2006, he was placed in a level 3 foster home after spending two weeks living in a hotel. This specialized family care home included four other children in care

and one biological child. At the time Alex was placed in this home, the foster care payment for the four other children in care totalled \$8,604.91 per month. The funding for Alex's care was an additional \$1,801.70 per month. In addition, the caregivers were funded for 35 hours of child care support per week at a cost of \$2,800 per month for Alex. Total cost of Alex's placement with these caregivers was more than \$4,600 per month.

Despite the level of financial support from the ministry, part-way through the month of August, Alex's foster mother told MCFD that he could not remain in her home. With no back-up plan in place, social workers arranged at the last minute for Alex to be placed with his stepmother under a restricted foster parent agreement. Under this arrangement, Alex's stepmother received only \$701.55 in monthly support from MCFD, and she didn't get the 35 hours per week of child care support that the foster home had received.

Alex was moved to his stepmother's home on Aug. 31, 2006, just prior to the start of the school year. However, unbeknownst to either Alex's stepmother or his social worker, the school required a plan for his gradual re-entry because of his support needs. The inability of Alex to attend school during the day until a plan was in place complicated the placement with his stepmother, as she was working full-time and could not stay home during the day to look after Alex. When she attempted to arrange daycare for Alex through his social workers, she was told that because her home study hadn't been completed and a file had not been opened for her restricted placement, her daycare costs could not be funded.

Case notes show that the delay in processing the home study was due to ongoing staffing shortages at the local MCFD office. Denied any immediate financial support, Alex's stepmother scrambled to find a daycare that was available part-time and was capable of managing Alex's behaviours. After a couple of weeks of patchwork daycare she arranged by staying home from work or by enlisting family members, she found one care provider who agreed to take Alex and wait for the ministry to sort out payment.

After several delays, funding was finally approved for daycare services. Alex's social worker made contact with his school to arrange a gradual entry program that included Alex attending school for two hours, twice a week at the beginning and returning to full-time classes within a month. At the same time, Alex's stepmother was advocating for supports she had been promised by MCFD. She requested that MCFD provide her with a respite caregiver, a support that had been provided to Alex's previous foster mother.

Correspondence from this period indicates that MCFD supervisors saw Alex's stepmother as unreasonably demanding. The resource team lead emailed Alex's social worker: *"I can't guarantee supports . . . she needs to understand and know that we can only request from time to time and see what approvals we receive. I would still support moving the child and her having access, visits etc. If in the future she does not get what she wants then she again will be upset . . . do we have options for placement?"*

In addition to bureaucratic obstacles at MCFD, Alex's stepmother was also dealing with her former spouse. Despite their separation, Alex's father continually showed up at her apartment demanding to be let in. On one occasion, Alex's stepmother let the father

Protection Order

A protection order is a court order issued under the *Family Law Act* which usually requires that there be no direct or indirect contact between the person who is the subject of the order and his or her partner and or children. Disobeying an order is a criminal offence and can result in charges, which can result in serious consequences such as a fine, probation or jail time.

in to prevent him from escalating his disruptive behaviour in the common area of her apartment building. This led to a psychotic episode, with Alex's father screaming and yelling at both her and Alex and accusing them of wildly abusive acts. As a result of this incident and subsequent similar incidents, Alex's stepmother sought and was granted a protection order against Alex's father in October 2006.

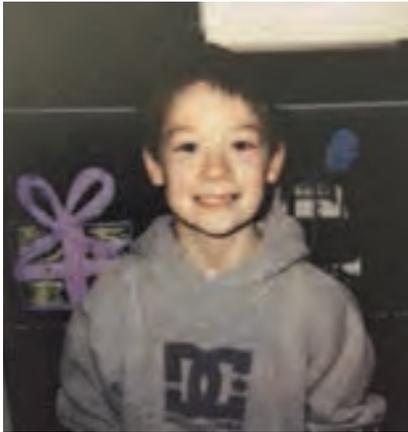
Alex's stepmother continued to request respite support from MCFD but, due to severe backlogs in the processing of resource files and the inability of resource social workers to complete the home study

in a timely fashion, it was months before she was told she would be able to get respite. By this time, the stepmother was pleading with social workers, saying that she was at the end of her rope. In an email to Alex's social worker, his stepmother wrote: *"Are you any closer to getting me a respite care home? Alex is a lot to manage. When I took him on you did offer me respite, once a month, at least until he settled. He is doing better in my home than he has anywhere else BUT that does not make me a machine. I need some down time, some time with my adult friends, some time where I can relax and be refreshed. He is too much on an ongoing basis. I am going crazy!"*

In November 2006, Alex's stepmother wrote a letter to her MCFD social workers giving notice that she wouldn't be able to look after Alex any longer. Six days later, she rescinded that notice and again sought respite care support.

Before this issue could be resolved, on Nov. 28, 2006, social workers received a report from Alex's school principal that Alex had scratch marks on his nose and that he had told another child at school that his stepmother had hit him. Alex said that his father had visited during the weekend and that his parents had been fighting. Due to workload issues, this report was not followed up by MCFD until early December when social workers determined that, although the injury had been an accident, the stepmother had contravened the terms of the peace bond by allowing Alex's father to visit his son. As a result of this unsanctioned access, and despite the deep connection Alex had to his stepmother, social workers made the decision to remove nine-year-old Alex from her care.

Social workers decided to physically remove Alex while he was at school rather than from his home. On the day scheduled for the removal, after multiple unsuccessful attempts to get him into his social worker's car, police were called to assist, and ended up having to forcibly remove Alex from the school grounds. Because no other foster placements were available for Alex, social workers temporarily placed him in a resource outside his city and school district. This resource was a short-term emergency placement intended to help high-needs children such as Alex stabilize and then move on to more appropriate long-term placements.



Alex was placed there on Dec. 8, 2006. Although the intent was short-term stabilization, Alex ended up spending five months in this resource. The assessment and stabilization home provided care for up to six children between the ages of six and 12 in a “home-like setting”. The program was staffed around the clock. From the time he moved out of this assessment and stabilization home, right up until the time of his death, Alex consistently complained to social workers, family members and friends about experiencing serious maltreatment while at this placement. In particular, Alex complained that the staff treated him “like a little shit” and that he was locked in his room for hours at a time and was forced to urinate into containers because he was not permitted access to the washroom.

Five years later, in February 2012, Alex described his five-month stay in this home to a psychologist who was conducting an assessment on him. The psychologist told investigators that Alex described this supposedly home-like residence as “highly institutionalized”. The psychologist said:

“This placement apparently locked misbehaving residents within their rooms [with locks on the outside of doors]. They would shut off power to the bedroom once it reached the youth’s bedtime. Alex reported that he would ‘get locked’ about once every couple days and this would occur for periods of four to six hours [not including the period after his bedtime]. He stated that he would kick, swear, yell and damage property while confined in the room. He also reported that there was an older youth who bullied and physically assaulted all of the other residents and that ‘I got beat up by [the older youth] all the time . . . one time he hit me in the face right in front of staff and they didn’t do anything.’”

Limited documentation exists describing Alex’s time at this facility, but interviews with current and former staff of the centre and a review of the interim reports and progress logs prepared by staff show that Alex struggled to adjust there and never fully stabilized. In a report prepared on Alex’s behaviours about a month after his arrival, staff wrote that Alex was prone to tantrums and had to be moved to the “safe room” on a temporary basis. One such tantrum was documented to have lasted for 14 hours, but staff response to Alex’s tantrum in this case was not documented, nor did any staff recall the incident. When asked about the safe room, some staff said that it did not exist, while others said that it was a room with thicker glass and more durable furniture which would be less likely to incur damage if occupied by a violent or destructive child. RCY investigators toured the facility and observed the safe rooms, which were hardier versions of the regular bedrooms in the home. While workers stated that children were never locked in their rooms, staff and social workers did admit that children at the centre would be asked to stay in their rooms, and that sometimes the children’s room doors would be closed with the children inside and the staff standing outside the door.

While Alex was in residence at the centre, he did not attend school because of the expectation that he would be re-enrolled once a permanent placement for him had been found. Instead of school, a tutor was provided for Alex for only two hours every

week. In the evenings, activities outside of the home were offered but children had to earn the privilege of attending these activities by meeting the goals that workers set for them and by following the house rules. Alex participated when he met the goals and was described by staff as enjoying the physical activities such as swimming, hiking and nature walks.

Records show, and staff members recall, that Alex's stepmother visited him every weekend and would take him out into the community on those visits. Alex and his stepmother were reported to be affectionate with each other and staff noticed that he was often upbeat and happy after a visit with her. In fact, investigators were told that Alex referred to his stepmother as "Mom" and, for all intents and purposes, their relationship was just that – a mother and her boy, closely connected and excited to return to one another. Progress notes in Alex's file indicate that he frequently requested to return home to live with his stepmother, and staff stated that social workers led them to believe that the placement plan for Alex was indeed to return him to her care.

However, MCFD social workers confirmed to RCY investigators that, after he was removed from his stepmother's home, they never considered returning Alex to her care. In fact, while he was a resident at the assessment and stabilization centre, planning was underway to place Alex in another level 3 foster home that his social workers believed had the capacity to support Alex appropriately.

Alex finished his time at the assessment and stabilization centre on May 11, 2007, and was told that he would not be returning to his stepmother's home. Instead, he was moved to another level 3 foster home, where he resided for 10 months. This was his 15th placement since coming into care less than 2½ years earlier, a staggering degree of instability in the life of such a young boy.

Cultural Connection and a Visit with Extended Family

When Alex first arrived in B.C., MCFD documentation identified him as Aboriginal and his 'band' as Métis Community/Métis Family Services.

MCFD documentation on Alex's first Comprehensive Plan of Care (CPOC, see text box) in November 2005 stated that *"Alex knows he is 'Indian' (sic) and would like to take part in . . . his cultural identity."* Later, the CPOC noted that he *"does not have a positive role model from the same culture or religion as himself."* Nor did he *"have a contact person from his cultural community to maintain connections."* Under the *"needs arising from assessment"* heading, the social worker noted that she needed to explore Alex's wishes around how he wanted to take part in his heritage. But there is no evidence that this occurred during the 18 months prior to Alex's ROOTS referral.

In May 2007, a worker at the ROOTS program (see textbox) reviewed Alex's file and reached out to his family in Eastern Canada to determine his Métis heritage and to assess whether any of his family members would be interested in connecting with him. Over a number of months, the worker corresponded with Alex's mother and maternal aunt. Alex's father refused to speak with the worker, and her calls and letters to the father's extended family went unanswered.

Comprehensive Plan of Care

A CPOC is an assessment conducted by the child's social worker for the purpose of getting the child's views and involvement in planning for his or her care, involving the family and cultural community in his or her care and making certain that an Indigenous child has Indigenous community involvement. The assessment tool includes the following components – placement, health care, identity, culture and religion, family and social relationships, social presentation, emotional and behavioural development, and self-care skills. MCFD policy states that CPOCs are to be reviewed every six months and redone in full annually.*

* As of June 2013, the CPOC is now known as a Care Plan.

The worker documented her difficulty in tracing Alex's Métis background, which she said was largely due to his father's refusal to speak with her and because anecdotal reporting by other family members was conflicted and unverified.

ROOTS involvement with Alex ended in December 2007 with the worker concluding, consistent with the *CFCS Act*, that Alex would be identified as Métis on the basis of his father's self-identification. In spite of the lack of support for appropriate cultural planning over the course of Alex's time in care in B.C., MCFD, his schools and the DAA which eventually took his file considered him Métis.

One of the most meaningful pieces of ROOTS involvement with Alex's file was that the worker was able to make a strong connection with Alex's aunt, who resided in Québec, and who had previously shown a strong interest in Alex's well-being. This aunt had been interested in caring for Alex when he was first removed from his birth parents. However, during this period,

Alex's father was making death threats against the aunt. As a result of these threats and the subsequent police report filed by Alex's aunt against the father, the already strained relationship between Alex's father and aunt resulted in all contact between Alex and his aunt being lost. Soon after this incident happened, the father took Alex and moved to the other side of Ontario. Not long after, Alex's father was given sole custody of him and they moved to B.C.

From almost the first time she was contacted by the ROOTS worker in 2007, Alex's aunt showed interest in taking Alex into her home and looking after him. Alex's aunt was well connected to his mother and had assisted her over the years with her day-to-day living needs and in her transition into and out of various psychiatric hospitals. Further, the aunt had been actively involved in caring for Alex's half-brother and had been instrumental in getting the half-brother removed from his mother's care and placed with his biological father after his mother's mental health began to decline. Alex's aunt and her husband both had stable careers, and a large lakefront property on which they lived with their own son.

As soon as the ROOTS worker made contact with her, Alex's aunt asked to be kept informed of his status and any psychological or behavioural assessments he underwent. She told the ROOTS worker that Alex had a lot of family in Ontario and Québec and said it would be beneficial for him to move back to that part of the country. After she was told about Alex's behavioural challenges and multiple placements, she advised the worker that she would be looking into support services in her area that might be able to assist if Alex was to move into her care. She also arranged for Alex to come to her Québec home for a one-week visit in August 2007. During this visit, she re-introduced

ROOTS – A Child's ROOTS are Forever

The ROOTS program is an MCFD initiative developed in response to the disproportionate number of Indigenous children in care with the aim to reduce this number. The purpose of ROOTS work is to respect and preserve children's Aboriginal identity and ties to their family, community and heritage. The ROOTS workers or practitioners explore alternatives to foster care by considering the child's family, extended family and community as spaces of reunification. Culturally specific plans are developed for each child that will preserve his or her culture. ROOTS workers cannot make guardianship decisions but rather present their family findings and make recommendations.

Since Alex's involvement, the ROOTS program has changed. Workers are now referred to as Permanency Cultural Coordinators. According to the MCFD website, there are three contracted positions allocated for the province and their areas of responsibility are divided up as follows – the Interior and the North, the Lower Mainland and Vancouver Island and Out of Province Referrals. Their responsibilities include: completing cultural plans, providing assistance with contacting First Nations communities and assisting in exceptions work with regard to adoptions. The Representative could find no information regarding the funding levels for this work or confirmation that these are permanent base-funded positions.

Alex to his mother, and to his half-brother, who had expressed interest in getting to know Alex and exchanging letters and phone calls with him after he returned to B.C.

Upon Alex's return to B.C., his aunt expressed her desire to have him live with her. She spoke with the ROOTS worker about this and told the worker that her only concern was allowing Alex contact with his father. She told the worker that Alex's father was threatening and dangerous and she wanted to protect her family.

In her summary notes written when she closed the ROOTS file, the ROOTS worker indicated that Alex's aunt and social worker "*have remained connected so that they can continue to explore a possible placement with [Alex's aunt] in Québec*". However, contact between Alex's social worker and his aunt declined sharply after the ROOTS worker stopped her involvement. The only documentation on file after that was a brief email correspondence between Alex's aunt and his social worker in September in which the aunt requested that Alex's mother be funded to come to B.C. to visit with Alex. This visit was discouraged by Alex's social worker at the time due to a lack of mental health supports or accommodations for Alex's mother, and the visit never took place.

In February 2008, Alex asked to return to Québec to visit with his mother and aunt, and several emails went back and forth between resource social workers and team leaders regarding planning for

this visit, and about the potential of Alex going to live in Québec permanently. Alex's social worker was assigned the task of looking into this permanency option, but neither she nor her team leader appears to have followed up regarding that possibility. When asked about this by RCY investigators, the team leader stated that the office at the time was dealing with high caseloads which resulted in permanency planning being given a very low priority.

In the view of Alex's aunt, the ministry refused to consider her as a placement because of her unwillingness to engage with his father. Social workers responsible for Alex's planning agreed that this likely would have been a factor in their decision-making. Ironically, after Alex returned from his visit to Québec, he had little to no contact with his father during the remainder of his life in B.C., largely due to social workers wanting him to avoid contact that they believed would be disturbing to Alex.

Age 10 to 17: Mental Health Assessments, Breakdown of Final Foster Placement, Long-term Placement at Contracted Resource, and Transfer of File to DAA

In December 2007, when Alex was 10-years-old, he was assessed by a psychiatrist at BC Children's Hospital who ended up providing psychiatric services to Alex until January 2013. By December 2007, a second referral to CYMH had been attempted by his social worker to connect Alex with counselling. However, social workers told RCY investigators that, because of his frequent moves between different areas and because his case was not rated as a high priority in terms of severity, Alex had again not received any CYMH services.

After reviewing Alex's medical and psychological history and after discussion with his social worker and current foster parent, the psychiatrist noted that Alex was a child with "*significant anxiety and oppositional behaviour*" which she attributed to an unstable upbringing, exposure to abuse and "*chaotic home situations*". At the conclusion of her assessment, the psychiatrist recommended psychotherapy and the attachment of Alex to a stable caseworker and counsellor. She also recommended a medication regime involving a trial of a low dose of anti-psychotic medication. She emphasized that, because of his attachment issues, MCFD should do its utmost to create stability in Alex's current foster placement for the sake of his "*mental health and well-being*".

Unfortunately, less than two months later, Alex's specialized foster placement was beginning to break down. In February 2008, Alex's foster parent wrote to his social worker complaining about the lack of resources and respite offered by MCFD to support the placement, and the lack of effort by MCFD to facilitate visits with Alex's family. By March 2008, Alex himself expressed a desire to be moved from the placement as he felt he was being treated unfairly by his foster parents and not given the same level of care as the other children in the home.

Staffed Residential Care Homes

Staffed residential care homes, sometimes referred to as group homes, are quite different than foster placements. They are generally rental homes capable of accommodating a small number of children in which children are looked after by a rotating roster of staff members called respite caregivers. These staff are paid a per-diem for 12- or 24-hour shifts supervising the children in the home. A primary caregiver oversees and contracts with the respite caregivers and is the primary liaison with the child or youth's social workers.

Many of these homes operate on a "contractor" business model in which the agency has no employees, but contracts out casework to individual caregivers.

After being removed from the home on March 14, 2008, 10-year-old Alex spent the next 18 days at his second hotel stay – this one a Ramada Inn in the Lower Mainland.

Initial Placement with the Residential Agency

Psychiatric Services and Alex

Alex was a patient of a child psychiatrist in Vancouver from December 2007 until January 2013, when his case was transferred to his Fraser Valley community for ongoing psychiatric management because the Vancouver doctor could no longer provide services. Of note is the fact that the Vancouver doctor was clear that she did not provide counselling or therapy and that the Fraser Valley psychiatrist was clear that children's psychiatry was not an area of expertise. The Fraser Valley psychiatrist described feeling compelled to take Alex as a patient to manage his medication as there wasn't another practitioner in the area who could do this.

In April 2008, as Alex was approaching his 11th birthday, he was placed in the care of a for-profit residential agency that contracted with MCFD to provide staffed residential care homes for vulnerable, high-needs children and youth. On its website, the agency described its clientele in the following terms: *"Most of the individuals within these residences have multiple diagnoses, a history of violent behaviour, were previously resistant to treatment, often have been heavily involved with substance abuse, and have experienced multiple placement breakdowns."*

Alex's MCFD social worker felt that, because he was placed at a contracted agency, her role had changed and she would be able to take a more *"hands off"* approach with Alex's guardianship.

RCY investigators were informed by several workers that this view was typical of the practice approach at the time to working with contracted agencies. Said one social worker: *"We had, like a hands off approach to the contractors . . . They're a business . . . We buy the service and we need to ensure that they are providing the service, but we don't hand hold them and we don't provide support to their staff. They provide support to their staff because we pay them premium dollars for that support."*

In May 2008, Alex received another psychological assessment to determine whether he had fetal alcohol spectrum disorder (FASD). The results of Alex's FASD assessment revealed that he did not meet the diagnostic criteria despite reports from the Children's Aid Society in Ontario that his mother had consumed substances while pregnant. However, the assessment did state that Alex had *"neurobehavioural disorder"*, which was attributed to prenatal substance use, genetic loading of mental health issues, physical abuse, multiple home placements and neglect. Placement stability and close mental health monitoring and counselling were recommended.

Resource and Guardianship Social Workers

Social workers often function as either resource or guardianship workers. Resource social workers work to recruit and maintain residential placements where children live while in care. Guardianship social workers are the legal guardians of children in care and function as prudent parents in all aspects of the child's care.

During Alex's placement with the agency, various social workers and team leaders described his physical and emotional state as *"stable"*. When asked by RCY investigators what this meant, social workers defined this as the continuing ability of the caregiver to look after him, the absence of incident reports, progress at school and the avoidance of criminal activity.

During 2008 and 2009, Alex's file was transferred between two different MCFD social workers. Both felt that Alex was stable enough that he did not demand too much of their attention. In June 2008, Alex was

again referred to CYMH. This was his third such referral. Once again, the CYMH referral was rejected and the reason was recorded as *“family found services elsewhere, they are going to see a psychiatrist”* despite the fact that the Vancouver psychiatrist he was seeing did not provide counselling or therapy but rather only medication management. The lack of active involvement by the social workers led to the caregiver becoming more intimately involved in the implementation, or lack of implementation, of important interventions for Alex including the determination that counselling was to be substituted by visits to the psychiatrist.

In January 2009, a fourth referral was made to CYMH by Alex’s psychiatrist because Alex was still not connected with mental health services. That referral was rejected in August 2009. File notes indicate that CYMH wanted to provide in-house group training to the resource where Alex lived to help staff deal with his angry outbursts, but Alex’s primary caregiver chose not to participate.



In June 2009, Alex’s Grade 6 report card indicated that he was doing well at school and that he no longer required intensive behavioural supports as detailed on his Individual Education Plan (IEP). Despite this positive change in school and what social workers described as *“stability”*,

long-term planning for Alex remained absent. Although the initial intention may have been to treat this staffed residential resource as a short-term placement while his social workers looked for permanency, his social worker told RCY investigators: *“I think it kind of got dropped and it got too busy.”*

Several years earlier, social workers had also discontinued Alex’s visits with his father due to the father’s inappropriate behaviour during these visits. Although Alex’s stepmother visited regularly, she told RCY investigators that she had significant difficulty accessing Alex. She told investigators that on more than one occasion she was turned away and advised that Alex was being denied the visit due to his bad behaviour.

In December 2009, Alex’s primary caregiver at the agency contacted his social worker to say that Alex’s stepbrother and stepsister-in-law were considering having him live with them. Alex’s caregiver warned the social worker against this because, in his view, Alex had not had sufficient contact with them. The caregiver also believed that Alex’s stepmother was pressuring the couple to take him in and, if Alex were to be moved, his family would encourage contact with his father. No action on this potential opportunity for permanency with family was ever taken.

Transfer of Alex's File to the Delegated Aboriginal Agency

Alex was placed with the contracted agency for a total of seven years. During this time period, he lived in three different homes in his Fraser Valley community. While his primary caregiver remained the same throughout his time with the contracted agency,

Indigenous Child Welfare in B.C.

Through delegation agreements, the Provincial Director of Child Welfare gives authority to DAAs to administer all or parts of the *CFCS Act*. Delegated levels of authority are negotiated with First Nations bands, with the highest level of authority being the removal of children. According to MCFD, of the approximately 198 First Nations bands in B.C., 148 are represented by DAAs that *"have, or are actively planning toward delegation agreements to manage their own child and family services."*

The idea is to return responsibilities for the care, support and protection of Indigenous children to their communities.

When a child or family is Indigenous, the office that provides services will be a DAA (if one exists) or an MCFD Aboriginal Services team.

Alex was also being cared for by 26 rotating respite staff. For the first two years of his time with the agency, Alex's file was held by MCFD Aboriginal Services. On Feb. 16, 2010, Alex's file was transferred to the DAA when resource workers came to the conclusion that this was more appropriate as his home was located in Abbotsford.

On Feb. 16, 2010, a brief transfer meeting took place between Alex's MCFD social worker and his new DAA social worker. His DAA social worker was new on the job when she got Alex's file. This was her first transfer meeting.

During the 2½ years that this DAA social worker carried Alex's file, she paid little attention to his long-term care plan and felt that the best plan for him was to stay in the resource until he aged out of care at 19. Further, she reported that adoption was not an option at the agency and that a family home placement was impossible because the DAA had so few homes available. When RCY investigators questioned the

DAA staff about adoption, investigators were told that the policy had changed over time. MCFD authority to undertake adoptions was at one time not given to the DAA but while Alex was in care, adoption was technically possible. Senior staff described the process of adoption as complex but agreed the concept was a good one. One staff person commented, *"Where there is good reconciliation that occurs with all parties, it can be a beautiful thing. We fully support it."* Interviews with front-line social workers involved in Alex's care consistently revealed that their understanding was that adoption was not an option for Alex. It is apparent that being placed in a forever family home through adoption was not ever a serious consideration for Alex, either by MCFD or the DAA.

In September 2010, Alex's social worker instructed his primary caregiver to complete a clothing inventory after Alex, now 13, complained to her that he did not have adequate clothing. The caregiver responded several days later by email stating that Alex had the following articles of clothing: three pairs of socks; three pairs of underwear; one long-sleeve hoody; two pairs of pants; five t-shirts; some assorted winter outdoor wear; and one pair of shorts for gym class. The caregiver's explanation for why Alex had so little clothing was that Alex had *"expensive taste and does not stick to a budget"* and that he thought Alex had been selling his clothing, or had his clothing stolen.

After Alex exhibited some extremely troubling behaviour in June 2011, a fifth and final referral was made to CYMH but, once again, it was rejected more than a year later. File notes indicate *"child or youth refused service because of AWOL"* as the reason.

RCY investigators also learned about an undocumented incident in which Alex was stabbed in the neck. Alex had returned to his care home one night after being out with

Referral Documents

Referral documents, often called "ref docs", describe the combination of information that is documented about a child and his or her family from the initial contact with MCFD in order to help find a placement and/or provide services for the child and/or family. Typically, the information includes details of health, family and behavioural histories. This can include descriptions of problem behaviours which may or may not be founded, assessments, diagnoses and other relevant information. Often a summary of all the child's problematic behaviours is included and, even if behaviours change or inaccuracies are recorded, this information follows the child as he or she moves through services. Several workers told RCY investigators that behaviours described in Alex's referral documents had ceased or that they did not see them. Yet, the information contained in these documents was used as a reason to keep him from being placed in a family setting and characterizing him as a "problem".

friends and had a towel wrapped around his neck to control the bleeding. The circumstances of this event remain unclear, and accounts vary as to whether Alex was taken to hospital for his injuries. Multiple sources confirm that at least some staff at his group home were aware of the incident, but no incident report was ever completed, nor does it appear that Alex's social worker was ever informed.

Investigators also learned of another incident in which Alex and the other young man in his home had guns drawn on them by police in downtown Abbotsford when they were with a third youth who was in possession of a handgun. RCY investigators could find no record of this incident being reported.

In February 2012, Alex received a psychiatric assessment. The assessment characterized Alex as *"having ongoing aggressive and volatile behaviour to the point of essentially being unmanageable."* Although Alex had average intellectual abilities with strong perceptual abilities, the assessment said developing a trusting relationship in a therapeutic context would be a significant challenge for him.

The psychiatrist also noted that Alex's relationship with his stepmother was characterized by an underlying love and caring and that re-establishing and rebuilding it *"is*

likely the best long-term conduit to improve Alex's ability to form and maintain relationships . . . manage his emotions and stressors, and to ultimately build a prosocial life and future."

The psychiatrist concluded that *"environmental factors"* had an extremely *"potent effect"* on Alex's behaviours.

On May 27, 2012, Alex was involved in an accident with a car while riding his bike and sustained a broken collar bone as well as soft tissue injuries. Although caregivers took him to the hospital, there is no record of any follow-up medical treatment ever being offered to Alex despite ongoing pain and discomfort. Further, no report was made to police or to the Public Guardian and Trustee (PGT) regarding the injury. It wasn't until February 2015, when Alex began complaining about the physical discomfort in his shoulder caused by the accident, that his social worker contacted the PGT to follow up on a potential claim.

Between 2012 and 2013, several incident reports were received by Alex's social worker that raised more concern about Alex's behaviours. Alex's primary caregiver suspected that he was becoming gang-associated and may have been acting as an *"enforcer"*.

In January 2013, Alex was present during a meeting with his primary caregiver and social worker. He complained that one of his respite caregivers was criminally involved and had friends and acquaintances who were criminally involved and/or gang-entrenched. Alex said that this caregiver had physically threatened him. Alex also reported concerns about a lack of food in the house and what he described as the withholding of food as punishment. Alex's primary caregiver responded to these allegations in writing to Alex's social worker and assured her that, although the caregiver in question had in the past "*been involved with some questionable people and had an array of life experiences*", the caregiver had since turned his life around and was now married and leading a "*good life*" and that he and his wife were church-involved and "*ethical*". Alex's primary caregiver went on to characterize Alex as violent, manipulative and a liar. No further investigation into Alex's complaints occurred.

At the end of January 2013, Alex threatened to kill himself and was admitted to a local hospital. Records show that Alex stated he was having "*crazy thoughts*" that he couldn't control, was sobbing uncontrollably and saying he wanted to die and would kill himself. He said he had "*nothing to live for*" and that "*everywhere I go I only see people I hate*". Alex was discharged from the hospital after being assessed as not being at risk for suicide.

During this period in Alex's life, the monthly reports on him that the agency was responsible for preparing for his social worker appear to have been cut and pasted, with little to no change in them from month to month. The monthly report template did not include any area to detail attention to Alex's culture and/or religion until January 2012, more than three years after he was first placed with the agency. In the period after culture and/or religion were first included, the same statement was repeated for 2½ years: "*Caregivers have had conversations with youth about his cultural identity and religion and at this time youth is not interested in gaining further understanding or information*".

In March 2013, Alex was assigned a new social worker who took a much more active role in his case management and care planning, including going to his school to check in with his teacher. This active role seemed to cause some friction between Alex's caregiver and the social worker as the caregiver had previously managed Alex with almost complete autonomy.

In May 2013, Alex was observed to be in danger of possible suicide and self harm. In July 2013, when he was 16, Alex disclosed to his primary caregiver that his girlfriend was pregnant and that his stepmother was going to take him and his girlfriend in and help

Public Guardian and Trustee (PGT)

The **Public Guardian and Trustee (PGT)** protects the interests of British Columbians who lack legal capacity to protect their own interests. The mandate of the PGT is to:

- Protect the legal and financial interests of children under the age of 19 years;
- Protect the legal, financial, personal and health care interests of adults who require assistance in decision-making; and
- Administer the estates of deceased and missing persons.

Independent Living

Independent Living is a contractual agreement between MCFD or a DAA and a youth that provides funding for housing, food and other living expenses directly to the youth. The goal of the agreement is to help the youth become self-sufficient. Youth between the ages of 16 and 19 can be considered for Independent Living. Youth are still supported by their social worker while on an Independent Living agreement. Monthly support payments for youth are typically in the \$1,000 range, including \$375 for shelter allowance.

them to raise the baby. He seemed excited at the prospect of being a father and told his caregiver that he was going to give his child a different life than his parents had given him. Several weeks later, Alex told his caregiver that his girlfriend was no longer pregnant.

The Representative's investigators heard from several sources that, around this time, some caregivers hired to look after Alex and another youth at the house were heavily involved with drugs and gangs, and exposed the boys at the home to drug use. Investigators heard from several sources that several of Alex's caregivers would permit the boys to drink and do drugs while in the house, and in some cases would either supply the boys with drugs or, when the boys were older, purchase drugs from them. Further, investigators heard allegations that on weekends the boys would pay these caregivers to stay at hotels so the boys could host

parties at their house. According to some witnesses, such parties would involve large groups of people and would include consumption of large quantities of drugs and alcohol.

On Aug. 2, 2013, at the age of 16, Alex asked his social worker for Independent Living. He told his social worker that he didn't like his group home, that he hated being in care and the stigma it carried and that he felt deprived of the sense of belonging that a family home could provide. The social worker advised him that he was too young for Independent Living and that his behaviour in his placement made placing Alex in an apartment a challenge.

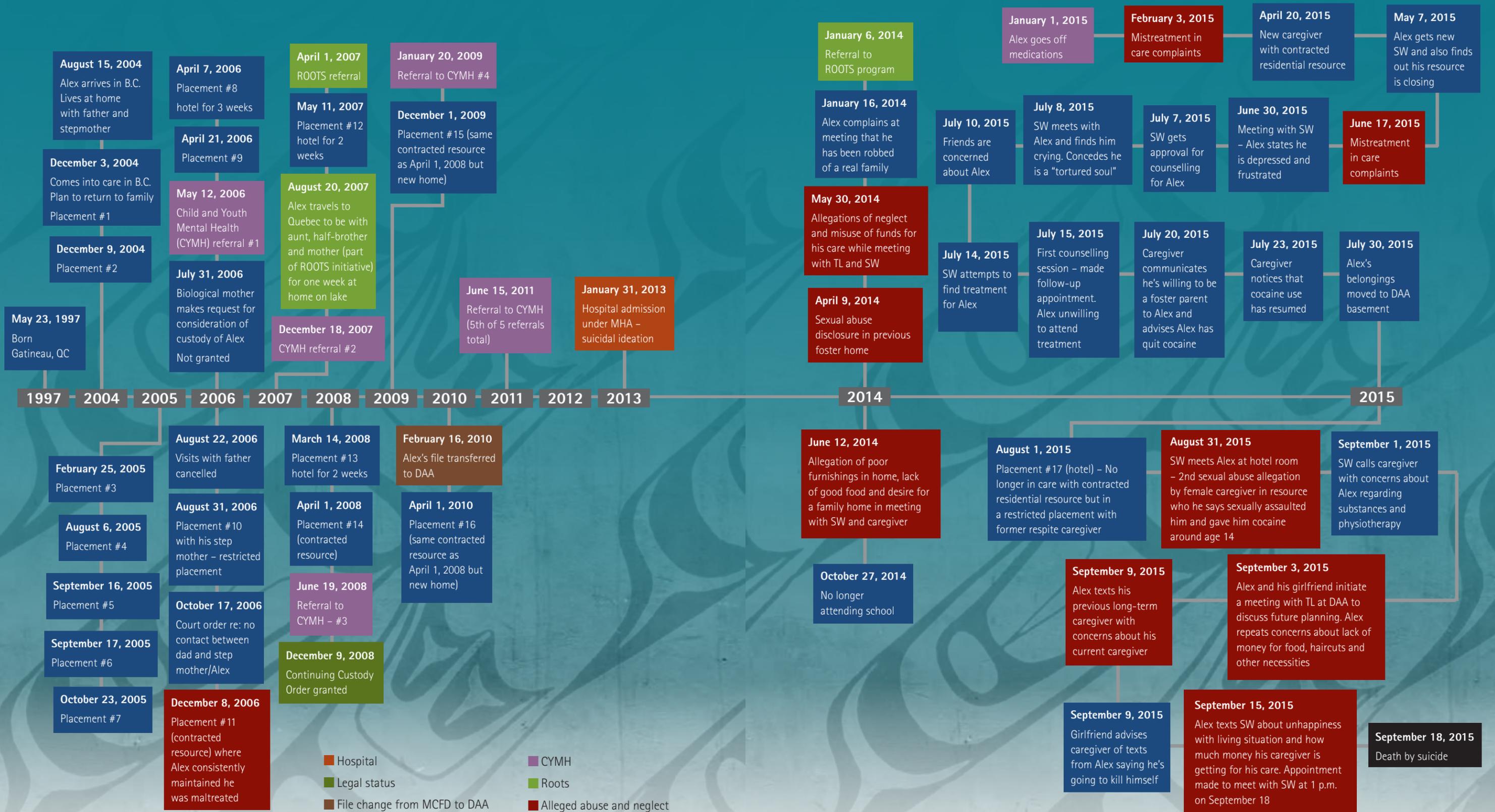
On Aug. 17, at 2 a.m., police attended the residence where Alex was placed after receiving a report that a handgun had been passed around during a house party there. Alex answered the door and told police that there had been a house party earlier as his "parents" were out for the night, but that it was over and he was not aware of any handgun being at the party. Police noted that Alex stated that only he and the other child in the residence were home. Police marked this incident as having been "founded" but did not lay any charges, and no further action was taken. When queried by RCY investigators about this incident, Alex's primary caregiver claimed not to know about it, and wondered how it could be possible that his respite caregivers wouldn't be there to deal with the police matter.

REACH

REACH was designed to accommodate students "falling through the cracks" and is delivered off-site at various community organizations, thereby creatively helping keep students attached and somewhat engaged with the school district.

Continued challenging behaviours caused Alex to be temporarily suspended from school in April 2013. His social worker and caregiver both contacted his school to arrange his return in the fall of 2013 with the goal of enrolling him in the Heavy Equipment Operator course. However, in September of 2013 when Alex was ready to return, he was informed by the principal that he was no longer welcome at the school and was instead being transferred to the alternative school in the district where

Alex's Story: A Timeline



school administrators felt his behaviours could better be managed. He was assigned to attend the REACH program at the alternative school and was promised the opportunity to return to his mainstream school for the second semester as long as he followed the rules and did well at the REACH program.

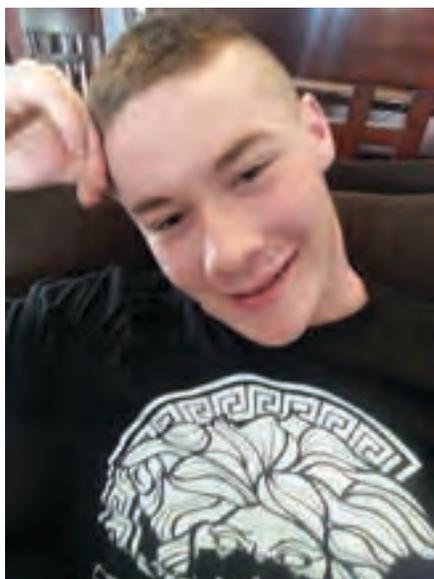
In January 2014, however, school administrators denied Alex re-entry into his old school. They cited his academic performance and safety concerns. Despite strong advocacy by both Alex's caregiver and social worker, he was told that he had to remain in the alternative program. As a compromise for Alex, the alternative school arranged for him to attend a pre-apprenticeship program that would have allowed him to gain experience in several trades, as well as to potentially complete several certificates to assist him in getting a job in the trades upon graduation. In the same month, Alex's social worker initiated a referral to the ROOTS program after her supervisor instructed her to do so in order to determine Alex's Indigenous ancestry. When asked by RCY investigators what happened with this referral, his social worker stated, "*I believe that the ROOTS referral just collapsed after that.*"

In February 2014, after having had no contact with his son for several years, Alex's father phoned his care home, trying to initiate communication. Alex's caregiver approached Alex about the call and Alex appeared interested in resuming contact with his father. However, after multiple failed attempts to contact the father, Alex and his caregiver stopped trying. As described in case notes, this experience left Alex disappointed and depressed. Further complicating his feelings, Alex's stepmother had decided to "*take a break*" from him after a family visit at Christmas had gone very poorly.

In April 2014, Alex disclosed to his primary caregiver that he had been sexually assaulted by two older children in one of his previous foster homes. The caregiver immediately disclosed this to his social worker, who then informed her team leader. The social worker met with Alex to discuss this disclosure. He was noted as becoming "*agitated*" and refused to provide any further details about the incident. Alex did tell his current social worker that he had disclosed this incident to his social worker at the time it occurred, but that he had been labelled a liar and had not received help. RCY investigators could not find any record of such disclosure documented in his files. No counselling or other mental health supports were offered to Alex after this meeting and no further action was taken on the issue.

In September 2014, Alex failed to return to school. While his social worker and caregiver believed he was doing well in the pre-apprenticeship program, Alex's teacher described him as sleepy and inattentive. Alex's teacher said that while he "*got through*" the pre-apprenticeship program, he failed to complete all of the written assignments required to obtain his certification. When asked about the teacher's observations, Alex told one of his caregivers that he wanted to be a drug dealer.

At the same time, a new respite caregiver was hired to work with Alex. This respite caregiver had a history of gun violence, gang involvement, drug dealing and use, but was nevertheless cleared by the Ministry of Justice to work with children or vulnerable adults, as were all other caregivers at the residential agency. He told his new employer that he had received a pardon for the charges against him and that he had turned his life around, which appeared to make him an excellent candidate to work with "*troubled*" youth. He was referred to the



agency by another respite caregiver. His professional qualifications included stints as a personal trainer and a bouncer.

A witness told RCY investigators that, during the transition to this new respite caregiver, several spot checks were done of Alex's home. As a result of the spot checks, it was discovered that there was insufficient food in the cupboards, and that the respite caregiver was seldom present at the residence. Serious concerns were raised about the respite caregiver at the time. The respite caregiver was unable to provide a satisfactory answer as to why the cupboards and fridge were bare and why he was never around. The witness told RCY investigators: *"[The respite caregiver] did not care about Alex or the other child at the residence."* The respite caregiver did not provide daily logs but instead just repeated that Alex *"was doing good."* This seemed unconvincing to the witness: *"Well, his answer was that they were doing good, but yet I would challenge him on those. Like how is a kid doing good when they're AWOL, right?"*

These concerns were raised with the contract managers and the executive director of the residential agency. However, the respite caregiver remained on the job. These issues were raised directly with the resource staff and team leader of the DAA but were ignored.

Alex's social worker was concerned about him and noted in October 2014 that Alex would be aging out of care in 17 months. What he would do as he moved into adulthood was uncertain. Alex by this time had decided to stop taking his prescription medication, was unable to find work and was not attending school – a trifecta of events that were described by one person who worked with him as *"the wheels beginning to fall off the bus"*.

In January 2015, Alex's psychiatrist discharged him from his care because he believed that Alex no longer had any mental health issues. However, Alex's social worker had concerns about his escalating use of illegal drugs. She noticed his rapid muscle growth and, on one occasion when she attended his placement, he answered the door shirtless and she noticed sores all over his chest and abdomen, suggesting possible steroid use. She also suspected Alex was using and possibly dealing hard drugs. During a meeting with Alex, the social worker's team leader had asked Alex where he got the money to purchase his noticeably expensive clothing, to which Alex replied: *"Where do you think?"*

Age 17: Protocol Investigation and Historical Concerns with Residential Agency

In January 2015, the office of the Provincial Director of Child Welfare launched an investigation into allegations of inappropriate care at 10 different resources operated by the same residential agency responsible for Alex's care. Alex was unaware of this investigation or what the future implications might be for him. At this point in Alex's life he was living in the basement of the residential resource and his primary caregiver described that he was making some progress and making better decisions. He had a new

girlfriend who had no association to the gang or criminally involved lifestyle of many of his other friends, didn't abuse substances, came from a strong family and was graduating from high school. While concerns existed about his possible steroid use, Alex appeared excited to be in a new relationship and cooked meals for the two of them in his resource, enjoying some sense of normalcy in his fractured life.

In February 2015, Alex went to a meeting with his social worker at the DAA office. He complained, again, about his treatment while he had been placed at the assessment and stabilization centre and wanted compensation for the mistreatment he said he had suffered. Alex's social worker reviewed his files to see if she could find anything that would give her more information about Alex's treatment at the centre, but she couldn't locate anything. Despite the lack of documentation, Alex's social worker decided to contact the PGT to discuss the possibility of legal action. According to handwritten notes detailing a phone conversation between herself and the PGT, Alex's social worker was advised to have him contact the PGT directly to discuss his concerns. It is unclear whether this information was ever passed on to Alex, but it appears that Alex never contacted the PGT to discuss the issue further.

At the same time, the investigation into the contracted residential agency was continuing and the Provincial Director of Child Welfare directed MCFD and DAA offices holding contracts with the agency to immediately send social workers out to assess the safety of the children in these resources.

As part of this "safety assessment" process, Alex's social worker visited him at his house and asked him how things were going and whether he felt safe. Case notes indicate that



Alex told the social worker that he felt safe and there were no problems with his placement. Alex's caregiver told RCY investigators that the visit lasted less than five minutes. In the end, Alex's placement was not investigated specifically or discussed in the findings of the protocol investigation. However, as a direct result of the investigation, two staff members at Alex's placement were fired for having criminal histories.

The final outcome of the investigation was that MCFD substantiated almost all of the allegations against the residential agency and its caregivers, and at least 12 youth were found to have been directly harmed as a result of being placed in the care of the contracted agency. Common themes included lack of proper criminal record checking of caregivers, caregivers neglecting youth by failing to provide necessities such as food and clothing, and caregivers participating in or at least condoning drug use by youth in the residences.

While Alex's placement was not investigated, concerns remained about the quality of the care he was receiving and the long-term future of the residential agency. One worker familiar with the agency and Alex's situation described it this way: *"He's got a caregiver that's, you know, a shit show and now he's gonna have no home. So that, for Alex I think just totally derailed him. Like that was the final kind of boiling point for him – they were talking about increased drug use, they were really essentially losing control."*

Age 17 to 18: Closure of Long-term Placement, Restricted Contract with Former Caregiver, Suicide

In spring of 2015, the Provincial Director of Child Welfare decided to cancel all the contracts with the residential agency and place all the children in its care elsewhere by June 30, 2015, with the possibility of an extension if necessary. In May 2015, Alex's social worker disclosed to Alex that his home would be closing. At the time, nobody else at the home knew about this and when Alex passed this information on to his caregiver, the caregiver became very concerned and contacted the social worker. Alex's social worker told the caregiver that Alex had misunderstood her and that the DAA was merely looking into getting Alex an Independent Living situation. Alex's social worker, primary caregiver and girlfriend all reported that the idea of losing his familiar placement was devastating to Alex.

Over the next two months, the DAA maintained to Alex, his caregiver and MCFD that the plan for Alex's transition in the months leading up to the June 30 deadline was to get him into an Independent Living situation. However, Alex was experiencing a significant decline in his mental health and ramping up his drug use. He was experiencing long and serious bouts of depression and was acting out violently on a more regular basis, causing significant damage to his residence. Because of this, Alex's social worker advised his care team that Independent Living was not *"feasible"* for Alex at this time.

Alex told his care team several times during the spring of 2015 that he wasn't ready for, or interested in, Independent Living. On June 12, 2015, one week after Alex's social worker had dropped off the paperwork for Independent Living, Alex told her that he was fine where he was and that he didn't want to move to a *"shithole that a \$600 IL would pay for."*

At the end of June 2015, Alex's social worker sought an extension from MCFD in order to get him placed elsewhere. The DAA was given until July 31 to secure an alternate placement for Alex while MCFD gave notice to end Alex's contract with the contracted residential agency on that date.

Most of the case notes in Alex's file for this time detail his complaints about all the changes in his life. *"Everyone has fucked off,"* was how he expressed it. He also directed detailed questions about money to his social worker, seeking to understand why he had been unable to have adequate clothing or food. Alex's girlfriend was now his primary source of emotional support, including counselling him to go to the hospital when he was suicidal one night in June 2015.

On July 8, his social worker arrived at the residence for a meeting with Alex. She found him on the edge of his bed crying and her notes indicate that he conceded that he was a *"tortured soul"*. In response to this disclosure and as a result of relationship conflict with his girlfriend, Alex agreed to attend counselling. The DAA approved the services of a counsellor outside of CYMH for three sessions. Alex attended the first session on July 15 with his girlfriend.

The DAA also began to pursue the option of contracting directly with the residential agency’s respite caregiver to provide care to Alex as a restricted foster parent and offered approximately 11 times more than the usual restricted foster parent amount to persuade the caregiver to agree.

The respite caregiver had serious concerns about taking over Alex’s care, describing him as deeply entrenched in drug dealing as well as his own substance use and deeply apprehensive about what would happen to him when he aged out of care. *“But I was begged, kind of like begged almost to stay cause they had nobody to fill that position,”* the respite caregiver told RCY investigators. The contract was finally signed in August, four days after the expiry of the residential agency’s contract. Under the new contract, the respite caregiver was to receive more than \$8,000 per month from the DAA to care for Alex.



Once the contract was signed, however, the owner of the house Alex had been living in refused to continue to rent it for his use because of the damage he had previously done. The DAA believed that it had no option but to contract with a nearby hotel, renting two adjoining rooms. The arrangement was that the caregiver would live in one room and Alex in the other.

In August 2015, one month before his death and while he was placed in the hotel, Alex disclosed to his social worker that he had been sexually abused by a female respite caregiver who had given him cocaine and then had sex with him when he was 14-years-old. Alex was unwilling to provide the name of the respite caregiver. When Alex’s social worker asked him for more details and to expand, he chose not to. He indicated that he would be willing to consider speaking to a male counsellor. Alex was provided with information about the Representative for Children and Youth’s Office but evidence shows that he did not contact RCY. No police report was made of the

alleged sexual assault and drug use by the caregiver.

Shortly after his death, some of Alex’s friends and acquaintances approached his social worker and advised her of Alex’s disclosure to them of this alleged sexual assault. They provided the name of the caregiver, and social workers finally filed a police report. Through this investigation, the Representative learned that this alleged assault had been witnessed, and that Alex had disclosed this information to numerous friends after it had happened.

Investigators also learned that Alex had disclosed this alleged assault to another of his agency caregivers before disclosing it to social workers in 2015, but that the caregiver did not pass the information on to anyone because in his view it was *“none of his business”* and that *“I come from a place where we don’t rat . . . I’m sorry, that’s the way I grew up, eh?”*

On Sept. 9, Alex's caregiver wrote to his social worker detailing how his relationship with Alex was deteriorating. The social worker sought assistance and direction from her supervisors. She characterized Alex as manipulative and threatening towards his caregiver and said he was *"making accusations which cannot be validated"* in relation to Alex's claim that the caregiver was pocketing money that should have been given to him. Her team leader followed up with a practice analyst the same day by email and added her own comment about how the DAA had *"sucked the well dry"* in terms of ideas for Alex moving forward.



RCY investigators learned that, during this time, Alex's contracted caregiver was almost never present at the hotel. Alex repeatedly told friends that he was not being provided with funds for food, clothing or other necessities. Multiple sources confirmed to RCY investigators their suspicions that Alex dealt illegal drugs during his hotel stay. Although social workers were aware of these suspicions of criminal activity, there was never any follow-up, nor even a visit to the hotel.

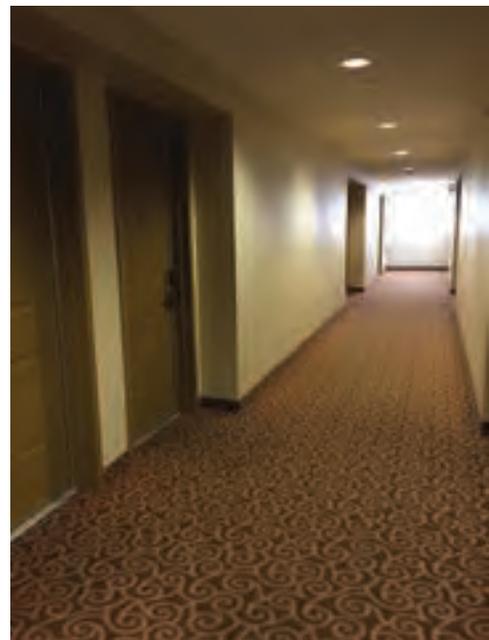
Evidence provided to RCY investigators indicated that his caregiver had last been at the hotel about 10 days before Alex's death. During a police interview, the caregiver admitted to

holding drugs for Alex as part of a strategy to be his friend. This was never reported to his social worker at the time.

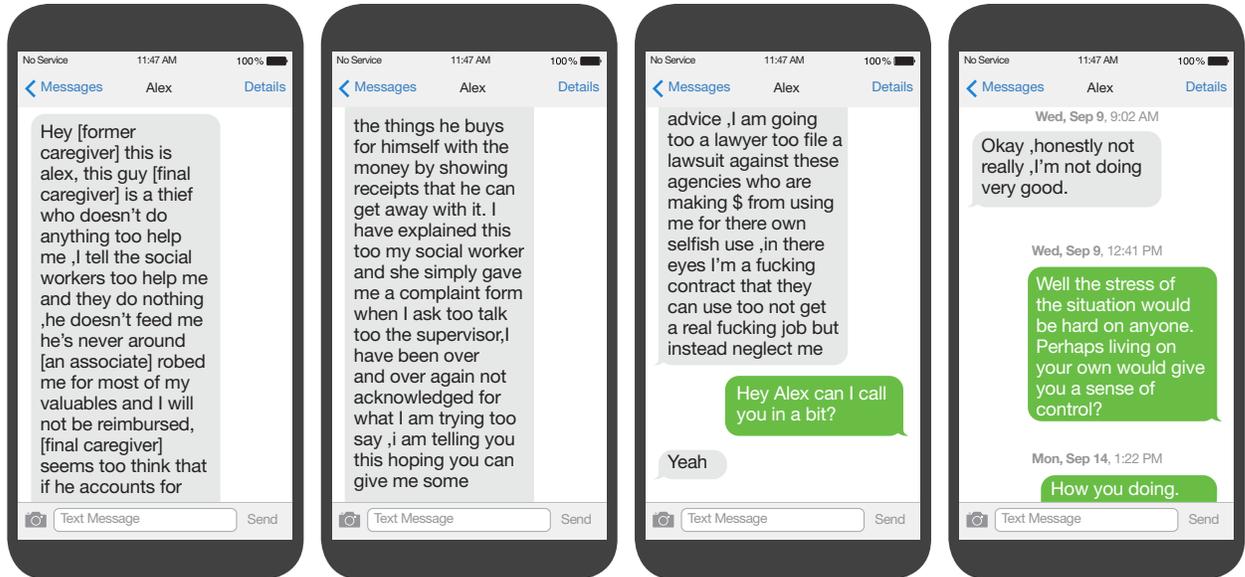
Hotel staff told RCY investigators that Alex was always respectful and polite and that he regularly had his girlfriend over spending the night. He also regularly had friends and acquaintances at the hotel to party and use drugs.

Investigators interviewed hotel staff and found that Alex's caregiver rarely stayed at the hotel and rarely visited. Instead, Alex's care was left to his girlfriend. His caregiver asked Alex's girlfriend to text him when she was with him so the caregiver could continue to be absent. Hotel staff confirmed to RCY investigators that the caregiver passed responsibility for *"watching"* Alex to them and would have hotel staff text him with details about who was visiting Alex or if he had overnight visitors.

In the weeks leading up to Alex's death, he and his caregiver kept in contact by text message. The caregiver was advised by Alex as well as his friends that Alex was extremely depressed and suicidal. This information was never passed on to Alex's social worker. On



Sept. 9, 2015, Alex reached out to his former caregiver for assistance on how to handle his situation. In a series of desperate text messages, Alex told this caregiver that he was being left alone at the hotel without food or other necessities.



Alex ultimately spent 49 days housed in the hotel. After Alex expressed to his social worker that she was “*like all the rest*”, that he was extremely unhappy with his living situation, and that his caregiver was misappropriating money allocated for his care, she agreed to meet him at 1 p.m. on Sept. 18, 2015.

Sadly, Alex did not make it to that appointment. On that same day, after a night of excessive cocaine use and a fight with his girlfriend about his drug use, Alex killed himself by smashing his fourth-storey window and jumping out of it. He had been alone in his hotel room at the time. His caregiver was not present in the adjoining room.

Findings and Analysis

Overall Finding: Alex's death was a predictable outcome of his journey through the child welfare system. Constant destabilizing ministry-initiated moves during his early life, along with lost opportunities for him to have found permanence with extended family or a connection to his Métis culture, left him with a burden of trauma that was never addressed. Multiple placements stripped him of attachments and connections that are the basic need and right of every child. His move into the care of a contracted agency at the age of 10, although providing the illusion of stability, resulted in the social workers tasked with caring for him largely ignoring Alex as they struggled to cope with what they perceived as more urgent demands in their caseloads. Left without secure attachments or an education that could have prepared him for some future success, it is unsurprising that Alex turned to substance use. His final weeks in care, as he faced aging out with no plan in place and a largely absent "caregiver", were a nightmarish combination of heavy substance use coupled with Alex's own overwhelming sense of abandonment.

Permanency

Finding: MCFD and the DAA consistently failed to find a culturally appropriate, permanent family placement for Alex, even though multiple opportunities to place him with extended family were available to them. These opportunities were lost, because the ministry and DAA either refused to provide appropriate supports to the placement or simply failed to follow through when opportunities were presented.

MCFD's permanency planning framework defines permanency as a permanent connection to a significant person or persons who can provide children with the stability and continuity they need to develop into healthy, secure adults. Wherever possible, kinship ties and a child or youth's attachment to extended family are preserved. For Aboriginal children and youth, these connections include permanent ties to their Aboriginal community to promote cultural continuity. For Alex, and other children in ministry care, this framework was more aspirational than acted upon.

The *CFCS Act* begins with "*definitions and interpretation*" in which point 1 in part 1 stipulates what defines an "*aboriginal child.*" Alex clearly met these criteria. It would appear that the writers of the *CFCS Act* intended to pay careful attention to Indigenous heritage by placing this definition at the outset of the Act, even before the guiding principles which follow in point 2. These include "*paramount considerations*" such as the "*family is the preferred environment for the care and upbringing of children*", as well as references to the importance of "*kinship ties and a child's attachment to the extended family*" and "*the cultural identity of aboriginal children*". These principles were not adhered to in Alex's case.

If a family is never found for a child or youth, he or she will often linger in the foster care system or in a residential resource until aging out of care at 19. The Representative has repeatedly described and research has documented the negative outcomes for youth who age out of care without ties to family or other significant adults, the situation Alex found himself facing prior to his death.

Permanency for children in care has been an issue of acute interest to the Office of the Representative for Children and Youth. In June 2014, the Office released *Finding Forever Families: A Review of the Provincial Adoption System*. In that report, the Representative called for a new sense of urgency to be attached to permanency planning and adoption with a high priority attached to the work to support that. The Representative was especially concerned about the lack of adequate permanency planning for Indigenous children in care. Like Alex, more Indigenous children and youth had Care Plans that called for them to remain in long-term foster care, rather than permanency planning options such as adoption or transfer of custody. Although Indigenous children comprised more than 63 per cent of the children in care in 2012/2013 – a percentage that has remained at more than 60 per cent since – they accounted for only 35 per cent of the children placed in adoptive homes that year.

Set against this were the challenges of maintaining a focus on long-term planning in a ministry beset by “*the tyranny of the urgent*”. One social worker summed it up by saying: “*We are told to deal with the crisis first, then do adoptions.*” The negative impact that social worker caseloads, or their perception of their caseloads, had on permanency planning can be clearly seen throughout Alex’s life in care. The Representative’s report, *The Thin Front Line: MCFD staffing crunch leaves social workers over-burdened, B.C. children under-protected* (October 2015) detailed how ongoing staffing issues, including worker shortages, recruitment lags and inadequate supervision, were all negatively impacting the quality of service being provided to children and families. This report focused on the most urgent child protection services; however, it was obvious in Alex’s case that the same pressures had an even greater impact on long-term planning for children in care. RCY investigators repeatedly heard from front-line staff during this investigation that urgent child protection files consistently meant that case planning for children already in care was delayed or simply never occurred.

Although it was evident early on that Alex’s biological parents would be unable to care for him, his father’s marriage to his stepmother in 2004 established a connection that for Alex would be life-long. His stepmother, who social workers characterized as stable and dependable, formed a deep affection for him despite her tumultuous relationship with Alex’s father. But it was the volatility of that relationship that resulted in MCFD placing Alex in foster care in December 2004 under a Voluntary Care Agreement. When his father tried to withdraw consent for the VCA, the ministry removed Alex from them, believing that Alex’s safety could not be guaranteed as long as his stepmother remained involved with his father.

For the next 2½ years, Alex was shuffled between 15 different foster placements, a staggering amount of instability for a child who social workers knew would respond to this turmoil by acting out. The failure to find even a modicum of security for him was compounded by social workers and caregivers blaming Alex for his “*challenging behaviours*.” RCY investigators could find no evidence that MCFD made any attempts to search for family, extended family or another Indigenous placement for Alex until a ROOTS worker’s involvement began in April 2007.

Alex's most promising opportunity for permanence occurred when his placement in a foster home collapsed unexpectedly and, with no other alternatives available, social

"I have run into that difficulty before when there's a VCA, they're just – resources are sort of unwilling to look at creating something that's specific to a child."

– Alex's family service social worker

workers placed him with his stepmother, now separated from his father, in August 2006. Both Alex and his stepmother had been consistent and vocal about their desire to reunite since they had been separated in 2004.

Unfortunately, it seemed that this placement with his stepmother as a restricted foster parent was set up for failure almost from the start. Given less than one-sixth of the funding that had been provided to the previous foster home and

repeatedly denied respite care, the pressure on Alex's stepmother was enormous. Staffing shortages delayed the home study that could have cleared the way to fund at least some additional supports. Email correspondence at the time between her social worker and that worker's team leader make it clear that they were frustrated by the stepmother's requests for assistance and already looking for yet another placement for Alex. In contrast to an agency placement, in which the child is, in effect, handed off to the agency, planning for and supporting a family placement can frequently be more time consuming for a social worker to manage, a significant disincentive when workloads are high.

This is not the first time an investigation by the Representative has uncovered caring and committed foster parents or other substitute caregivers being left without adequate support and finally suffering burnout and placement breakdown as a direct result. This same circumstance was described in *Who Protected Him: How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children* (2013), with a similar result for the child involved – removal from a home-like setting to a residential resource staffed by constantly-changing caregivers. And in RCY's May 2015 report, *Paige's Story: Abuse, Indifference and a Young Life Discarded*, a promising potential placement with extended family for a troubled Indigenous teenage girl was rejected without full consideration, in part because MCFD felt that the family was asking for too much support. Instead of being placed with her aunt and uncle, Paige spent three years shuffling between shelters, detox facilities and SRO hotels, eventually dying at 19 of a drug overdose.

It was Alex's father who ultimately provided a pretext for Alex's removal from his stepmother. His father had unexpectedly appeared at their home and Alex was accidentally scratched by his stepmother as she was struggling with his father. This comparatively minor incident was used to justify removal, a removal Alex resisted so violently that police had to be called. Alex described their separation as "*having [my] heart torn in half.*" It is difficult to understand why his stepmother's victimization would have been the basis for removal, rather than being seen as an opportunity for the ministry to offer the substantial and appropriate supports necessary.

Alex's stepmother was a regular visitor to the assessment and stabilization home in which MCFD placed him. Alex's file shows that he repeatedly asked to return to his stepmother's care, a move that staff working with him then believed was the long-term plan. Social workers, however, never considered returning him to his stepmother. Instead, he was moved to another foster home, his 15th.

With reunification with his stepmother not considered an option by MCFD, another potential family placement was identified by Alex's ROOTS worker. In the course of researching his family history in 2007, she made contact with his aunt who, even after being advised of Alex's behavioural challenges and multiple placements, pursued having him come to visit her family in Québec. In the wake of a successful week-long visit, his aunt told the ROOTS worker that she wanted Alex to live with her.

Alex obviously had made some connection with his relatives and, in February 2008, asked to return for another visit. This request fuelled some discussion between his social workers about the possibility of Alex being placed there permanently, but high caseloads in the MCFD office responsible for his care meant that no further action was ever taken.

In 2008, Alex moved into the residential agency-run home where he would remain for the next seven years. He was only 11-years-old. His care plan from this period indicated that his social worker's initial goal of returning him to his parents had now been replaced by a plan for eventually transitioning him to Independent Living.

In 2010, Alex's file passed from MCFD Aboriginal Services to the DAA responsible for the area where his home was located. His new social worker had just received her delegation, the office was short-staffed and she had a caseload of between 30 and 35 children and youth to manage, many of them high-risk young women. She described her days as consumed by the demands of this caseload, with little supervision or mentorship. She also described a "toxic" workplace with strained relations between staff and management. Her monthly meetings with Alex were unremarkable and, as he and his living situation appeared relatively stable, she devoted comparatively little time to his file.

Permanency options for Alex with the DAA were starkly limited. The DAA had few family foster homes available and also had a practice of not pursuing adoptions for children and youth in its care. RCY investigators asked about the possibility of a family placement and were told that, although the social worker would have pursued such an option if it was available, Alex's file contained no documentation about possible family connections.

In the wake of the Provincial Director of Child Welfare's investigation, and the subsequent decision to strip the residential agency of all its contracts, the prospect of leaving the only home he had known for seven years was profoundly unsettling for Alex. Although he had experienced abuse and instability in his placement, he had also had significant continuity in the presence of the same primary caregiver during the same time period. It was this individual who Alex reached out to in the last days of his life, in a series of increasingly desperate text messages.

Alex had an acute understanding that he represented, to many of his caregivers, what he described as nothing more than a "paycheque" or "a bag of cash". Although the Representative has frequently called attention to shortfalls in funding for programs, the most significant shortfall this investigation reveals is in the time and attention that should have been directed to allowing Alex to grow up as part of a family.

Oversight

Finding: The lack of oversight, by both MCFD and the DAA, of the contracted residential agency caring for Alex directly contributed to the multiple harms he suffered while in care and to his eventual death. Although MCFD and the DAAs are reliant on contracted agencies to provide care for children and youth, there are currently no robust and appropriate mechanisms to ensure the quality of that care or adequate financial accountability.

“[People] knew that we would pay a lot of money for staffed homes and they thought paying a lot of money meant that we would get good service, and it doesn’t.”

– Experienced MCFD social worker

MCFD uses a variety of contract arrangements to deliver residential care services to children – some for-profit, some not-for-profit; some licensed, some unlicensed; some accredited, some not accredited. As of January 2017, approximately 100 different contracted residential agencies were providing placements for about 700 children and youth in B.C. Residential agencies often have multiple contracts with MCFD, as was the case with the agency that was responsible for Alex. The Provincial Director of Child Welfare has undertaken three recent investigations into the operations of individual residential agencies based on quality-of-care concerns, with the residential agency caring for Alex being one of those investigated.

In the mid-1980s, MCFD devolved residential services and contracted with private for-profit and non-profit agencies to provide residential services for children and youth in B.C. Previously, these services had been provided ‘in house’. This business model change was seen in part as a way to provide efficient, cost-effective services by putting these services out to the free market. This removed the more expensive aspects of providing residential services such as unionized staff and staff training requirements. In this way, services to the most vulnerable children and youth were provided in the least costly way with minimal service and oversight standards. Thus MCFD designed and perpetuated the use of contracted agencies and the reliance on this model continues today.

The Representative has examined issues related to residential care in previous reports, including the February 2013 report *Who Protected Him? How B.C.’s Child Welfare System Failed One of its Most Vulnerable Children*. That investigation also highlighted the challenges with residential care, which was described by a psychiatrist as “*placing the most difficult kids with the people least able to care for them.*”

The residential agency caring for Alex was a for-profit corporation that had been in business for almost 20 years, providing fee-for-service contracted residential services to MCFD and DAAs. Its primary revenue source was MCFD contracts – the 2014/15 Public Accounts released by the B.C. government show that MCFD paid the agency \$3.5 million during that fiscal year.

Contracts for residential care for children were initiated by MCFD or a DAA and were negotiated with residential agency contract managers. This residential agency specialized

in creating placements for “*challenging*” children and youth and was often asked to find or create these placements on short notice. Contracts were child-specific, with the amount paid varying according to the perceived needs of the child. This residential agency was structured so that it operated almost exclusively through independent sub-contractors. Contract managers, family support workers, primary caregivers and respite caregivers acted as independent contractors.

MCFD and the DAA contracted with the residential agency and paid a lump sum amount per child to be housed. All persons under the executive director of the residential agency were not employees; they each had an independent contract with the person above them, including the persons directly under the executive director. Monies given through these independent contracts were disbursed in the hopes that they would be spent appropriately where the care of children was concerned.

No accountability between what monies were given by MCFD or the DAA existed in terms of whether monies were spent as apportioned. An employee-like relationship was purposefully avoided by the executive director. No taxes were withheld when monies were paid to the next layer down and neither were records kept by the residential agency of what was spent on the care of the children in the homes.

Primary caregivers typically rented a home that could house one or two youth. They then contracted with respite caregivers to provide care in these homes on a rotating schedule. A primary or respite caregiver was to remain in the home 24/7, including overnight. Respite caregivers would often work in multiple homes that were operated by the residential agency. A “*do not hire list*” was established to avoid dismissed staff from one home attaining employment within another of the residential agency’s homes. Just before the agency’s closure in February 2015, 24 homes were leased by primary caregivers housing 35 children and youth.

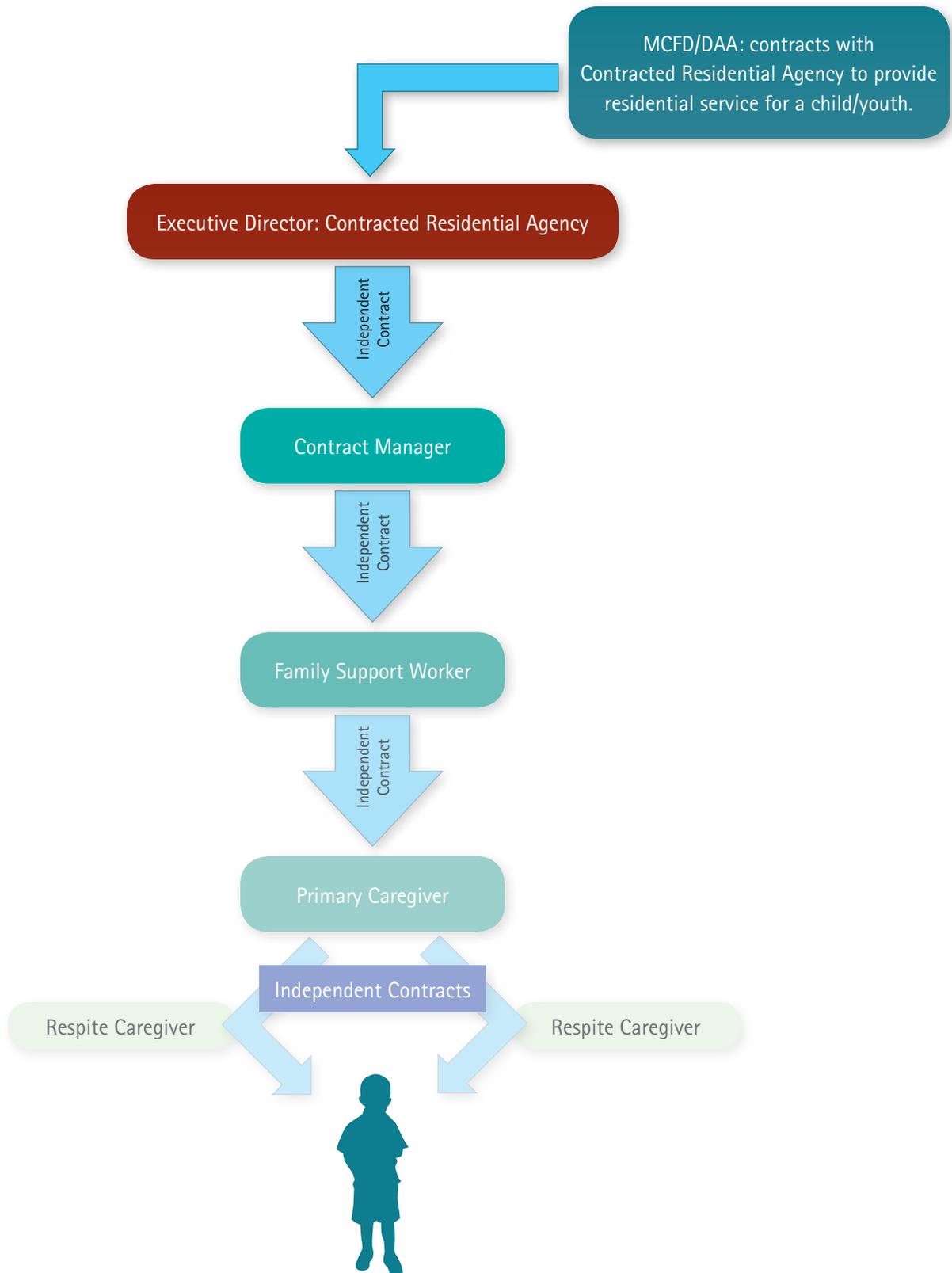
This business model of reliance on independent contractors is one that the executive director of the residential agency had copied from another agency where he had previously been employed. Using contractors rather than employees meant the agency was not responsible for collecting or declaring taxes, leaving compliance with tax rules the responsibility of the individual contractor. The consequence – intended or unintended – of this business model was that the agency was loath to direct how its subcontractors behaved, as doing so could have appeared to constitute an employer-employee relationship.

“The business model allows the agency not to be an employer. Because if our primary caregivers all have an independent contract with us, you look like an employer if you’re managing their respite [care] which means the economic model is out the window.”

– Residential agency executive director

Another effect of this business model was that each independent contractor placed between the child in care and the agency was another layer of insulation from potential legal liability in the event that something went wrong. The use of contractors, rather than employees, also diluted contract management and financial accountability by reducing

Contractual Flow Chart for Contracted Residential Agency that Provided Care to Alex



the residential agency's ability to apply an appropriate oversight regime, even over things as simple as tracking the money spent for groceries and clothing.

“There was a certain amount of things that we didn't have a lot of control over in the sense of receipts because, had we done that, they would have been employees.”

– Agency executive director

Although both Alex's primary caregiver and the executive director of the residential agency dismissed Alex's constant complaints about the lack of food and clothing, spot checks conducted during his time in care suggest that there were at least periods of time when neither food nor clothing were being adequately provided to him.

The Representative's investigators analyzed food logs, records of meals that were being prepared for Alex in his placement between Jan. 1, 2010 and June 30, 2014. This represents a 234-week time period when \$125 per week was allotted to Alex's food costs, for a total of \$29,250. Yet the logs show that caregivers prepared meals for Alex only 49.6 per cent of the time during this period, reducing actual food costs for the prepared meals closer to \$14,508. This raises concerning questions – about both how Alex was being cared for and the variance between budgeted and actual costs.

Alex was originally placed with the contracted residential agency in 2008. By December 2010, MCFD staff were becoming alarmed about the quality of care being provided by this particular residential agency. The triggering event appears to have been the overdose death of a respite caregiver at an agency resource. Minutes from a meeting convened by senior ministry staff detailed “*longstanding issues of hiring inexperienced staff and high staff turnover*”. Other concerns raised during this meeting included “*assault of a child in care by primary caregiver, primary caregiver viewing pornography while on shift, staff person arrived on shift drunk, staff left the resource and the child left on his own, lack of money for food, allowance and gifts, reports of a primary caregiver having a sexual relationship in the home and primary caregiver arrested for possession of child pornography.*” A final question arose in the meeting minutes; “*Where is the money going?*” in reference to the significantly greater cost of contracted agency placements compared to foster home placements. The only decision to emerge from this meeting was the placement of a moratorium on any future placements with the residential agency until the litany of concerns could be addressed.² However, no actual formal moratorium was placed on this agency by either MCFD or the Deputy Minister – that decision was made by the manager at the regional office that serviced this agency.

Three months after this informal moratorium was put in place, the residential agency came back to the regional MCFD office with a “*full plan that addressed the hiring and staffing concerns.*” MCFD social workers told RCY investigators that managers were happy with what was presented to them by the agency. As such, the decision was made by consensus at the regional MCFD office to lift the informal moratorium.

² The documentary record discloses that there were numerous complaints and problems with the contracted residential agency which predate the 2010 regional managers' meeting.

Despite this, social workers took little or no action to fulfill their mandated oversight and monitoring responsibilities. Instead, they took a hands-off approach to addressing concerns because the contracted agency was a private, “*arm’s-length*” business, and they believed they had no recourse except to bring issues about the quality of care to the residential agency’s attention so that the agency could deal with those concerns internally.

“We’re dealing with organizations that are private companies, and so we’ve got to make sure that they provide the services and the standards. But at the same time, we can’t manage their company because it’s their company.”

– MCFD social worker

This ambiguity about who actually monitored and controlled the quality of care for children in residential placements is not unique to this residential agency or this region. One senior MCFD official told RCY investigators: “[People] just don’t know and historically when you had a child protection concern about a kid in one of these [residential] agencies, you went to the ED and said ‘Hey, you know, you better investigate this’ and then you heard about what the outcome was . . . The message still, I would say for most front-line staff, is ‘Yeah, we don’t investigate this, we’ve never done this before, we don’t know how to do it even if we were told we had to do it’.”

Although several MCFD employees interviewed during this investigation acknowledged that they had the option of ending the contract with the residential agency if there were serious quality-of-care or child protection concerns, they also expressed a concern that exercising this option would result in the loss of placements for Alex and other youth with no one else available to provide such care. There were simply no available placement options. This created another significant barrier to genuine accountability. Even if social workers perceived problems with the care provider, they were reluctant to exercise their authority as MCFD and the DAAs are heavily dependent on the contracted residential agencies and the services they provide.

“A really fundamental problem with our relationship with these organizations is that we have a co-dependency. So, they are providing a service that we desperately need – it’s in our best interest to maintain a positive working relationship. If we start clawing money back, that’s going to ruffle feathers, it’s going to rock the boat, it’s going to potentially result in a poor working relationship . . . So people are kind of loath to . . . hold them accountable if it means that doing so will either throw them into financial chaos or really ruffle the feathers.”

– Senior MCFD official

The MCFD liaison officer who was tasked with managing the relationship with the residential agency told RCY investigators that one reason issues with the agency remained unresolved was that, after her first year in the role, her manager was transferred to another department and she was left with no one to report to. Although it initially seemed improbable that a staff member in a key oversight role would be left unsupported and unaccountable, RCY investigators learned that the liaison officer’s version of events was true. Her manager was transferred out of her role shortly after commencing

this important work, and the liaison officer was transferred to the corporate services department, where her responsibilities were primarily financial. Despite being in a critical oversight role and a key position for ensuring the well-being of young people in care, she was put in the impossible position of being forced to do the liaison work off the corner of her desk. Her new manager, a contract specialist with no social work practice experience, felt she was unable to provide assistance.

Over this time period, numerous high-risk children, including Alex, were kept in their placements despite knowledge of the problems with the residential agency. Even after the 2010 moratorium was in place, MCFD did not take active steps to comprehensively assess the situation of every child in the agency's care.

Many of the issues with contracted residential agencies were already well-known to MCFD. In 2008, the ministry established a working group to examine child care cost drivers, in response to concerns that the cost of residential care was “*beyond the Ministry's capacity to fund with existing budgets*”. The working group's review detailed the increased use of contracted resources at a cost almost nine times greater than a regular or restricted foster placement. Despite this, the working group also concluded that “*contracted resources rarely contributed to good outcomes for children in care*” and that “*in many cases contracted resources do not have the expertise to meet the child's individual needs and are being used as a last resort*”.³

In 2011, MCFD and the Federation of Community Social Services of BC published the first phase of the *Residential Review and Redesign Project*, a joint project which had its genesis in shared concerns about the experiences and outcomes for children in residential care in B.C. That two-year project was a joint effort by MCFD and the Federation, which comprehensively examined the entire range of residential services for children and youth, including kinship care, foster care, and staffed residential services through to tertiary care. The review identified the following criteria for success: “*Children and youth in residential care should be provided with high quality care, experience as few disruptions as possible, achieve permanence as soon as can be safely arranged, be prepared and supported for the transition to adulthood.*” It is difficult not to contrast this aspirational statement with Alex's actual experience in care, where he languished in various placements with no hope of permanence, experienced poor quality of care with rotating caregivers and faced aging out with no prospects for the future.

Following the above-noted report, the *Final Report of the Residential Review Project*⁴ was released in 2012. This wide-ranging report resulted in the identification of seven strategic directions, 32 recommendations and more than 90 supporting actions aimed at enhancing the child and youth residential care system in B.C. One of the seven strategic directions was “*enhancing accountability in residential care*”,⁵ which involved four recommendations with nine supporting actions and which, in summary, included: developing and implementing an accountability framework that includes both client

3 Ministry of Children and Family Development, *Child in Care Cost Driver Analysis* (Victoria: 2008).

4 Federation of Community Social Services of BC and Ministry of Children and Family Development, *Residential Review Project: Final Report* (Victoria: 2012).

5 Federation of Community Social Services of BC and Ministry of Children and Family Development, *Residential Review Project, Phase One: Findings Report* (Victoria: 2011).

outcome measures and measures of service quality, aligning and embedding the accountability framework within the ministry's ongoing quality assurance efforts and contracted service provider requirements, developing and implementing systems and structures to support monitoring of outcomes and service quality, and standardizing recording and reporting requirements for contracted residential services. Although the ministry's *Operational and Strategic Plan for 2012/13*⁶ committed to "acting on the recommendations of the Residential Review project", the elements related to strengthening quality assurance processes and oversight of residential services have not been implemented by the ministry, nor have most of the other substantive recommendations of that comprehensive review.

Financial Accountability and Oversight

"We have a big problem with our contract practices, we know that and it's not just a financial problem. It's not just a waste of taxpayers' money and a lack of accountability. It has implications at the practice level."

– Senior ministry official

In Alex's case, his contract mirrored all of the other residential agency agreements with MCFD, documents that outlined the allocation of funds for children's residential costs. In addition to fund allocation, the contracts provided a series of terms and conditions for how the residences were to be operated and how many staff were to be assigned to any given child or youth. Alex's contract, like all the others, also contained a series of financial provisions designed to hold the residential agency accountable to contract budgets and other terms.

Financial accountability was hampered by the absence of a single point of accountability for the multiple contracts held by the residential agency. The agency had multiple contracts with MCFD, various DAAs and other funders, and there was no single person or office that maintained overall oversight of the contractual relationship. This was clearly an oversight failure that had both quality-of-care and financial consequences.

"In terms of, like, one person overseeing the whole broad spectrum of what [the residential agency] offered MCFD, there wasn't a person who did that. Even though their files sat in Coquitlam . . . there wasn't one person that oversaw that file that knew how many contracts and how many kids and how much was happening in those homes."

– MCFD team lead, resources

When the Representative's investigators asked MCFD officials why there was a lack of appropriate financial oversight on even basic financial matters, the answer was the same as the response given for the ministry's failure to meaningfully oversee practice issues.

⁶ Ministry of Children and Family Development, *MCFD Operational and Strategic Directional Plan 2012/13* (Victoria: 2012).

Namely, that with respect to arm's-length businesses contracted to look after youth such as Alex, it is generally left up to the agency to decide how contract funds are to be spent, and to ensure they are being spent appropriately. In this case, agency oversight appears to have effectively meant no oversight, which was at times tantamount to gross negligence.

This was compounded by the fact that neither MCFD nor the DAA had any kind of audit protocol; whether for yearly audits of contracts, or one-time audits of specific contracts coming to the attention of MCFD or the DAA due to financial irregularities. The most that could be said about financial accountability was that it was sometimes provided at a basic level by a front-line resource social worker, usually with no financial training, who would try to look at the contract generally to see whether services were being provided as set out. Despite this lack of an appropriate oversight structure, there were many in MCFD who were concerned about the possible financial irregularities.

"[Whatever] the financial record, they [the residential agency] basically said, I spent all the money – line by line, there was no variance. That's just not possible. So, we know their books are cooked."

– Ministry staffer

Although tighter monitoring of money and staffing within contracted residential agencies would seem to be an obvious step for the ministry to take, such close supervision comes with some unintended consequences – potentially greater liability. As a senior ministry official explained: *"One of the problems with – one of the tensions in the oversight piece is around liabilities. So, if you're contracting with an agency and something goes wrong, then theoretically the agency owns the liability . . . However, if we – as we start to take more of a hands-on approach to these organizations – there's been discussion about what are the implications for our liability?"*

Ministry officials and front-line social workers also repeatedly rationalized their inability to provide meaningful financial oversight based on the perception that MCFD has little or no bargaining power when seeking placements for higher-risk youth, despite the fact that the primary source of income for contracted residential agencies is ministry funding.

"So the unethical agencies will do whatever they can to fly under these accountability processes and mechanisms – and then, of course, there's old MCFD that doesn't really do much anyway so – so they get off scot-free pretty much."

– Senior ministry official

In response to concerns about financial issues at the agency that had emerged during the Provincial Director of Child Welfare's investigation, MCFD contracted with a national accounting firm to carry out an initial assessment of the residential agency's internal control, financial reporting and contract compliance practices. The subsequent report identified several areas of high risk, both in general monitoring controls and in potential misrepresentation and/or misappropriation of assets.

Based on a sample of contracts between MCFD and the residential agency, the accounting firm concluded that there were significant variances between budgeted and actual amounts spent and recommended that further work be undertaken to determine whether the agency had been operating outside the parameters of its MCFD contracts and if the ministry was legally entitled to request the return of funds provided.

The accounting firm also proposed a more detailed follow-up review that would quantify the amount, if any, of overpayment and determine the actual costs of delivering the specified services by examining all the agreements that were in place.

MCFD declined to proceed with this further review as it had already decided to terminate all the residential agency's contracts and believed that further expenditure was not supportable on a cost-benefit basis. However, the Representative believes that the ministry should have considered the deterrent effect that a deeper review might have had on other residential agencies in the future.

“The reason we stopped and didn’t do a forensic audit is because it was going to be very expensive and we were shutting [the residential agency] down and probably wouldn’t have gotten any money back anyway.”

– Senior ministry official

Importance of Métis Identity

Finding: Despite existing legislation, standards and policy mandating that Indigenous children in care be connected to their culture in a meaningful and consistent way, Alex’s cultural identity was largely ignored by his 23 social workers and caregivers during the 11 years that he was in the care of the provincial government. Had Alex been given a real opportunity to develop a strong cultural identity and a feeling of belonging with his Métis community, the outcome for him may well have been different.

Culture

“Systems of belief, values, customs, and traditions that are transmitted from generation to generation through teachings, ecological knowledge and time-honoured landbased practices. Culture take many forms which include (but are not limited to) ceremonies, methods of hunting, fishing and gathering foods, the gathering and use of traditional medicines, traditional diet, spiritual journeying, and traditional art forms such as drumming, dancing and singing. It is also important to recognize that culture is not static, it is dynamic and ever-changing and each community, particularly urban communities, may define and experience it differently.”

– McIvor⁷

⁷ Onowa McIvor and Art Napoleon, “Language and Culture as Protective Factors for At-Risk Communities,” *Journal of Aboriginal Health* 5 (2009): 7.

The *CFCS Act* begins with “*definitions and interpretation*” whereby Part 1 in Section 1 stipulates what defines an “*aboriginal child*”. MCFD case notes indicated that Alex’s father’s paternal grandmother was Cree. The earliest MCFD documentation identified Alex as having Aboriginal ancestry and the term Métis was used by MCFD to describe his ancestry. Therefore, as per the *CFCS Act*, 1 (1) (c) when a child is “*under 12 years of age and has a biological parent who (i) is of aboriginal ancestry, and (ii) considers himself or herself to be aboriginal*” the child is Aboriginal. This fact, as laid out by the legislation, then forms the context for Alex’s story. RCY investigators were unable to find any conclusive evidence that could confirm or refute his Métis heritage.

While the *CFCS Act* defines an “*aboriginal child*” in the context of child welfare practice in B.C., Alex’s cultural identity existed not because of legislation but by virtue of his family of origin, his history, his story and his connection to community and land. All of these powerful mechanisms exist outside of legislation. Legislation informs funding and practice, whereas cultural identity is intrinsic.

Legislation is written from a Eurocentric⁸ perspective and this informs how people conduct themselves in systems. For example, the Aboriginal Operational and Practice Standards and Indicators (AOPSI) practice guidelines include reference to what a social worker must do when extended family or community placements aren’t available for a child. The social worker is to “*ensure the caregiver is sensitive and knowledgeable of the child’s heritage and identity and willing to support ongoing, regular contact with the child’s family; ensure the child has access to his or her community’s history, language, ceremonies, foods, and cultural, spiritual, artistic, athletic and recreational activities.*”

AOPSI Standard 1

Preserving the Identity of the Child in Care and Providing Culturally Appropriate Services, includes an overarching practice directive. It states that the Director will preserve and promote the cultural identity of the child in care and provide services sensitive to the child’s views, cultural heritage and spiritual beliefs.

MCFD considered Alex to be Indigenous from the beginning of its involvement with his file, identifying him as Métis. Three years later, his ROOTS worker in her closing report also wrote: “. . . *it appears as though the father . . . identifies as Métis. Therefore, Alex should be considered Métis unless new information is found.*” The Director, as Alex’s legal guardian, had the duty and obligation to explore, foster and nurture his cultural identity per the *CFCS Act* and the AOPSI standards.

Each month, for the last seven years that Alex was in care, his caregivers are documented as having had conversations with him about his cultural identity and religion. In each instance, they documented that Alex was not interested in gaining further understanding or information. An exact statement to this effect was cut and pasted month after month, meaning that attention to Alex’s cultural needs was clearly not meeting AOPSI standards. This pattern certainly failed to adhere to the intent behind AOPSI. Compounding this fact, Alex had non-Aboriginal caregivers and non-Aboriginal social workers and was

⁸ Definition: centred on Europe or Europeans; especially reflecting a tendency to interpret the world in terms of European or Anglo-Canadian values and experiences.

surrounded by people who were neither sensitive nor knowledgeable about his culture and heritage. As a result, he was left culturally disconnected which the Representative can only conclude left him struggling with his identity.

Throughout the time that Alex was in care, his cultural identity was largely ignored – initially by MCFD and later by the DAA. This is particularly troubling since DAAs are supposed to, by their very existence, have a deeper understanding of the importance of cultural identity, cultural heritage, cultural reconnection and cultural preservation. The abject failure of the DAA to provide Alex with his basic right to cultural connection is highly concerning to the Representative. It is difficult to understand how, over the almost 11 years that he was in care, legislation, standards and policy designed to ensure that he remain culturally connected went mostly ignored by his eight social workers and 15 caregivers.

While the ROOTS program itself has excellent goals that fit within AOPSI guidelines, RCY investigators discovered that funding cuts to this important program seriously hampered its ability to reach its goals. In Alex's case, an initial trip to meet and visit family in Québec was facilitated through ROOTS, but a subsequent trip did not occur as the program's travel budget had been cut and there were insufficient funds. This speaks clearly to the lack of value placed on Indigenous culture by the provincial care system and those who design and administer it. AOPSI standards, ROOTS initiatives and other mechanisms for ensuring cultural connection, while explicitly good, seem to lack effective funding and the genuine backing of senior leadership in the ministry.

While the ROOTS program initially connected Alex to his extended family, the failure to follow through on supporting these family connections most likely meant that a possible family placement option for him was lost. The negative impact on Alex of the care system failing to properly pursue these family connections was reinforced when RCY investigators met with Alex's half-brother. He, too, had been removed from their mother at a young age but, unlike Alex, he was surrounded by extended family and is now leading a productive life, supported by that family.

United Nations Convention on the Rights of the Child (UNCRC)

The *UNCRC* is a human rights treaty that sets out the civil, political, economic, health and cultural rights of children. These rights are specific to children's needs and affirm that every child has basic rights which include the right to life, the right to a name and identify, the right to be raised by parents within a family or cultural grouping and the right to have relationships with both parents even if they are separated.

The role of the Director was to find a permanent placement option for Alex. The ROOTS worker was able to locate family, and it was the responsibility of the Director, through the guardianship social worker, to further explore the suitability of this option. Alex had a right to a permanent placement and a right to be with family. Those rights, which are culturally inherent and ensured by both the Rights of a Child in Care and the *United Nations Convention on the Rights of the Child*, were ignored. The cost for Alex was tragic.

RCY investigators found that in the earliest record, social workers noted that Alex was indeed interested in connecting with who he was as a Métis person.

However, his social workers consistently failed to adequately support any connections for Alex to his culture. It is therefore not surprising that social workers and caregivers later, and until his death, documented his lack of interest in his Métis heritage.

Social workers who dealt with Alex failed to explore the reasons for his resistance to his Métis heritage. Reasons for this are unclear but the ministry was clearly obligated to connect Alex to positive role models and elders in the Métis community if cultural connection through family was not possible.

It is the role of the social worker to support a child or youth to develop a strong identity. A variety of research⁹ has shown that culture is a protective factor for children and youth. If Alex had been given the opportunity to develop a strong cultural identity and a feeling of belonging with his Métis community, and if his cultural rights had been encouraged and supported, the outcome for him may have been quite different.

It is interesting to note that when RCY investigators asked social workers about AOPSI standards and Alex's Métis heritage, two responses were consistently given. One was that Alex wasn't interested in his heritage and the second was that AOPSI standards are mostly impossible to meet due to high caseloads, coupled with the complexity of the caseloads.

Report to the Métis Commission for Children and Families of British Columbia: Framework for Métis Child and Family Wellness in British Columbia

MCFD jointly funded a project in March 2011 by the British Columbia Métis Commission. That report clearly outlines traditional Métis values as well as recommendations that included the need for:

- Collaboration to examine broader issues such as poverty, housing, addictions, family violence and health concerns, including access to mental health services;
- Cultural and spiritual ties for children in care be enhanced to foster a positive Métis identity;
- Reconnection support for programs such as ROOTS, and;
- Treatment centres for Métis youth as a necessary component of the continuum of services for Métis children, youth and families.

Jeannine Carriere, *Our Past, Present, and Future.....Report to the Metis Commission for Children and Families of British Columbia: Framework for Metis Child and Family Wellness in British Columbia* (2011), 23-24.

With regard to Alex and his own lack of interest in his Métis heritage, it is not uncommon for Indigenous children who are surrounded by non-Indigenous peers and raised exclusively by non-Indigenous caregivers to reject their Indigenous heritage. Palmeto (2011) states, “*individuals judge themselves and others based on where they fit in the ‘Indianness scale’ which is a creation of the colonizers. Colonizers . . . created the image of what it is to be Indian based on ‘one Indian people who existed at a frozen point in time.’*”¹⁰

9 Kathleen Bennett, “Cultural Permanence for Indigenous Children and Youth: Reflections from a Delegated Aboriginal Agency in British Columbia,” *First Peoples Child and Family Review* 10 (2015): 105.
10 Natalie St. Denis and Christine Walsh, “Reclaiming my Indigenous Identity and the Emerging Warrior: An Autoethnography,” *Journal of Indigenous Social Development* 5 (2016): 9.

It is clear that Alex's lack of interest in his Métis culture, which was compounded by the trauma of being shuttled through a litany of care placements for most of his young life, was not a valid excuse or justification for not making more meaningful efforts to engage him with the Métis part of his identity. The Representative has to ask: was Alex's lack of interest in exploring his Métis heritage, culture and identity more accurately a lack of understanding? In essence, was he suffering from an identity crisis? Research has shown that there is a direct correlation between high-risk behaviours and the loss of cultural identity.¹¹

Putting the blame for the situation and the responsibility for finding the solution on Alex, when the *CFCS Act* pays careful attention to Indigenous heritage, is wrong. Alex failed to receive a unified approach and respect for his cultural needs as well as the “paramount considerations” that are supposed to be assigned to culture as cited in the Act, which states that the “family is the preferred environment for the care and upbringing of children”, and which extols the benefits of “kinship ties and a child's attachment to the extended family” and “the cultural identity of aboriginal children”. None of these aspects of the *CFCS Act* were applied in Alex's case. As a result, Alex lacked awareness of what it meant to be Métis, lacked knowledge about his culture and never had the opportunity to be supported by Métis relationships.

The responsibility for supporting Alex to explore his heritage and working through whatever barriers that may have existed lay solely with his guardian, the state. Further, if social workers are unable to fulfil this right, then it is the responsibility of government to ensure that caseloads are manageable enough that Indigenous youth, historically traumatized by state practices, are protected from continued disassociation from their land, people and cultural practices.

Mental Health

Finding: Despite five separate referrals to Child and Youth Mental Health services, and overwhelming evidence that Alex desperately needed robust and effective mental health interventions to cope with repeated traumatization, he was never connected to appropriate services and this failure had a direct link to his subsequent death.

“As a child, Alex has experienced significant trauma involving neglect and has witnessed and experienced physical abuse chronically. He has been removed multiple times from his biological parents. Alex has had chaotic home environments with multiple foster care settings and without any stable attachment figures in his life. He has not had any stable follow-up with a mental health team or a counsellor.”

– Psychiatrist who conducted BCCH assessment on Alex at age 10

Alex had a life characterized by early losses and repeated, wrenching instability caused in large part by the many moves he was subjected to during his time in care. These events inevitably left him with significant trauma that research shows can have life-long adverse effects. What is striking, however, was how the professionals responsible for his well-being

¹¹ Dr. Martin Brokenleg, <http://martinbrokenleg.com/>

repeatedly acted in ways that contributed to his burden of trauma and then took no concrete steps to try to mitigate the damage that had been done.

Children and youth in the child welfare system have a significant chance of engaging in behaviours that threaten their health, including substance use, suicidality and aggressive behaviour.¹² CYMH services, designed at least in part to support the child and youth in care population, are among ministry services that are described as “voluntary”. Participation in them is a choice, not a compulsory direction. In Alex’s case, however, he never had a meaningful or timely opportunity to participate in services that could have mitigated some of his overwhelming loss and sadness.

Child and Youth Mental Health

Alex’s first two referrals to CYMH came in May 2006 and December 2007. The first referral collapsed when Alex was moved from one placement to another, with no follow-up. The second referral also failed based on both his changed location and the perception that his need for help was not urgent.



In June 2008, the referral was closed because Alex had been connected to a psychiatrist – the same psychiatrist who would refer him back to CYMH seven months later, in that case hoping that CYMH would provide in-house training for Alex’s coterie of caregivers. Alex’s primary caregiver declined to participate in this proposed training, a startling choice that should have prompted a response from the social worker who was supposed to be the decision-maker in this critical area of Alex’s life.

A 2008 psych assessment found that: “Alex is an interesting, likeable, and talented 11 year old who has been living in chronically unstable situations with multiple losses and transitions through the years.” Coupled with the findings of the psych assessment completed two years earlier, it should have been no secret to anyone connected with his file that Alex needed serious ongoing therapeutic supports. The only psychiatrist connected with Alex for any extended period of time was really only involved in prescribing medication for him, not actually providing therapy, and the net outcome for Alex was no real mental health services despite his obvious and well-documented needs.

Alex’s final CYMH referral was in June 2011. This referral was rejected a year later because Alex was deemed to be “AWOL” or absent from his placement.

12 L.K. Leslie et al., “Health risk behaviours in young adolescents in the child welfare system,” *Journal of Adolescent Health* 47 (2010): 26-34.

Despite being identified as Métis from the beginning of his involvement with the ministry, Alex was never provided with access to Aboriginal Child and Youth Mental Health – a program stream that is supposed to provide culturally appropriate services to Indigenous youth. This is a particularly alarming omission given the years he spent in the care of a DAA.

The issue of timely access to mental health services will not be a new one to regular readers of RCY reports. This topic was the focus of *Tragedy in Waiting: How B.C.'s mental health system failed one First Nations youth* (September 2016), in which the Representative called on MCFD to appropriately resource mental health services for Aboriginal children and youth to reduce wait lists. This aligned with the recommendation made by the Select Standing Committee on Children and Youth in its report *Concrete Actions for Systemic Change* (January 2016). In that report, the Committee called for the establishment of clear timelines for the provision of services, recommending that children and youth presenting with mental health concerns be assessed within 30 days and provided treatment within a further 30 days. Despite this widespread consensus, concrete action on the part of government in this area has yet to occur.

In his 2007 assessment, Alex's psychiatrist recommended attaching him to a caseworker and counsellor with the goal of helping him develop coping skills and tools to reduce his anxiety and acting out. Rather than skilled therapeutic professionals, however, Alex was left in the care of individuals whose professional backgrounds included truck driving and working as the doorman at a bar.

The same 2007 assessment noted Alex's multiple strengths, including his considerable athletic skills, his talents with arts and crafts, his politeness and good manners and his attachment to his stepmother and his aunt's family in Ontario. Unsupported, these positive factors could not help Alex to overcome a life-long history of trauma and abuse.



Recommendations

Recommendation 1

That the Ministry of Children and Family Development provide necessary support for children and youth in care who are unable to return to their birth family to achieve permanency with extended family or another adult with a positive connection, as articulated in the ministry's own legislation and policy. This would be accomplished by the ministry creating a robust support model that would provide family members with the services required to support such placements and social workers with the time necessary to facilitate such placements.

Details:

- Services and supports provided to families to include, as necessary, child care, respite care, mental health assessment and treatment services, caregiver training, cultural competency training and support, family counselling, and any other resource or service that would increase the likelihood that such a placement can provide long-term stability for a child or youth.
- Recognizing that supporting such family placements requires not just funding but also significant levels of social worker engagement and planning, social workers to be provided with the additional time and resources necessary to avoid, whenever possible, a child or youth moving into the care of a contracted agency.
- MCFD to implement quality control measures to ensure that the permanency planning that is required as part of all Care Plans thoroughly considers all out-of-care options as placements before placing a child elsewhere.
- MCFD to ensure that the ROOTS and Family Finders programs be funded to levels necessary to support guardianship workers in connecting with extended family of children and youth.

Draft plan to accomplish these changes to be presented to the Representative by Sept. 1, 2017.

Recommendation 2

MCFD to take action on fulfilling recommendations made by both the Representative for Children and Youth in *Finding Forever Families: A Review of the Provincial Adoption System* (June 2014) and Grand Chief Ed John in *Indigenous Resilience, Connectedness and Reunification – From Root Causes to Root Solutions* (November 2016) to bring Care Plans into compliance with standards already called for in legislation and policy. Key ingredients in these plans that must be prioritized are steps to ensure that permanency is being actively pursued for every child or youth who is on a CCO; and that every Indigenous child or youth on a CCO has a robust cultural plan connecting them to their Indigenous heritage.

Details:

- Resources to be provided to social workers to ensure that they have the time and support required to complete this important cultural and permanency work.
- Training to be provided to social workers to ensure they have sufficient competency to complete and action a robust cultural plan for each Indigenous child or youth in care.
- MCFD to work in partnership with B.C.'s Indigenous communities to develop an effective system to ensure that Indigenous expertise and contacts are available so that cultural plans can be developed specific to children and youth from all First Nations and Métis groups in B.C., no matter the location of the child or youth.
- MCFD to audit all Care Plans of children and youth residing in a contracted residential home on an annual basis to ensure their needs are being met and that permanency options are being explored.
- MCFD to regularly audit Care Plans for permanency and cultural planning and progress and report results publicly on an annual basis.
- Representative's Office to provide ongoing oversight by conducting additional periodic audits of Care Plans.

Draft plan to be presented to the Representative by Sept. 1, 2017.

Recommendation 3

That MCFD ensure that children or youth in care who have been identified with mental health needs receive timely and uninterrupted mental health services, regardless of any changing circumstances in their lives.

Details:

- MCFD to sufficiently resource ACYMH so that it is able to accommodate all Indigenous children and youth who require screening, assessment and/or outreach services in a timely manner.
- MCFD to ensure that mental health supports are provided for youth experiencing distress over aging out of care.

Draft plan to accomplish these service changes to be presented to Representative by Sept. 1, 2017.

Recommendation 4

That MCFD allocate additional resources within the ministry to significantly enhance the provision of quality assurance oversight and financial accountability for all contracted residential agencies. The Representative supports the Auditor General's plan to review the ministry's use of contracted services but calls on MCFD, in the meantime, to take immediate action.

Details:

- The highest priority to be given to the monitoring of service delivery quality and outcomes for children and youth in care by contracted residential services, using rigorous and clearly articulated standards. This activity, over and above the regular activities of resource and guardianship social workers, to be focused on the quality of care, and to include an immediate assessment of the circumstances of every child and youth in care in a contracted residential service. Ministry to create new criteria for the screening and assessment of all caregivers employed by contracted residential agencies to ensure that they have the background, skills and abilities necessary to support positive outcomes for the children and youth in their care.
- Ministry to review the background and qualifications of all staff who are currently providing care to children and youth in contracted residential agencies against new criteria.
- Recognizing that more than 60 per cent of the children and youth in care are Indigenous, priority in hiring to be given to Indigenous applicants. Standards to require that all staff to have training in addressing the cultural needs of Indigenous children and youth.
- Mandatory annual financial audits to be conducted by ministry staff on each residential service contract, ensuring that funding is both adequate for the needs of the child or youth and that public funds are being appropriately allocated and dispersed by the contracted agency. Random and unannounced visits to contracted resources should form an integral part of both the quality assurance and financial accountability framework.

Draft plan to ensure such oversight and accountability to be presented to the Representative by Sept. 1, 2017.

Glossary

Aboriginal: “Aboriginal” is the official term in Canada for First Nations, Inuit and Métis people. The term “Aboriginal” is used when it is embedded in the name of an agency or program. The preferred term is “Indigenous.”

Adoption: Adoption is a legal and social process whereby a person becomes the parent of a child. In terms of the law, the adoptive parents have the same responsibility to an adopted child as a birth child.

Age Out: In B.C. youth “age out” of foster care when they reach 19. At this time, MCFD is no longer the legal guardian of the youth and the youth is considered an adult.

Child Protection Services: Services delivered under the *Child, Family and Community Service Act* in response to reports of child abuse or neglect. Child protection services can include investigation, providing or arranging for support services to families, supervising the care of children in their homes, and protecting children through removal from their families and placement with relatives, foster families or specialized residential resources.

Child, Family and Community Service Act (CFCS Act): Legislation enacted in 1996 that governs child protection in British Columbia.

Federation of Community Social Services of BC: An organization that represents 140 member agencies that offer support through a wide spectrum of services that include employment programs, early childhood education, disabilities services, homeless outreach and family programs.

Fetal Alcohol Spectrum Disorder (FASD): FASD is an umbrella term describing the range of effects caused by prenatal exposure to alcohol. These may include physical, mental, behavioural, and/or learning disabilities.

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*.

Indigenous: This report uses the terms “Indigenous” and “Aboriginal” interchangeably. The term “Aboriginal” is used when it is embedded in the name of an agency or program. The preferred term is “Indigenous.” “Aboriginal” is the official term in Canada for First Nations, Inuit and Métis people.

Individual Education Plan (IEP): An IEP is designed for a student in consultation with parent/s, the student, teacher, school counsellor, education assistant and other people as needed and includes one or more of the following:

- (a) learning outcomes for a course, subject and grade that are different from or in addition to the expected learning outcomes for a course, or subject and grade set out in the applicable educational program guide for that course, subject and grade, as the case may be;
- (b) a list of support services required for the student to achieve the learning outcomes established for the student;

(c) a list of the adapted materials, or instructional or assessment methods required by the student to meet the learning outcomes established for the student in the IEP, pursuant to a ministerial order or in a local program.

Métis: This is a contested term which a Supreme Court of Canada ruling in 2003 clarified thereby including Métis people as ‘status Indians’ allowing them access to the benefits and legal rights formerly denied them. Generally in western Canada, Métis is defined as a person of mixed First Nations and Euro-Canadian ancestry who self-identifies as Métis, is distinct from other Indigenous peoples, enjoys contemporary Métis community acceptance and is of a group of such people who in the 19th century constituted the Métis nation in the areas around the Red and Saskatchewan rivers.

Permanency: In a child welfare context, this term refers to the practice of finding safe, permanent homes for children and youth as quickly as possible. This might mean reuniting with family but in many cases children and youth find permanency with relatives or adoptive families. Permanency in B.C. is generally considered to include three dimensions:

- Relational permanence consists of enduring, loving, and trusting relationships with parents or foster parents, and access to extended family, siblings and friends.
- Physical permanence, often referred to as ecological permanence, is characterized by stability of environment, which includes school, community and neighbourhood.
- Legal permanence consists of the court determined relationship between the child and primary caregiver(s).

Permanent Ward: A term used throughout Canada (also Crown wards in Ontario) describing the relevant provincial government’s legal responsibility as legal guardian of the ward; a child or youth.

Pre-apprenticeship Program: A foundation program allowing a student to acquire the basic knowledge and skills needed for entry into a trade.

Protocol Investigation: An investigation initiated by MCFD or the DAA when allegations of abuse or neglect are made regarding a child or youth placed in a foster home.

Provincial Director of Child Welfare: MCFD staff person who since April 2011 provides oversight to child welfare practice and quality assurance as outlined in the *Child, Family and Community Service Act*. This person acts as a central point of contact and accountability for child welfare issues in B.C.

Quality of Care Review: An investigation initiated by MCFD or the DAA when allegations that the rights of a child or youth in care have been breached or the quality of care provided to a child or youth has not met the standards described in MCFD’s standards for foster homes.

Residential Agency: This term is interchangeable with ‘group home’, ‘staffed residential care home’ and ‘staffed residential resource’. A residential agency is a home-like setting in which one or two children or youth are housed with at least one rotating 24-hour staff caring for them. These agencies are contracted with MCFD or the DAA and are mostly for-profit agencies (approximately 75 per cent) with the remaining amount non-profit.

Respite Care: Temporary care provided by MCFD or the DAA to alleviate the emotional and physical demands of caring for a child or youth.

Society Wardship Order: An Ontario term also called a 'wardship order' which places a child or youth in the care and custody of an Ontario Children's Aid Society for a period of up to 12 months.

Steroid: A common term for an organic compound used by some athletes and body builders to enhance their physical appearance. The synthetic variation of the male sex hormone, testosterone, is an anabolic-androgenic steroid. The term anabolic refers to muscle building while androgenic refers to male sex characteristics.

Transfer of Custody: There are two types of Transfer of Custody orders: Transfer of Custody (54.1) – This allows a person other than a child's/youth's parent to be the guardian of a child/youth, who is in the continuing custody of the ministry, until they are age 19. Transfer of Custody (54.01) – This allows a person other than a child's/youth's parent to be the guardian of a child/youth until they are age 19 years. This option is an alternative to bringing the child/youth into the Director's care and applying for permanence after a Continuing Custody Order.

Appendix A: Interviews Conducted During the Representative's Investigation

- CYMH (2)
- DAA (11)
- Family and Friends (10)
- Hotel Staff (4)
- MCFD (17)
- Medical Professionals (5)
- Public Guardian and Trustee (1)
- School staff members (6)
- Staffed residential resources staff members (12)

Total number of interviews conducted: 68

Appendix B: Documents Reviewed for the Representative's Investigation

BC Coroners Service Records

Kimble report for Alex
Coroner's report for Alex

MCFD Records

Family service file
Child service file
CYMH files
Critical Incident files (2)
Placement files (2)
Resource files (11)
Contracted resource protocol report
Loose filings (receipts, daily logs, incident reports, monthly reports)
Reportable circumstance report
Delegation agreement

Police Records

Relevant regional police files

Ministry of Education Records

School records in relevant school districts

Medical Records

Family doctor records
Psychiatrist records
Counselling records

Text Messages

PGT files

Contracted Resources Files

Records pertaining to any of the individual homes Alex was placed at while in the care of the contracted resource
Internal and external correspondence regarding Alex
Reports and/or notes concerning Alex
Records pertaining to all staff members who worked with Alex over the years – both primary and relief caregivers

Legislation, Regulations, Standards, and Policy

Child, Family and Community Service Act (1996). Victoria, B.C. Queen's Printer.

Ministry of Children and Family Development. (2006). *Child and Youth Mental Health Standards*.

Ministry of Children and Family Development. (2005). *Aboriginal Operational and Practice Standards and Indicators*.

Ministry of Children and Family Development. (2006). *Caregiver Support Service Standards*.

Ministry of Children and Family Development. (2003). *Child in Care Service Standards*.

Coroners Act (2007). Victoria, B.C. Queen's Printer.

Family Law Act (2011). Victoria, B.C. Queen's Printer.

Appendix C: Multidisciplinary Team

Under Part 4 of the *Representative for Children and Youth Act*, 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

Following is the list of members that comprised the team when the report was last reviewed:

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.

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.

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. 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.

Dr. Christine Hall – Dr. Hall is the Medical Director of Trauma Services for the Vancouver Island Health Authority, 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.

Deputy Chief Derren Lench – Derren Lench is currently with the Central Saanich Police Service where he is Chief Superintendent, Deputy Criminal Operations Officer in Core Policing. He recently joined the municipal service after 35 years with the RCMP. Deputy Chief Lench is the outgoing President of the BC Association of Chiefs of Police.

Margaret Colbourne, MD, FRCPC – Dr. Colbourne is a clinical associate professor in the Dept. of Pediatrics at UBC and Director of the Child Protection Service Unit [CPSU] at BC Children's Hospital. Margaret has worked both as a Pediatric Emergency Physician and a CPSU pediatrician since joining the hospital staff at BC Children's Hospital in 1994. She has served as a committee member of the Royal College of Physicians and Surgeons of Canada's Pediatric Emergency Medicine Examination Board and holds a Founder designation in Pediatric Emergency Medicine. Margaret is actively involved in many aspects of medical education and clinical research. Her areas of interest including topics in both pediatric emergency medicine as well as child maltreatment.

Dave Attfield – RCMP Chief Superintendent Attfield is the Deputy Criminal Operations Officer for Core Policing in B.C. This area includes oversight of our provincial programs relating to children and youth which are delivered through "E-Division" Crime Prevention Services. Dave serves on several BCACP committees including Violence Against Women; Mental Health and Addictions; and Crown-Police Liaison.

Deb Whitten – Deb Whitten is currently an associate superintendent of schools in the Greater Victoria School District (SD 61). Prior to this role, she was the District Principal of Student Services where she worked closely with students and families in supporting their educational goals. Deb is an advocate for youth as they transition through our schools and into adulthood. Deb has been working collaboratively with community stakeholder groups to address mental health concerns and continuity of support and services.

Dr. Rachelle Hole – Dr. Hole is an associate professor at UBC’s School of Social Work in the Okanagan and co-director of the Centre for Inclusion and Citizenship at UBC. Dr. Hole’s research includes a focus on human rights and social inclusion, supports and services for individuals with intellectual disabilities and their families, and transitioning youth with disabilities. Prior to pursuing her academic career, Dr. Hole was a community mental health worker and a family support worker.

Michael Egilson – Michael Egilson is the Chair of the Child Death Review Unit for the BC Coroners Service. Michael has worked in the public sector for the past 30 years in various capacities related to the health and well-being of children and youth. Over the past three years, he has convened a number of child death review panels culminating in public recommendations to improve public safety and prevent similar deaths in the future.

Kate Hodgson – Kate is the Coordinator at Ray-Cam Co-operative Centre, one of the key partners in Our Place – a collaboration of residents, community organizations, local business and community leaders in Vancouver’s Inner City committed to ensuring that our children and youth have every opportunity for success. She has extensive experience working in Vancouver’s Downtown Eastside/Strathcona neighbourhood over the past 16 years, including as the Executive Director for the Network of Inner-City Community Services Society. She has been a director on the board of the Federation of BC Youth in Care Networks and an advisor to the Vancouver Foundation’s Youth Homelessness Initiative.

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Contacts

Phone

In Victoria: 250-356-6710

Elsewhere in B.C.: 1-800-476-3933

E-mail

rcy@rcybc.ca

Fax

Victoria: 250-356-0837

Prince George: 250-561-4624

Burnaby: 604-775-3205

Website

www.rcybc.ca

Offices

400 – 1019 Wharf Street

Victoria, B.C. V8W 2Y9

1475 10th Avenue

Prince George, B.C. V2L 2L2

#150 4664 Lougheed Hwy.

Burnaby, B.C. V5C 5T5



B.C.'s Representative
for Children and Youth
and RCYBC Youth



@rcybc and @rcybcyouth



Rep4Youth



@rcybcyouth



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