REPRESENTATIVE FOR
CHILDREN AND YOUTH

Representative's Report

Critical Injuries and Deaths: Reviews and Investigations
Update # 31

Reporting period: June 1, 2017 to March 31, 2018

Purpose

The purpose of the Representative for Children and Youth's (RCY) reviews and investigations of child deaths and critical injuries is to identify and thoughtfully analyze issues, particularly in service delivery. The intent is to help prevent similar deaths or injuries in the future and to inform improvements to services.

Independently reviewing, investigating and reporting out on these deaths and critical injuries are essential elements of public accountability and promoting public confidence in the child-serving systems. These reviews and investigations are done in an independent, fair, respectful and thorough manner.[1]

Process

Critical injuries and deaths involving children and youth receiving reviewable services at the time of, or in the 12 months previous to, the incident must be reported to the Representative. The vast majority of these reports are sent to the Representative from the Ministry of Children and Family Development (MCFD), Child and Youth Mental Health (CYMH) and/or Youth Justice (YJ) service streams. The Coroners Service sends the Representative death notifications.

The Representative's staff conducts an initial review of each injury or death report to identify whether the report meets the Office's mandate. In about 58 per cent of cases, no service-delivery issues are identified. In these cases, the report is considered to be outside the scope of the Representative's mandate. Such cases include situations where, for example, the child was medically fragile and the death was expected, or the cause was clearly accidental.

This update includes descriptive statistical data on the approximately 42 per cent of cases that do meet the Representative's mandate. Of these cases, some are selected for a comprehensive review during which the Representative considers whether service delivery issues may have been a key factor in the death or critical injury. When conducting a comprehensive review, staff take a more in-depth look at the circumstances of the incident, including ordering and examining records from various public bodies. A comprehensive review report is prepared.

The Representative selects from the comprehensive reviews a small number of cases for full investigation based on a determination that the services received by the child or youth – or lack of needed services – may have significantly contributed to the injury or death, that the injury or death was self-inflicted or inflicted by someone else, that the circumstances of the case were suspicious, or that there is evidence

[1] Previous *CID Updates* have reported on data for four-month periods that have not aligned with the RCY fiscal year (April 1 to March 31). In order to align reporting periods with fiscal years, this *CID Update* includes data from the last report until March 31, 2018.

that abuse or neglect may have been a factor in the incident.[2] A list of the Representative's investigations to date is included in this update. If the Representative decides not to conduct an investigation, the results of the comprehensive review are shared with the public body responsible for the service.

Changes to this report

During the 2017/2018 fiscal year, many changes occurred at the Representative's Office including the arrival of the second Representative, Bernard Richard, who identified addressing the need to reduce the over-representation of Indigenous children and youth in the child-serving system as a key strategic priority.

In order to assist in realizing this goal, the Representative's database was updated in September 2017 to include the ability to record an Indigenous child or youth's Indigeneity by whether they are First Nations, Métis or Inuit.

This edition of the *CID Update* is the final iteration of the report in this format. The Representative and his staff are redesigning a report to more effectively communicate the summary statistics of the injury and death reports that the Office receives. The Representative hopes that he can begin to consider more qualitative analysis of the over-representation of Indigenous young people in the child-serving system using data on whether an injury or death report of an Indigenous child or youth involves a First Nations, Métis or Inuit child or youth. The Representative is aware that First Nations, Métis and Inuit peoples have historically been subjects of research without consideration of the uniqueness of each group. He hopes that, by adhering to Indigenous research methodologies, respectful relationships will be enhanced and maintained.

A new version of this report is expected in December 2018. Subsequent reports will be published biannually.

In-Mandate Critical Injuries and Deaths

Reporting Period: June 1, 2017 to March 31, 2018[3]
During this reporting period, **669** injuries and **98** deaths of B.C. children and youth who were in care or receiving reviewable services within the previous year received an initial review by the Representative's staff and were determined to be in-mandate. A summary of the data related to these reports follows.

Critical Injuries:

669 injuries were determined to be in-mandate after receiving an initial review.

[2] Since fiscal 2009/2010 to 2016/2017, the average number of comprehensive reviews conducted by the Representative has been 19 per fiscal year.
[3] Information in this report is based on reports received by the Representative's Office at the time of this update. These numbers may change if additional reports of critical injuries or deaths that occurred in this reporting period are subsequently received by the Representative, or if additional information is received.

A. In-Mandate Critical Injuries by Age Category

Age	Number
Under 1-year-old	6
Age 1 – 5 years	28
Age 6 – 12 years	90
Age 13 – 18 years	545
Age 19 and over	0
Total	**669**

B. Care Status of In-Mandate Critical Injuries

Age	Child or Youth In Care	Child or Youth Not In Care
Under 1-year-old	4	2
Age 1 – 5 years	19	9
Age 6 – 12 years	71	19
Age 13 – 18 years	425	120
Age 19 and over	0	0
Total	**519**	**150**

C. Number of In-Mandate Critical Injuries by Indigeneity[4]

Age	Indigenous: First Nations	Indigenous: Métis	Indigenous: Inuit	Non-Indigenous	Unknown
Under 1-year-old	4	0	0	2	0
Age 1 – 5 years	15	4	1	7	1
Age 6 – 12 years	55	10	1	24	0
Age 13 – 18 years	277	45	0	223	0
Age 19 and over	0	0	0	0	0
Total	**351**	**59**	**2**	**256**	**1**

[4] The category "Indigenous children and youth," which has been used in previous *CID Updates*, is now broken down into the following categories: First Nations, Métis, Inuit, where specific Indigeneity is not known, 'Indigenous: Unspecified', and where Indigeneity is unknown, 'Unknown'.

Deaths:

98 deaths were determined to be in-mandate after receiving an initial review.

A. In-Mandate Deaths by Age Category

Age	Number
Under 1-year-old	22
Age 1 – 5 years	17
Age 6 – 12 years	17
Age 13 – 18 years	40
Age 19 and over	2
Total	**98**

B. In-Care Status of In-Mandate Deaths

Deaths	Child or Youth In Care	Child or Youth Not In Care
Under 1-year-old	1	21
Age 1 – 5 years	2	15
Age 6 – 12 years	2	15
Age 13 – 18 years	6	34
Age 19 and over	0	2
Total	**11**	**87**

C. Number of In-Mandate Deaths by Indigeneity

Age	Indigenous: First Nations	Indigenous: Métis	Indigenous: Unspecified	Non-Indigenous	Unknown
Under 1-year-old	5	1	1	12	3
Age 1 – 5 years	2	1	0	13	1
Age 6 – 12 years	5	1	0	8	3
Age 13 – 18 years	16	2	0	19	3
Age 19 and over	1	0	0	0	1
Total	**29**	**5**	**1**	**52**	**11**

Overall Summary:

June 1, 2017 to March 31, 2018

Each of the **669** mandate injury reports and **98** mandate death reports received an initial review. During this reporting period, **12** comprehensive reviews were completed. Of these comprehensive reviews, one included a review of several mandate critical injuries suffered by one youth.

During this reporting period, two projects involving aggregated injury and death data are being conducted as well as one investigation.

June 1, 2007[5] to March 31, 2018

During this period, **4,124** critical injuries and **1,097** deaths of B.C. children and youth who were in care or who were receiving reviewable services within the previous year were determined to meet mandate after an initial review.

Completed Critical Injury Reviews and Investigations:

- An RCY investigation of a critical injury was completed and a public report *(Isolated and Invisible: When Children with Special Needs are Seen but Not Seen) w*as released in June 2011.
- An RCY aggregate review, including 74 of these critical injuries, was completed, and a public report (*Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm*) was released in November 2012.
- An RCY investigation of a critical injury was completed and a public report (*Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children*) was released in February 2013.
- An RCY investigation of a critical injury was completed and a public report (*Children at Risk: The Case for a Better Response to Parental Addiction*) was released in June 2014.
- *An RCY aggregate review*, including 29 of these critical injuries, was completed, and a public report (*Who Cares? B.C. Children with Complex Medical, Psychological and Developmental Needs and their Families Deserve Better*) was released in December 2014.
- An RCY investigation of a critical injury was completed and a public statement on the report *Approach with Caution: Why the Story of One Vulnerable B.C. Youth Can't be Told* was released in May 2016.

[5] The reporting period begins June 1, 2007 because Part 4 of the *Representative for Children and Youth Act* was proclaimed on that date, giving the Representative legislative power to conduct reviews and investigations.

- An RCY aggregate review, including 145 of these critical injuries, was completed and a public report (*Too Many Victims: Sexualized Violence in the Lives of Children and Youth in Care)* was released in October 2016.

The investigations and reports listed above have been publicly released and are available at www.rcybc.ca.

Completed Death Reviews and Investigations:

- Two RCY investigations of four of these deaths have been completed and public reports have been released *(Honouring Christian Lee – No Private Matter: Protecting Children Living With Domestic Violence* was released in September 2009 and *Honouring Kaitlynne, Max and Cordon: Make Their Voices Heard Now* was released in March 2012).

- An RCY aggregate review, including 19 of these deaths, was completed, and a public report *(Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Infants)* was released in January 2011.

- An RCY aggregate review, including 11 of these deaths, was completed, and a public report (*Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm*) was released in November 2012.

- An investigation into one death was completed and a public report (*Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl*) was released in February 2014.

- An RCY aggregate review, including two of these deaths, was completed, and a public report (*Who Cares? B.C. Children with Complex Medical, Psychological and Developmental Needs and their Families Deserve Better*) was released in December 2014.

- An RCY investigation into the death of a young woman was completed and a public report (*Paige's Story: Abuse, Indifference and a Young Life Discarded*) was released in May 2015.

- An RCY investigation into the death of a young man was completed and a public report (*A Tragedy in Waiting: How B.C.'s mental health system failed one First Nations youth*) was released in September 2016.

- An RCY investigation into the death of a young man was completed and a public report (*Last Resort: One family's tragic struggle to find help for their son*) was released in October 2016.

- An RCY investigation into the death of a young man was completed and a public report (*Broken Promises: Alex's Story*) was released in February 2017.

- An RCY investigation into the death of a young man was completed and a public report (*Missing Pieces: Joshua's Story*) was released in October 2017.

- The remaining deaths will be included in future aggregate reviews, are being individually

- reviewed or have been individually reviewed.

The investigations and reviews listed above have been publicly released and are available at www.rcybc.ca.

Select Standing Committee Referrals Update:

The Select Standing Committee on Children and Youth referred an additional 20 deaths and two critical injuries to the Representative for Children and Youth. These deaths and critical injuries are not included in the Overall Summary numbers above and all occurred prior to June 1, 2007, at which time legislation was passed giving the Representative power to conduct reviews and investigations. All 20 deaths and both critical injuries have been reviewed and have resulted either in aggregate reviews and/or investigations, or no further action.

The investigations and reviews listed above have been publicly released and are available at www.rcybc.ca.

DEFINITIONS

Initial Review:

The Representative receives reports of injuries or deaths of children who were in care or receiving reviewable services at the time of the incident, or in the year previous. These reports receive an initial review to determine if they meet mandate, under the *Representative for Children and Youth Act*.

Comprehensive Review:

Critical injuries and deaths that do meet the criteria under the *Representative for Children and Youth Act* may proceed to a comprehensive review, which examines the circumstances and the services delivered to the child.

This may include examining medical records, MCFD case files, relevant policies and standards. As well, consultation with the Coroners Service and discussions with service providers, caregivers and parents may occur.

The purpose of a comprehensive review is to determine if there are service delivery issues or other circumstances that would require an investigation (defined below). Comprehensive reviews can be aggregated to identify and analyze recurring circumstances or trends in order to improve the effectiveness and responsiveness of reviewable services.

Investigation:

The Representative initiates an RCY investigation when the circumstances of the injury or death are suspicious, self-inflicted or when there is a question as to whether neglect, abuse or services the child received may have played a role in events leading to the injury or death.

By law, an RCY investigation must not inhibit the work of others. An RCY investigation does not proceed until police investigations and criminal court proceedings are completed. If there are no criminal proceedings, the RCY investigation proceeds when other processes, such as ministry reviews or coroner's inquests, are completed, or one year after the incident, whichever is earlier.

RCY investigation reports are presented to the Select Standing Committee on Children and Youth, and may be publicly released.

Aggregation of Data:

Data is aggregated to identify and analyze recurring circumstances or trends in child deaths and critical injuries. This is in keeping with recommendations made in the 2006 *BC Children and Youth Review*, in which the Hon. Ted Hughes noted: *"The primary method of reviewing child injury and deaths will be to examine aggregated information, and identify and analyze trends that will inform improvements to the child welfare system as well as broader public policy initiatives."* [6]

Reviewable Services:

Reviewable services are services or programs under the *Child, Family and Community Service Act* and the *Youth Justice Act*; mental health services for children; addiction services for children; services to children

[6] E.N. Hughes, *BC Children and Youth Review: An Independent Review of BC's Child Protection System* (Victoria, B.C.: Ministry of Children and Family Development), 2006, 36.

with special needs delivered by MCFD and Community Living BC; and additional “designated services” that may be designated under a Regulation.

MCFD Critical Injury Definition:

A critical injury is an injury to a child or youth that has resulted in, or that may in the future result in, a serious impairment of the child or youth’s health.

MCFD Serious Incident Reportable Circumstance Reports:

MCFD’s Reportable Circumstance Policy (June 1, 2015) describes two types of incidents: critical injuries and serious incidents. The Representative conducts an initial screening on all of the reportable circumstance reports received by MCFD regardless of the type of reportable circumstance report provided. The Representative determines which reports submitted by MCFD meet RCY’s criteria for a critical injury. In general, MCFD critical injury reports are reports of a child or youth who has received, or whose family has received, an MCFD/DAA-provided reviewable service within the preceding 12 months. MCFD serious incident reports are serious incidents involving a child or youth who is receiving a reviewable service AND is in care under the *CFCS Act*, is in care under the *Adoption Act,* is in an out-of-care placement including respite care under the *CFCS Act* s.5(2)(d); s.8; s.35(2) or s.41(2), is under a youth agreement under the *CFCS Act* s.12.2 and/or is under the guardianship of the director and the PGT.

RCY Critical Injury:

The *Representative for Children and Youth* Act definition of a critical injury is an injury to a child that may result in the child’s death, or cause serious or long-term impairment of the child’s health.