REPRESENTATIVE FOR
CHILDREN AND YOUTH

# *Who Protected Him?*

## How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children

February 2013

February 7, 2013

The Honourable Bill Barisoff
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting the report *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its most Vulnerable Children* 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,

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Mr. Craig James, QC
Clerk of the Legislative Assembly

Ms. Joan McIntyre
Chair, Select Standing Committee on Children and Youth

# Contents

# Executive Summary

At its essence, a child welfare system should protect society's most vulnerable children from abuse and neglect and fill the role of "prudent parent" for the children it takes into care.

This report details how British Columbia's child welfare system failed on both counts to fulfill these basic roles and it outlines the devastating effects that failure has had on the life of one Aboriginal child.

The report finds that the Ministry of Children and Family Development (MCFD) did not follow basic child welfare practice standards, leaving this child for more than two years in his parental home, where he suffered abuse and neglect.

After the ministry took the child into care, it failed to adequately fulfill the role of prudent parent. Basic child welfare practice standards that would have protected the child from further abuse and neglect were ignored and the child's special needs, education, health and cultural identity have all suffered from a lack of oversight and action by the ministry.

After removing him from his parental family, the ministry placed the child in a foster home where he lived for three years. In this home, he was subject to further physical and emotional abuse and neglect.

Not long afterward, the child went to live with a foster parent who made extraordinary efforts to address his special needs. He was doing very well in this home, but the foster parent needed support in order to continue in the role. The ministry did not provide those supports, resulting in another move for the child.

Inexplicably, the child was returned to his natural mother despite a clear lack of evidence that her parenting skills had improved sufficiently to justify this move. This return lasted less than a year and has been followed by nine more placements for the child to this date.

The ministry also failed to fully explore a promising adoption opportunity with an Aboriginal family that might have given the child a chance for a richer life.

As a prudent parent, the ministry is responsible for nurturing this child and all others in its care. Despite this, MCFD has clearly not yet found a lasting match that could be considered even adequate for this child's complex special needs and behavioural issues. As a result, during his time under the ministry's care, this child has been subject to a parade of ever-changing caregivers, living in 15 different foster or residential placements, not including hospitalizations, since 2001.

There is no doubt that the child who is the subject of this report presents behavioural issues that are extremely challenging for caregivers. But this does not excuse the ministry from its duty to provide care and nurturing for this child and others like him. The ministry's core business is to care for B.C.'s most vulnerable children. Its responsibility is to find ways to do so that further the child's development and protect him from harm.

Instead, the Representative has found through this investigation that all the residential placements the child has lived in since he was eight-years-old have featured a "safe room" –

a place where the child has been isolated for his safety and that of the staff working with him when his behaviours became aggressive.

The facilities in which the ministry has placed this child have used this tactic despite the fact there is no policy or legislation in B.C. that permits use of isolation outside of mental health facilities. The Representative finds it inconceivable that the ministry could allow use of such a room given the fact the child was reportedly traumatized by earlier confinement in both his natural home and one foster home. The Representative believes that these rooms have also been used as a punitive measure in a futile attempt to control the child's behaviours.

The failure to find a proper match for this child's special needs and behaviours illustrates the dire need for the ministry to develop a continuum of residential services for children and youth in B.C. with complex needs that cannot be met in traditional foster home or group home settings. Too often in this child's case, professionals involved felt they had to work outside the rules in order to actually help him.

Too often, workers involved with this child felt the need to call police in order to manage his behaviours. Police were called to assist caregivers on April 7, 2011, in an incident that resulted in the child being Tasered by an officer – the critical injury incident that led to the Representative preparing this report.

The key recommendation of this report is that the ministry immediately develop a robust plan to address this critical deficiency in matching children in care who have complex needs with a suitable residential placement that is properly staffed and equipped to help them rather than simply house them.

The Representative also recommends that MCFD immediately discontinue use of isolation and restraint as behaviour management strategies for children in residential care. Instances in which restraint is unavoidable during a crisis in order to protect the safety of the child or others should be reported to the Representative as critical injuries and followed up by a review of the child's plan of care.

As well as stressing the obvious need to meet basic child protection standards – something that was too often ignored in this child's case – the Representative recommends that the Office of the Provincial Director develop policy and standards to ensure that active senior management oversight is in place over the planning and delivery of services to and guardianship of children with complex special needs. This should include a system by which warning signs such as number of residential moves, lack of educational instruction, and use of police to manage behaviour are flagged. The Representative also recommends that the ministry develop an internal clinical unit to support residential care staff, social workers and policy makers who deal with children with these needs.

The story of this child is one that, in a compassionate society with a strong child welfare system, should never have to be told.

The Representative is aware that there are other children with similar complex needs in B.C. By telling the story of this child, pointing out where the system failed him, and recommending ways to improve that system, the Representative's aim is to help other children such as him avoid a similar fate.

# Introduction

The Tasering of an 11-year-old child precipitated this investigation by the Representative. Rather than viewing that single event in isolation, however, the Representative's investigation examined the child's entire life and the full spectrum of services that he and his family received, as well as all 22 reportable incidents involving the child – nine of which occurred after the Tasering.

The incident that sparked this investigation was widely reported in the media, and the identities and locations of some of those involved in providing care to the child were revealed. The child himself remains in the care of the ministry and must not be publicly identified by name. The Representative feels strongly that the privacy of the child, his parents and siblings should be respected by all in order to prevent further harm to the child.[1]

This report does not examine whether police use of a conducted energy weapon (Taser) was legally justified. That issue was examined during the course of an external investigation conducted by the West Vancouver Police Department, with the assistance of a police use-of-force expert. That investigation concluded that the police officers involved did not exceed the powers granted to them under the *Criminal Code of Canada*.

This report does examine the circumstances leading up to that use of force by police, including events that were well-known triggers for the child's anxiety and subsequent acting out. It also documents the frequent use of police to assist in managing the child's behaviour when it became too challenging for his caregivers.

The report examines whether the ministry adhered to its own standards of practice in its care for the child. It also examines whether the ministry fulfilled its duty as the prudent parent of this child. How the health care and education systems in B.C. served a child with a number of profound special needs who had experienced significant emotional and physical abuse and neglect, as well as the resulting trauma, is also documented.

As in every investigation by the Representative, the goal is not to assign blame or to hold individuals to account for actions or decisions that fall short of perfection. Rather, the goal is to identify recommendations for systemic improvement that will benefit all other children across B.C. like the child at the centre of this investigation.

In examining the work of the professionals who were involved with the child, the Representative does not apply a standard of perfect 20-20 hindsight vision. The standard applied is whether these professionals acted reasonably and appropriately given the available information and circumstances, within existing and known practices and policies in place at the time.

1 Section 16(1) of the *Representative for Children and Youth Act* specifies that reports will not contain information in an individually identifiable form.

The Representative acknowledges that many of the professionals who worked closely with the child stepped outside the boundaries of their mandates and jurisdictions to provide services to him. Their efforts should be commended, but the fact they believed it necessary to do so points to system barriers that must be addressed.

To achieve lasting and meaningful improvement to our system of supports and services to vulnerable children requires that we have a full understanding of their lives that can inform our future actions. This report is intended to provide that understanding.

# Methodology

The *Representative for Children and Youth Act (RCY Act)* empowers the Representative to review and investigate critical injuries and deaths of children in care of MCFD, as well as children and their families who have received specific government services during the past year.

MCFD has a legal duty to promptly alert the Representative of deaths and critical injuries of these children.

This report examines the period from June 1999, when the child was born, to December 2012.

Interviews were conducted with ministry staff, medical and education professionals, past and present caregivers and the mother of the child. In accordance with section 14 of the *RCY Act*, witnesses were ordered to appear, they answered questions under oath, and their interviews were recorded.

The child who is the subject of this report was not interviewed as part of this investigation, as the Representative determined that the facts required could be gathered through others without the risk of further traumatizing the child. Two of the Representative's investigators did have the opportunity to meet the child, solely for the purpose of assessing his current status.

The Representative's Multidisciplinary Team (see Appendix C) was briefed on the progress of the investigation, and provided comments to inform the ongoing work.

The Representative's Advisory Committee on Services to Special Needs Children and Youth (see Appendix D), which provides overall advice and guidance to the Representative with respect to children and youth with special needs in B.C., also provided significant assistance.

Organizations and individuals who provided evidence to this investigation were given an opportunity to review and provide comments on the facts in the report for the purpose of administrative fairness.

# Chronology

## Prior to Birth

The parents of the child who is the subject of this report met when they were 16-years-old. They lived in a small town in British Columbia. Their first child was born in 1997, when the mother was 17. The young parents struggled with their own troubled backgrounds.

The child's father, a young Aboriginal man, had been removed from his parental home because of alcohol-related neglect and domestic violence. He reported being the victim of violent physical abuse by a man who knew the family, and was taken into government care on a permanent basis in another province, where his family had lived. He moved frequently between foster homes, group homes, and other placements.

The child's mother had been raised by a relative from the age of 10. As a young child, she had been diagnosed with a learning disability and she struggled in school. She left home at age 16.

On Sept. 10, 1998, MCFD received a call from a relative, alleging that partying and domestic violence were occurring and that police had visited the couple's home.

Thirteen days later, the ministry received a call from police about the same residence. Police had again visited the home, finding both parents highly intoxicated, and concluded that physical violence had occurred prior to their arrival. Police persuaded the father to leave the home, but they remained extremely concerned about the baby. The mother refused to hand over the three-month-old – the older sibling of the child who is the subject of this report – to police, demanding that a social worker be called. A social worker attended the home and took both the mother and baby to a transition home for the night.

The parents' behaviour and the risk it posed to the child led MCFD staff to conclude that immediate intervention was required. The ministry removed the baby from the care of the parents.

Relatives of the mother, who lived in another province, became involved and made an application under the *Family Relations Act (FRA)* for custody of the baby. Child welfare authorities in the other province felt that this would be a suitable placement, and the B.C. ministry withdrew its own application for custody, allowing the family placement to proceed.

## A Second Child is Born

In the fall of 1998, MCFD social workers who were involved with the family learned from the mother that she was pregnant. File notes made by ministry staff at the time indicate that neither parent had engaged in any of the suggested counselling services that would prepare them to regain their first child or nurture the expected child. The father was on probation for previous convictions of possession of stolen property, sexual assault and assault and had refused any assistance. The mother had just begun to see an alcohol and drug counsellor. Although the file was closed at this point, the writer noted *"we believe that MCF will have future involvements with these young parents."*

According to social workers' notes, the mother described her second pregnancy as a time of significant stress. She described being physically abused by her partner and believed that her baby may have been injured while still in-utero. She was eating poorly, but said she didn't smoke or drink during the pregnancy.

In April 1999, the ministry received a call alleging that domestic violence was again occurring and also that there was no food in the couple's home.

MCFD did not open an intake as a result of this complaint, nor did a social worker visit the home. The Representative's investigators note that MCFD workers believed they could not initiate an intake because there was no child in the care of the parents at the time. Investigators could find no evidence of an alert being placed on the file, either.

The next documentation regarding this family was on June 8, 1999, when the ministry social worker was informed by a foster parent that the mother had given birth three days earlier to the child who is the subject of this report. The delivery was normal and the infant boy appeared to be healthy.

That same day, the family's financial assistance worker also notified the social worker of the birth and wondered if there were any concerns around the care of the baby given the fact the older sibling continued to live with extended family.

On June 10, the social worker consulted about this development with the team leader. No reports of concerns for the baby had been received by the ministry. Collateral checks were to be done with the Public Health nurse and RCMP.

Four days later, the ministry received a call reporting that the father had been arrested and was being held in jail for allegedly sexually assaulting another woman the day the baby was born. The social worker told the caller that the ministry was not currently investigating the new baby's situation and that unless a new report was received, Public Health had concerns, or RCMP records indicated violence, the ministry would not be involved.

On June 18, 1999, the social worker spoke with the Public Health nurse who had no concerns about the baby. The Representative's investigators could find no record that the social worker contacted the RCMP for an update.

## The Child's First Two Years

Some of the professionals familiar with the young family were extremely concerned about the capacity of the parents to care for their new baby. They told the Representative's investigators during interviews that they believed the ministry's desire to keep families together had unnecessarily delayed what they saw as the inevitability of the child being brought into care.

Shortly after his birth, the child began projectile vomiting. This was found to be the result of a narrowing of the opening between the stomach and the small intestine. This was surgically corrected when the child was six-weeks-old.

The father continued to be in conflict with the law during this period. The charge of sexual assault that had allegedly occurred the day his son was born was still being pursued. He was incarcerated for other charges shortly after the child's birth, and then went to trial for the sexual assault and an unrelated break-and-enter. He was free on bail until eventually being convicted of both offences in early January 2000 and sentenced to 14 months in jail.

On Sept. 15, 1999, MCFD recorded another complaint regarding this family after a caller reported concerns about domestic violence, lack of food in the home, and inappropriate caregivers taking care of the baby for long periods of time. By October 1999, ministry staff had determined that the child was at risk in the care of his parents. A Comprehensive Risk Assessment (CRA) for both parents was completed on Oct. 20. The overall risk rating was "high" for the child who is the subject of this report.

The CRA noted the mother's responses to the child's needs were inconsistent: *"On one occasion when [the child] had thrush, she did not follow through in taking him to the doctor until threatened that the ministry would be notified."*

The CRA also noted that: *"[the father] will place expectations onto [the child] that are well beyond the child's ability and comprehension. As [the child] is only three months of age, he is at risk of physical harm by the way [the father] handles [the child]. [The mother] seems to collide with [the father's] style of parenting and therefore will not intervene in these situations of possible risk . . ."*

The social worker, with the support of the supervisor, met with the parents and explained that they would have to agree to a new Support Services Agreement (SSA) or the ministry would remove the children from their custody. A Risk Reduction Service Plan was also completed following that meeting. (The Representative notes that this sequence of actions by the ministry in working with the family was unusual.)

The Risk Reduction Service Plan was put in place on Nov. 8, 1999, outlining steps the parents were expected to take, including refraining from violent behaviour toward each other and attending the Building Blocks parenting program. The plan also required the father to attend alcohol and drug counselling. Although there was discussion among

ministry staff about applying for a Supervision Order for the child who is the subject of this report, the parents ultimately accepted an SSA, which listed as its first goal: *"No more violence between [the father] and [the mother]."*

Respite care with a local care-provider was arranged for two days a week, beginning in February 2000. At the same time, the mother began attending a parent support program.

During this period, the mother also began to question the placement of her first child and felt her visitation rights were not being respected. The placement broke down shortly afterwards, when the relative caring for the older sibling became ill, and the sibling was returned to the mother's care in early May 2000. The Representative notes that the ministry was aware of the sibling's return to the home but that there is no documentation to indicate the Risk Reduction Service Plan was modified to reflect this change.

Social workers involved with the family noted that the mother was more compliant with their direction when she was on her own but, when the father returned to the home on parole in mid-December 2000, the situation worsened.

The home situation was complicated by the father's parole conditions – one of which stipulated that he was not permitted to be in the presence of children under the age of 12, with the exception of his son, without another adult present to supervise. This meant that he could not provide unsupervised care for the older sibling and he was resentful of the need to find another person to be present.

The parents struggled with the children's behaviours – most notably the child who is the subject of this report's habit of feces-smearing and head-banging at bedtime. They also struggled with ongoing poverty. They moved frequently, working only for short periods of time at low-paying jobs. The grandparents would sometimes buy groceries for the family when the parents' financial hardship was extreme.

In February 2001, another SSA was initiated. It called for the couple to gain parenting skills in a defined program, and for the father to attend alcohol and drug counselling as well as anger management classes.

Respite care for both children continued, although there was ongoing friction between the respite care provider and the mother. The friction was primarily related to bruises on the body of the child who is the subject of this report. The respite worker and the mother pointed to each other's home environments and parenting styles as the source of the bruises. The respite worker said bed-time behaviours such as head-banging and feces smearing that the child exhibited in the mother's home were not occurring in her home. There was also general tension around scheduling and cancelling of visits and respite days.

The child's older sibling was suspected to have a hearing loss, which was confirmed by an audiologist. Social workers were concerned that the parents seemed unable to grasp the significance of this. The father, in particular, believed that the sibling was simply refusing to listen to direction. Subsequently, in April 2001, the child who is the subject of this report was also tested by an audiologist, and was found to have mild to moderate hearing loss in one ear and moderately severe to severe hearing loss in the other.

In May 2001, the child's parents sought help from social workers. According to the parents, he was banging his head, sometimes for more than an hour, and was having tantrums at frequent intervals. He wouldn't settle at night, a source of particular frustration for his mother and father. Social workers noted that the child was very active, describing him as "on the go" and "into everything." They also suspected that the parents had begun locking their children into their bedrooms at night as a means of controlling their behaviour.

A support worker was assigned to assist the family. A renewal of the SSA occurred in May 2001 despite observations by social workers that the parents: *"[did] not appear to be buying into offered services to any great extent and [were] viewed as quite resistant."*

The child and his older sibling were attending a Child Development Centre (CDC), where staff observed that the sibling often appeared exhausted and hungry. The sibling was oppositional about dressing or putting on shoes, and sometimes resorted to self-hitting or head-banging behaviours that staff believed could be related to the hearing loss.

CDC staff were also starting to observe the same behaviours in the child who is the subject of this report and reported this to the ministry in May 2001. Although the child had been provided with hearing aids, it was difficult to persuade him to leave them in and he would sometimes damage them when he was angry or frustrated. Maintaining the hearing aids as he grew was another ongoing challenge, with the result that the aids were often inoperative.

Efforts by hearing-loss specialists to provide training to the parents were cut short by the father's disruptive conduct during a session. His parole officer characterized him as impulsive, lacking both self-control and coping skills.

Social workers involved with the family remained very concerned about the father's behaviours. The father was seen by a social worker purchasing a case of beer at the liquor store even though there was an abstinence clause in his parole order. He was also seen interacting with the child in an aggressive manner and using inappropriate language toward both children. There was continual fighting in the home and the father had little patience when it came to working with the CDC on parenting skills, sign language and how to manage his children's special needs.

In June 2001, the respite care provider reported that the child had bruises on his forehead that a doctor believed were not the result of his head-banging behaviour. Although police investigated, they were unable to reach any conclusions about how the bruises had occurred. Social workers noted that the child often had a variety of minor injuries – including a bump on his head and a bruise under his chin – with inconsistent explanations provided by the parents for these injuries. In an email to her team leader that month, the social worker said she had *"discussed the possibility/benefits of obtaining a parenting assessment"* and added that she was currently working on completing a formal assessment of the risk of future abuse and neglect of the child.

The father's continued resistance to social workers' involvement and apparent unwillingness to take direction about the care of his children prompted the ministry to complete another CRA.

The CRA was completed at the end of June 2001, when the child was two-years-old. It concluded that both children were at high risk:

*"A major problem has been that the parents have dismissed many of the suggestions [MCFD] would like to see the parents implement immediately and consistently . . . Parents will need to demonstrate consistent follow through with acting upon the advice and suggestions by [CDC] staff in order for the risk assessment rating to be lowered. Also there needs to follow a lessening of reported child care concerns and reports from parents, service providers and community that [the parents] are successfully using positive parenting practices and the child[ren's] concerning behaviours are improving."*

The combined stresses on the family were taking their toll. The relationship between the mother and father was breaking down. Following a domestic violence incident on July 10, 2001 – just one month after the CRA had been completed – police attended and arrested the father for assault. He was released on conditions that included a requirement for him to leave the mother's presence at her request and to abstain from the consumption of alcohol and drugs. The mother told social workers she wanted "him back in her life even if he has to live somewhere else."

The mother sought and received respite care for her two children on the night of the incident. The next day – July 11, 2001 – the mother overdosed on Tylenol and stabbed herself in the abdomen. She was admitted to hospital that day and diagnosed with depression before being released three days later, on July 14, 2001.

While in hospital, the mother met with social workers and told them she feared the ministry would take her children away. For reasons not clear to the Representative, social workers assured the mother that the children could remain, at least temporarily, with their maternal grandmother. While the mother was in hospital, drug tests showed the presence of cocaine and marijuana in her system.

The maternal grandmother cared for the children for three weeks, and the mother began discussing the possibility of the two of them applying for "joint custody" of the children. When the father asked to visit the children and the grandmother agreed, the mother demanded the children be returned to her.

The grandmother complied. The ministry was made aware that the father moved back in with the mother in late summer and their relationship remained volatile. The children remained in their care.

## MCFD Takes Children Into Care

In mid-September 2001, the ministry received the fifth report that year – and seventh overall – about the family, this one centred on the child's older sibling. A member of the community saw the older sibling running out of the house screaming and crying. The mother followed and tried to pull the sibling up from the sidewalk where the sibling was sitting. When the mother failed to pull the sibling into a standing position, the father came out of the house, grabbed the sibling roughly by the arm, and tossed the sibling into the back seat of a taxi that had been called to pick up the mother and children. According to the witness, the father then turned to the mother and asked: "What was so fucking hard about that?"

When ministry social workers interviewed the parents concerning this incident, the father became so agitated that he left before the meeting was over, phoning the ministry office later to say that if he had stayed he would have "punched out" one of the workers.

The mother admitted to social workers that she had sometimes resorted to locking the children in their bedrooms at night, particularly the child who is the subject of this report, because he refused to settle for hours and would constantly get up and wander the house. She recalled an earlier incident when the child's father had tied the child's bedroom door shut with a sheet and the child became so agitated that he pulled the door off its hinges.

The social workers concluded that the parents did not co-operate with the supports that had been designed to lower the risk to the children and, after consulting with their team leader, the social workers removed both children from their parents' care on Sept. 18, 2001. The child who is the subject of this report was now two-years-old; his older sibling was three-years-old.

Social workers arranged for a physician to conduct admission medical examinations on both children as they were brought into care. The physician found the child had a multitude of bruises and scratches, an ear infection and hand, foot and mouth disease. His older sibling had multiple dental cavities.

The children were placed in a foster home that same day. This was the first foster care placement for the child who is the subject of this report. However, despite the fact that both he and his older sibling had obvious special needs, the Representative's investigators could find no documentation of any attempt by MCFD to appropriately match those needs to skills and resources in a foster placement.

The first foster home the children were placed in gave notice almost immediately to the ministry that it could not continue caring for the children. The foster parents felt it was beyond their ability to provide the one-on-one supervision that the child who is the subject of this report required. By the end of September, the children had been moved to their second foster placement, the home of the former respite care-provider about whom the mother had complained.

At the time the children were placed in foster care, ministry standards allowed for a maximum of six children in this home. The addition of the two children to the six already living in the second foster home meant the home was over-capacity.

However, the resource social worker was away from work when the children were placed in the second home and did not realize it was over-capacity until she returned to the office. She asked her supervisor via an email on Nov. 27, 2001 for written approval for an exemption to the standards. The supervisor received approval to continue the over-capacity arrangement for 30 days to give the workers time to plan for a long-term placement.

On Dec. 4, 2001, the resource worker emailed her supervisor and the child's social worker stating: "*this overplacement occurred during my absence and now [ministry management] has directed that we have 30 days to find another placement for the sibling group, I am requesting that you have another team member facilitate this as quickly and sensitively as possible*."

One day later, the social worker responded, emailing: "*hold on here, it is definitely not in the best interests of these high special needs hearing impaired young children to move to an alternate resource to save a buck as they are stable and settled in this home with a highly skilled caregiver managing quite well . . . please forward this note to whoever it concerns re: continuing to make an exception as necessary for these children to remain where they are*." The same day, an MCFD manager emailed both the social worker and resource worker to inform them that approval for the over-capacity placement would continue.

Ministry standards at the time allowed for an exemption to policy when trying to keep sibling groups together. This appears to be the underlying reason that this foster home was over-capacity for a six-month period until the other sibling group moved out in March 2002.

During this time, the children were the subject of a Temporary Custody Order (TCO) – a court order that placed them in the custody of the ministry. The TCO was made with the consent of the parents. As part of the court process, the judge ordered an assessment of the parenting skills of the mother and father. The psychologist who interviewed and tested both of them concluded that the mother's parenting abilities were poor, and that the father's parenting abilities were so poor the children were at risk in his care. The psychologist made a number of recommendations about how the parents could improve their skills.

The TCO was extended twice, again with parental consent, until October 2002. The children returned to their parents' home for supervised visits, twice a week for two hours at a time. These visits occurred regularly except for a few sessions that were cancelled due to parental illness.

At the beginning of December 2001, the father was placed on a peace bond, requiring him to leave the mother's presence immediately on her request and to not return without her permission. The Representative's investigators have concluded that the peace bond was imposed in an effort to manage conflict between the parents after the assault charge against the father from July 2001 was stayed. This peace bond was in effect for a year. During this time, the father continued to leave the family for work or personal reasons at unpredictable intervals.

The mother became pregnant for a third time, giving birth in August 2002. This child was immediately removed, based on the family's history, including the lack of capacity

identified in the court-ordered assessment, and the consistent failure of the parents to follow through with suggested supports. Five days later, the ministry returned the baby to the mother under a Supervision Order. It is unclear to the Representative's investigators why the ministry returned the infant to the mother.

In September 2002, the mother herself was placed on a peace bond after an incident the previous month in which, according to social workers' notes, she allegedly accosted and verbally harassed another young woman who was romantically involved with the child's father. The mother was placed on a peace bond for one year and ordered to have no direct or indirect contact with this woman.

Nevertheless, the ministry planned to help the mother as a single parent to develop her skills with her newborn, with the long-term goal of returning her two older children to her care. In-home support was provided to assist her in this process.

In-home support services were provided through the CDC. The CDC worker provided parenting support to the mother twice a week for two hours at a time. The CDC worker felt the mother would need time to transition to full-time care of her children because she needed *"quite a bit of support."* The CDC worker noted that the mother struggled with taking all three children out to play. The CDC worker stated that *"with short term parenting training, [the mother] can learn, but where she struggles is the application ... visits have been hit and miss, the kids act up when there are changes."*

For reasons not understood by the Representative's investigators, the social worker wanted to reduce the CDC worker's time with the mother by 50 per cent by the end of November 2002 with the goal to increase the frequency of the mother's visits with the children to three days a week from two.

In October 2002, the mother signed a Voluntary Care Agreement (VCA) respecting the two older children that extended their time in the care of the ministry until April 2003. The two older children remained together in their foster home. As the psychologist's assessment had indicated the mother would need at least a year to complete the recommended steps to improve her parenting skills, the ministry agreed to provide the mother with more time through this agreement rather than proceeding to court with an application for a Continuing Custody Order (CCO). The Representative notes that this seems unusual given the clear time limits set out in section 45 of the *Child, Family and Community Service Act (CFCS Act)*.

The child who is the subject of this report attended the CDC pre-school from December 2001 to June 2004. He attended the Building Blocks child care program at the CDC three mornings a week. He shared an aide with another student at the centre.

CDC workers observed the child to be more impulsive and less coordinated than other children his age. A fine motor assessment completed in November 2002 – when the child was 3 ½ years old – found that his development was delayed. The same CDC workers observed that his mother seemed to be unaware that her children had been removed for issues related to basic parenting skills, believing instead that if "she found the right piece to the puzzle, the ministry would be proved wrong."

By January 2003, the father – absent for much of the previous year – had returned to the community. Social workers believed he was again living with the mother, although the mother denied this in interviews with the Representative's investigators. In the view of the ministry, the safety and well-being of the children could no longer be guaranteed as the Supervision Order respecting the new baby and the VCA that applied to the two older children both placed restrictions on the father's access to the children.

The baby was subsequently removed from the parents' care and placed in the siblings' foster home. By Jan. 15, 2003, the ministry had obtained an Interim Custody Order (ICO) for all three children and planned to apply for a CCO. The father left the mother shortly after this occurred.

Another CRA was completed by MCFD on Feb. 8, 2003. The overall risk for all three children was rated as "high." The social worker who conducted the assessment reported:

*"With there being present 13 highly rated risk factors ... the overall risk of future neglect and abuse to the children is assessed as high ... given the length of past protection history and of parents being either unable or unwilling to make needed changes ... the Ministry is now making an application for CCO status with regard to all 3 children."*

## New Man in the Home

By March 2003, the mother was in a new relationship. As the new boyfriend was living with the mother and would be a caregiver for the children, the ministry sought an initial assessment of her new partner as well as another assessment of the mother's parenting capacity. The mother was now 23, her new partner was 21. The oldest sibling was five, the child who is the subject of this report was nearly four and the baby was seven months.

The parental assessment was completed in September 2003. The recommendations were clear:

*"That the children remain in the care of the Director, and that the issue of permanent residence be resolved at this time. The mother has improved in functioning, such as the absence of substance abuse, but she presents with many of the same, chronic deficits that pose a serious risk to the children."*

Despite the conclusions of the risk assessment, by December 2003 the ministry had entered into a new SSA with the mother and the baby was returned to her care. The mother was to attend parenting classes with the baby and receive respite care from MCFD as part of that agreement.

Also in December 2003, the ministry returned to court to seek an order placing the two older children in continuing custody, based on the September assessment of parental capacity. The ministry was successful in its application.

The child's mother and her partner, however, continued to have access to the child and his older sibling. The two children continued to live in their foster home, which was located on a rural property some distance outside the town centre.

Based on the court's decision, the ministry began to look for a long-term placement for the child and his older sibling, with adoption one possible option. The ministry had located an Aboriginal adoptive home in another community and wanted to proceed with pre-placement visits. The ministry believed the prospective adoptive parents had the skills necessary to assist with both children's communication deficits and other challenges. The child's maternal grandmother was also being considered at the same time as a possible adoptive parent.

The ministry felt it was necessary to terminate the access previously granted to the mother and her boyfriend in order to allow the prospective adoptive parents the opportunity to form a bond with the two children. The child's mother consented to abandon her access rights, based on her hope and belief that the children would go to her mother. In March 2004, the ministry obtained a court order rescinding the previous order that had allowed the mother and her boyfriend access to the children.

By May 2004, the grandmother had abandoned the idea of adopting the two children, although the placement with an Aboriginal family remained a possibility in the ministry's eyes. The child's mother then returned to court in an effort to set aside the CCO, stating in a letter to counsel for the ministry that she had only agreed to the removal of her access rights due to her mother agreeing to adopt the children. The court dismissed the mother's application to rescind the CCO, but allowed her to have supervised access visits with her children.

An assessment of the child who is the subject of this report, conducted by the Sunny Hill Health Centre for Children during this same month, concluded that his cognitive ability was at the low end of the average range non-verbally and that his verbal ability was lower still. The psychologist found that the boy's language was under-developed, even with his hearing loss taken into account. A trial of Ritalin for what the psychologist believed to be attention deficit hyperactivity disorder (ADHD) was suggested.

As the child grew older, medical care professionals would prescribe a range of medications to assist in managing his behaviour. Drugs prescribed included Ritalin and Concerta, aimed at alleviating the symptoms of ADHD, anti-psychotic medications Olanzapine and Seroquel, and drugs such as Clonidine and divalproex. These medication profiles were regularly reassessed for their effectiveness, including reviews during his subsequent hospitalizations at BC Children's Hospital.

## Abuse in the Foster Home

From the beginning, there had been conflict between the child's mother and his foster parent, who had previously been his respite caregiver. The child's mother raised concerns with her social worker about the children having unexplained bruising, missing clothing and poor attendance at the CDC. Many of these complaints were regarded by the mother's social worker as "trouble making."

In April 2004, when the child was four-years-old, an anonymous caller to the ministry reported that the foster parent had been using cold showers to discipline him for toileting accidents. The social worker did not meet with the foster parent about these concerns

until three months later, at which time the foster parent admitted to the use of cold showers as a disciplinary tool.

The ministry responded by providing three days a week of relief for the foster parent and recommending that the children be in regular attendance at the CDC. However, the children's attendance at the CDC continued to be sporadic.

The child began Kindergarten at a local elementary school in September 2004 with the support of a full-time educational aide. An Individual Education Plan (IEP) was developed by his school-based and external team, which consisted of his ministry social worker and school personnel, including a teacher of deaf and hard of hearing children. During an IEP meeting, the teacher of deaf and hard of hearing children described the child as *"rarely speaking in complete sentences."*

On Oct. 20, 2004, the ministry received a call that the foster parent was difficult to locate in emergencies, that the child was not receiving medications prescribed by his physicians and that the child appeared fearful when in the presence of the foster parent. As a result, the ministry initiated a quality of care investigation.

Before that investigation could begin, MCFD received another report on Oct. 22 alleging the use of physical discipline on the child, including cold showers, spanking, placing hot sauce in his mouth and confining him to his room for long periods. As these concerns were related to emotional and physical harm and neglect by a caregiver, ministry guidelines dictated that an investigation under the protocol with the BC Federation of Foster Parent Associations was required. The ministry decided to incorporate the quality of care review into this investigation and the children were removed from the foster home on Oct. 29, when the investigation began.

The investigation concluded that complaints about physical discipline were substantiated, and also noted that the foster parent had neglected the child's need for speech therapy: *"The lack of involvement in speech therapy is neglectful because [the child] has severe communication difficulties that would likely improve with consistent intervention."*

Despite the substantiated findings, the ministry made no report to police – as required by MCFD policy – that could have triggered a criminal investigation. The Representative could find no documentation of any report by the ministry to the Public Guardian and Trustee, which might have been able to assess the child's legal position.

A social worker familiar with the file told the Representative's investigators that she had learned more details about the foster home and how the child had been treated there. It was her belief that the child had been locked in a shed on the property for unknown periods of time and that he had repeatedly been held face-down in a barrel of water by other children in the home. It was also reported that the social worker responsible for overseeing the foster placement had a practice of calling the foster parents in to meetings at the ministry office, rather than actually going out to inspect the home herself.

The child's Comprehensive Plan of Care (CPOC) for 2004 does not include any record of visits by social workers with the child in the foster home. The Representative's investigators were unable to locate any such documentation in the child's files.

When the guardianship social worker went to retrieve the child and his older sibling from that foster home, she was shocked by their appearance, which she described as "feral." She remembered the child's arms and legs sticking out of a shirt and pair of pants that were many sizes too small for him. The child was also excessively timid and fearful. Later, when his new foster parents tried to place him in a shower to wash him, he became hysterical. He calmed when an astute worker offered the alternative of a bath.

After 13 years in operation, the foster home was closed. The Representative reiterates that there was no criminal investigation of the foster home and no follow-up of the potential for a civil suit.

The foster home's location in a rural area would become relevant later, as the child's care team noted that he would associate any rural setting with his experience of trauma.

## A Succession of Foster Homes

The child and his older sibling were moved by the ministry to their third different foster home on Oct. 29, 2004, but stayed there only six days because that home already housed six children, the maximum number allowed by ministry standards.

A fourth foster home kept them for only 13 days before the foster parent concluded that she didn't have the skills required to manage the child.

The fifth foster home they were placed in belonged to a woman who had known the child and his older sibling for a number of years because she had worked at the same CDC that had provided services to the family. This placement, on Nov. 17, 2004, would provide the children with a degree of care and stability previously absent from their lives. The child who is the subject of this report was now five and his older sibling was six.

This foster parent faced immediate challenges trying to provide the children with a place where they could feel safe. The social worker who had removed the children from the rural foster placement recalled this new foster parent having to remove all the interior doors in her home because the child's fear of confinement was so acute. The child was also extremely fearful that monsters could be hidden under a bed, so the foster parent placed all the mattresses on the floor.

In January 2005, another CRA was conducted – this time concluding that the child's youngest sibling *"should continue to live within the family unit"* and that the oldest sibling's *"unsupervised visits should be increased to the point that [the oldest sibling] is spending more time with the mother and boyfriend than with the foster parent. The foster parent and CDC should be encouraged to teach the mother successful parenting and active stimulation with this child. As the mother begins to feel more competent, MCFD could consider full reunification by applying to court to rescind the CCO."*

As for the child who is the subject of this report, the CRA said his *"behaviours at this time present huge difficulties for any caregiver... [the mother and boyfriend] would not be able to effectively or safely parent this child at this time, especially if they are working at introducing the [older sibling] back into the family. It is recommended that [the child] remain in foster*

*care and receive intensive work at reducing his aggressive and disruptive behaviours, as well as concentrated efforts to further his communication, which may be a contributor to his frustration … however [his] access visits should continue."*

The child, now nearly six-years-old, responded positively to life with his latest foster parent, making particular gains with his speech and language skills. He began attending preschool and his behaviour, especially around other children, became less aggressive. The child continued in the local elementary school. The goals for him in the 2005 school term included speaking in simple sentences, reading for 30 minutes each day, identifying some numbers and letters and being able to identify, label and match shapes and colours.

The foster parent also reported that she felt the mother was making gains with her own parenting skills, although the boyfriend remained largely uninvolved.

## New Social Worker, New Direction

Despite the progress the child was making in foster care and the outstanding concerns identified in the various parental capacity assessments conducted, the CCO that had been in place since 2003 was cancelled in a July 2005 court proceeding. All parties, including the Director, consented to the application. This cancellation came about, at least in part, because the new social worker responsible for the file believed that her predecessor had been too negative in her dealings with the child's mother, and that necessary services and supports could be provided without the ministry moving forward to have the children adopted.

As a result, the mother regained legal custody of all three children on July 20, 2005. The older sibling returned home under an SSA. The child who is the subject of this report remained with his foster parent under a Special Needs Agreement, with access provided to his mother. The Representative was unable to find documentation of any new assessment to support this decision, and believes it was driven solely by the philosophical approach of the new social worker who placed greater emphasis on family reunification.

Social workers involved with the family recognized that the mother would need supports to assist her in caring for both siblings and noted that poverty continued to be a major issue in the mother's life.

In December 2005, the foster parent of the child who is the subject of this report gave notice to the ministry that she could not continue providing care for the child long-term. She had a full-time job and meeting the demands of that job, in addition to the high needs of the child, was pushing her to exhaustion. The child was very active and had to be closely supervised in order to keep him safe. He was also extremely sensitive to change, especially unplanned events, which could trigger an emotional outburst.

The child remained in the foster parent's care while the ministry considered the options available for him.

Now in his second year of elementary school, the child was assessed by his school psychologist in January 2006. He was assessed as being at the extreme low end of the range of IQ and adaptive functioning for his age peers.

By April 2006, the foster parent had found regular respite care to support her, and now felt she could continue caring for the child if another caregiver could be found who could deal with issues that might arise during school hours. However, this second caregiver was never put in place.

The professional team working with the child consulted with a behavioural psychologist, seeking strategies to assist in managing the child's behaviour. The behavioural psychologist stressed the importance of a well-structured environment with consistency and routine. He believed the child had problems with anxiety, lacked insight into his own behaviour, and lacked the ability to predict future events. The child's inability to predict the future and his history of trauma meant that he was always expecting the worst to happen, and that mindset predisposed him to acting out when he was confronted by anything new or unexpected.

The child's older sibling, who had been residing with the mother and her boyfriend, returned to foster care under a Special Needs Agreement in June 2006. The sibling was returned to the same foster parent who was caring for the child who is the subject of this report. The older sibling had begun to display increasingly challenging behaviours, including dramatic mood swings punctuated by screaming. The mother had concluded that she did not have the skills that would allow her to cope successfully with this behaviour.

In November 2006, the foster parent who had been caring for the child for two years moved to another community. Even though the child's most recent Special Needs Agreement – signed in July 2005 – acknowledged that his mother was unable to provide the high level of care he required, the ministry returned the child to her on Nov. 19, 2006.

The child's older sibling, who had been in the care of the same foster parent, was taken into the care of an aunt for a short period of time and then was also returned to the mother. By December 2006, all three children – now ages eight, seven and four – were living with the mother and her boyfriend.

On Jan. 9, 2007, the ministry put into place an SSA that covered all three of the children. The goals of service that the parent and the Director agreed upon were:

*"The Director will support and encourage [the mother's] continued success by providing services and assisting [the mother] to purchase services to assist [the mother] in caring for her children within her own home. [The mother's] children were in care because of their special needs and [the mother] has gradually taken over as primary caregiver with support and assistance from MCFD."*

The day the SSA was signed, the former foster parent, who was still in contact with the family, telephoned the ministry to express concern and ask for more support for the mother, who was already struggling to deal with the child's behaviours.

The day after the SSA was signed, the social worker assigned to the family visited the home and documented that the mother had no food in the home, the child was "going off the wall" and the mother was feeling overwhelmed and depressed.

Poverty continued to be a major issue for the family, even though the mother's boyfriend had found work out of town. The rent for their home was due, utility and telephone bills were in arrears, and their house was so small that all three children were sleeping in a single room.

The child continued to have a full-time education support worker at the local elementary school as well as a classroom teacher and a teacher of deaf and hard of hearing children as part of his team. The social worker also took part in the formulation of the child's IEP, although the mother did not. That IEP, dated Jan. 23, 2007 – the year in which the child would turn eight – listed four main desired outcomes:

*"a) [the child] will improve his communication skills*

*b) [the child] will be able to self-regulate his behaviour*

*c) [the child] will feel successful and secure*

*d) [the child] will follow the Grade One academic outcomes with adaptations and support . . ."*

By March 2007, the mother told a social worker that she was considering returning the children to the care of the ministry because of a lack of money. Her boyfriend had been out of work and the mother described wearing out her welcome at the local food bank.

The social workers responsible for the family worked to get the mother access to supports, including respite care, and tried to support the family with financial assistance, but it was becoming clear that the situation was unsustainable. The mother was reporting that both the child and his older sibling were "out of control" and the elementary school was reporting that the child was regressing. The mother was fearful of the child's behaviours, and concerned that if she was seen disciplining him, someone would complain and she would lose all access.

By May 2007, the mother and her social workers were making plans to move the child out of the family home and into a foster placement. As the child became aware of what was occurring, he began to tell his classmates at school that he was a bad boy and that his mother didn't want him anymore.

His child psychiatrist was also expressing concern for the child's future, noting that he could quickly exhaust caregivers.

## Back Into Foster Care

The child was placed in a foster home – his sixth – in a rural area outside his home community on June 1, 2007. Although his new foster parents were skilled and experienced in caring for special needs children, the child's transition to a new home predictably sparked an outburst of violent behaviour given his attachment issues and his sensitivity to unplanned change.

Nineteen days after the child had moved into this foster home, the foster parents – one of whom was a social worker with the ministry – could not calm or de-escalate him and he was described as "raging." The foster parents took him to the local ministry office, where he was physically restrained. The foster mother struggled with the child, who bit her, spat in her face and clawed at her arms.

This episode was witnessed by a child psychiatrist who was familiar with the child and diagnosed the episode as the result of reactive attachment disorder. This psychiatrist concluded the condition was so severe that the child could no longer remain safely in a regular foster care setting. He was particularly concerned that the child had physically assaulted his female foster parent.

The psychiatrist concluded:

*"I think this child needs to be placed in a staffed resource, such as a group home or a specialized foster home, with child care worker staff. When his behaviour becomes difficult, it is simply too much for a parent figure to manage. He has Attachment Disorder, and it becomes impossible if his caregiver has to increase physical contact to the point of physical restraint on this level. I do not think [the child] can tolerate that kind of physical contact. I believe that things will work much better in a resource where it is possible to contain his behaviour with professional staff, and without physical restraint, and with some sort of quiet room where he can settle down when he is out of control. It will still be very difficult, but won't have the additional problems associated with forcing his caregivers to become physically in contact with him."*

The psychiatrist went on to point out the importance of the child preserving his prior relationships, even if a move was necessary:

*"Because of his attachment difficulties, it will be important for [the child] to maintain some kind of relationship with the people who are important to him, after he is in his new placement."*

The child was now just eight-years-old.

Less than a month after moving to his sixth foster home, the child was moved again – this time to a staffed residential resource in his home community in June 2007. A few days after this move, the child's behaviour became aggressive and police and paramedics were called to remove him from the home and take him to hospital on June 26, 2007.

This marked the first time police were used to manage the child's behaviour.

The staffed residential resource notified the child's Child and Youth with Special Needs (CYSN) program worker about his hospitalization and also told her they would not care for the child any longer. The CYSN social worker stayed with the child in hospital for three days until arrangements could be made to transport him to BC Children's Hospital in Vancouver for assessment.

On June 28, 2007, the child was admitted to the Child and Adolescent Psychiatric Emergency (CAPE) Unit at BC Children's Hospital for stabilization. He was discharged from CAPE on July 5.

While waiting for re-admission to BC Children's Hospital for a full assessment, the child stayed at a specialized group home in the Lower Mainland. He was removed from this placement after a physical incident with an older child and placed in a new resource created specifically for him. The staff at the new resource called police two weeks after his arrival when the child lost control and began punching holes in the walls of the house.

On Aug. 21, 2007, the child was admitted to the BC Children's Hospital in-patient psychiatric unit for assessment. He remained there for a month. His diagnoses at this point included reactive attachment disorder, disruptive behaviour disorder, attention deficit hyperactivity disorder, post-traumatic stress disorder, mixed expressive and receptive language disorder, cognitive impairment, and moderate to severe hearing loss.

Although he continued to display some challenging behaviours, and always had two staff with him at all times, it was noted by staff that the child settled quickly into the hospital routine and appeared to thrive in the highly structured environment. He was also surrounded by professionals who understood the nature of his condition and responded quickly when he showed signs his behaviours were escalating. Staff there recognized the importance of providing the child with consistency and predictability and worked to avoid surprises that could trigger fear and confusion in him.

Given the child's now well-documented challenges and the difficulties in successfully placing him, it would seem logical that by this point a senior person in the ministry would have been assigned to oversee the child's case. However, the Representative's investigators could find no such documentation in the child's files.

On Sept. 28, 2007, the ministry returned the child to a staffed residential resource in his home community. While this was the child's fourth staffed residential resource, it was different in that it housed only him. The care team and residential resource staff developed a very clear daily behavioural plan and a highly structured routine, similar to the one created at BC Children's Hospital. This plan was to be followed by all of his care workers. In October, the child began attending a local elementary school with a full-time educational aide.

## "Safe Room" Use Begins

The use of a "safe room" – a place where the child would be put for a time-out when his behaviours escalated – began when he was placed in residential care in his home community at the age of eight. This first occurred in September 2007 and continued despite the fact no ministry policy or legislation exists in B.C. that allows for the use of a "safe room" outside of a designated mental health facility.

The premise behind use of such a room was that it was for therapeutic purposes, to help the child calm himself. As advised by one psychologist, the "calm down room" was only to be used as part of a behavioural treatment intervention plan with appropriate clinical oversight.

The team of professionals that was now working to support the child included a Child and Youth Mental Health (CYMH) worker, a CYSN social worker, a child psychiatrist who visited the community periodically, and his family physician.

The fall of 2007 seems to have been a period of relative stability for the child; he was hospitalized only once for having a rage episode. But he suffered an educational setback when he was removed from his elementary school after a November incident in which two teaching support workers were injured. And by the beginning of 2008, there was a noticeable deterioration in his behaviour that began to alarm everyone involved in caring for him.

In January 2008, the child raged for almost two hours before police were called to assist in taking him to hospital, where he was sedated.

Less than two weeks later, he broke down two doors and smashed through a wall before police and ambulance personnel intervened and took him back to the hospital.

Eleven days later, the child hit and injured his care staff. When he was subsequently placed in the "safe room," he tore up the baseboards and again threatened staff.

Although the child's care team relied on the local hospital to support them when the child was raging and they could not calm him, they encountered difficulties when the child was taken to Emergency by police or paramedics. Despite the existence of a hospital protocol developed by the child's psychiatrist, his team faced resistance from doctors and staff when they tried to have the child admitted. Because the local hospital had only adult psychiatric beds, the child had to be placed in a regular ward, where staff from his group home would stay with him until he was released.

The child was now regularly coming into contact with police, who would be called to assist in transporting him to hospital. Both his residential resource caregivers and his ministry workers had made an effort to inform police about the child's condition. Sometimes, the mere presence of an officer would have a calming effect on the child if he was beginning to spiral out of control. The child's social worker observed how police officers became attached to the child and how upset they became when he was "falling apart" and no solution seemed to exist.

The professional team, which included residential resource caregivers, ministry workers and a child psychiatrist, continued working to find solutions to what they all saw as the child's deteriorating behaviours, including making changes to his medications. He was now no longer attending school, even for short periods. It was increasingly difficult to contain him in the single-bed resource in which he lived. Visits with his mother appeared to be very difficult for the child, who reacted when he wasn't allowed to return home with her at the end of their visits.

The child psychiatrist and the child's CYSN social worker discussed the possibility of moving the child to a larger, fully staffed residential treatment unit. As there wasn't such a facility in British Columbia, the social worker began looking for one in Alberta.

In correspondence with the child's general practitioner, the child psychiatrist made the following observations:

*"In my opinion, [the child] is already in residential treatment, but it is the worst of both worlds; it is neither a family home, which he cannot tolerate, nor is it a big enough resource to have the number of staff available at all times that he needs in order to contain his outbursts. One of the reasons he did so well at BC Children's Hospital was that as soon as he became out-of-control, at least three or four staff would appear beside him, giving a powerful, non-verbal message that he needed to calm down. That was often the only intervention necessary. I think we need him in a resource with that kind of structure. The encouraging part of all this is that, from [the child's] perspective, he will tell you he was happy at BCCH, and clearly responded to that kind of structure in a positive way."*

Although the child remained in the same group home, it seems that the latter part of 2008 was again a period of relative calm for him. He began to attach closely to one of his care workers, and the continued emphasis on providing him with a structured environment, in which he could feel safe, appeared successful in reducing his anxiety.

The staff focused on that reduction in anxiety, believing that if the child's anxiety level rose it would result in acting out. They also coordinated with the school district for an educational assistant to come to their residence to provide the child with individualized instruction.

## New Behavioural Concerns

In March 2009, when the child was nine-years-old, he was at a public pool with a careworker. A young girl told the lifeguard that the child had been sexually intrusive with her. When the lifeguard asked the staff accompanying the child to remove him from the pool, the child began screaming and ran away from the staff. Staff could not calm him and called the police to help. The child was finally calmed and was returned to his home.

This kind of behaviour represented a new challenge for the child's care team who were concerned that, while there had been a pause in his major physically aggressive outbursts, this could be another form of acting out.

The child's social worker planned to move him to a new local public elementary school beginning in the fall of 2009. But between September 2009 and June 2010, the child attended this school for only approximately one hour per morning.

School records show that plans to extend those school hours were put on hold due to the child's sometimes aggressive behaviour at school and physical injuries he had caused to school support workers. Instead, an alternate plan for his education was developed, calling for the child to be home-schooled.

At an IEP meeting in December 2009, which included group home staff and school staff, the education team decided that one support staff was better for the boy than multiple support staff because *"a change in support staff makes him unfocused."* One school support person was assigned to work with the child for the entire hour that he was at school daily.

Visual aids were used to help him see when he had successfully completed work. To increase his socialization, he was encouraged to play a math game with a peer in the classroom.

The child's care staff were now directed to always have him within arm's length when in public places. A safety plan restricted his access to the pool during times when other young children were present.

By the beginning of 2010, the child's behaviours began to escalate to a new level. In late January, staff at the child's residential resource placed him in the "safe room" after an outburst because they were unsuccessful at calming him. The child began to punch through the walls of the "safe room" in an effort to escape. Three police officers were required to restrain him and transport him to hospital.

Two days later, the child ripped a door off its hinges and then broke it in two before again punching holes in the walls of the house. Staff were now becoming increasingly concerned about their ability to control him. They reported to his social workers that when he was raging he was so strong they could no longer physically restrain him when it was necessary to keep him safe.

This time when the child was transported to hospital by police, the Emergency Room physician was unaware of the child's diagnoses and the need for sedation to calm him. The CYMH worker was able to arrange a teleconference with the child's psychiatrist in Vancouver and the Emergency Room physician, but the local doctor placed the child in a regular ward while discussions with BC Children's Hospital were in progress. His care team and staff were concerned that the child was too volatile to be in such a setting and his CYSN social worker actually drove to the child's residence to take pictures of the damage in order to impress upon hospital staff the need for a comprehensive safety plan.

The care team concluded that the home was too badly damaged to return the child to that environment and that extensive repairs would be necessary before it was safe for the child and staff to return. Staff reported being exhausted and feeling as if they would not be able to cope much longer with the challenges they were facing.

By now, it was abundantly clear that existing supports and interventions were not sufficient to keep the child and others safe. While in hospital in his home community, he continued to be aggressive and act out. The child had again been placed on a regular ward as there were no psychiatric facilities for children in the community, and he was heavily medicated in an effort to manage his behaviour. A subsequent MCFD comprehensive review noted that the child was on an ever-changing regime of psychoactive drugs: *"The social worker later identified concern about the amount of medication that the hospital was using to keep [the child] calm . . . It was noted that he was on 500mgs of Quetiapine. Olanzapine was discontinued. He was started on Chlorpromazine increasing to 700mgs per day. Benztropine was started at 1mg and the child psychiatrist had recommended that this be increased to three times per day as [the child] had signs of pyramidal activity, i.e. tremors, vacant staring, confusion, incontinence, drooling, 136 heart rate and very high blood pressure."*

A decision was made to return the child to BC Children's Hospital for further assessment and stabilization. Transportation of the child to Vancouver posed its own challenges. Due to his behaviour, he could not travel by a commercial airline. An air ambulance was arranged so he could be safely moved, under sedation, to BC Children's Hospital.

## BC Children's Hospital Admission

After an initial assessment at the CAPE Unit of BC Children's Hospital, the child was returned home to his community on March 3, 2010. His social worker flew to Vancouver to accompany him home on the trip. On March 26, the child was admitted to the BC Children's Hospital in-patient psychiatric unit for a full assessment lasting nearly a month.

Once at BC Children's Hospital, the child's medications were reassessed and he was given further psychiatric evaluation. The child had a medication profile that was described as "quite extensive" and several medications were either reduced or eliminated now that the child was housed in a secure in-patient facility. As seen in his previous hospitalizations, the child settled quickly and the aggressive behaviours receded in the highly structured hospital environment in which he interacted with peers under the close supervision of staff. His discharge summary included the following observations:

*"There have been a number of behavioural strategies that have been implemented that have been particularly helpful. [The child's] day has been broken up into half-hour chunks so he knows exactly what the schedule is. This use of a very concrete structure has been quite successful. [The child] does well with front loading in which any changes to the schedule are known well in advance. He often becomes dysregulated [sic] when he is excited or bored and, as such, his activities are to be kept short. He does extremely well with routine as this avoids confusion and he is very reactive to unpredictability."*

An unexpected discovery at BC Children's Hospital found that the child had developed long QT syndrome, a disorder of the electrical functioning of the heart. Long QT syndrome can predispose someone to sudden heart arrhythmias in response to stress or strenuous exercise. It was later determined that the syndrome had developed as a side effect of the anti-psychotic medications he had received.

The CAPE assessment concluded that the child should continue to receive psychiatric follow-up from his child psychiatrist, receive an altered regimen of medications, and have his health monitored in relation to reducing his risk of cardiac disease or complications.

In relation to his community placement, the CAPE assessment stated the following:

*"With [the child's] difficulties it is imperative that there be a consistent treatment plan that is followed in his home, school, and with his family. Regarding his workers, it may be beneficial to have further training to deal with the patient's behaviours. Crisis Prevention Institute training could help de-escalate situations before they become violent. Other options would be training in skills for working with people with language problems, difficult temperaments, and sexually inappropriate behaviour. As well, days with more structured activities would hopefully lead to less acting out as he is likely bored during the day. We are aware of the*

*communities [sic] concerns regarding sexualized behaviour, but wonder if there was a time when the community pool or gym were empty and he could be in the facility alone, but supervised by his worker."*

In the meantime, discussion continued between the social worker responsible for overseeing his care and senior management within the ministry, with input from the physician, focused on where the child could next be placed. There was a concern that the medical facilities in his home community were inadequate to meet his complex mental and physical health needs. This was confirmed when the child's physician concluded that the medical community in his hometown could no longer support him. From the perspective of the child's social worker, it was these medical issues that drove the decision to place the child somewhere else. A larger community in the same region was now the focus for the care team's planning.

## Placement in a New Community

The child psychiatrist was clear that the child needed to be placed in a well-organized residential treatment facility with other children his age, with staffing adequate to protect the child and staff in the event of a violent outburst.

Although his social worker had discussions about a possible placement for the child in the Lower Mainland where services would be most accessible, this option was not accepted by MCFD senior management.

A senior manager in the ministry responded to the child psychiatrist, stating:

*"We absolutely agree that the correct staffed residential program is critical for successfully meeting [the child's] needs. This resource will need to be supported by [the child's] medical and psychiatric team.*

*"Ministry of Children and Family Development believe that [the child's] needs can be met in [a new community]. We have engaged a contractor in [the new community] to set up a specialized placement to meet [the child's] needs. We are working with [the contractor] to develop a residence for [the child]. This contractor works with children and youth that have developmental delays, behavioural problems and mental illness. They have a good success rate with their placements. The provider has a large number of staffed resources and will be able to provide skilled staff population to diffuse the impact of [the child's] more challenging behaviours."*

Ministry staff and medical staff familiar with the resource characterized it differently, however, describing it as one that was more accustomed to dealing with street-involved youth or those involved in the criminal justice system.

When the child's hometown social worker visited the proposed placement, she was immediately concerned – at least in part because it was in a rural location that she feared might be a trigger for the child because it mirrored his previous abusive foster home placement. There was also only a shower, which she feared could reignite the child's past

trauma because a shower had been used for disciplinary purposes in the abusive foster home. She was also concerned that the home was very small, and that the "safe room" was a tiny space that staff could not see into because it had no windows.

She returned to her office and informed her team leader that she refused to place the child in the proposed space, a position supported by her team leader in the new community. A new home, operated by the same contractor, was hastily identified, and plans were made to build a "safe room" at that location. The ministry official engaged in managing the file described having to task the contractor with creating an entirely new resource in only 24 hours, the time left before the child would be arriving in the new community. That official felt the social worker's concerns were exaggerated, and questioned the source and the validity of the information about the child's previous abuse in the foster home.

The professionals caring for the child describe the transition from the hospital to the new staffed residential resource in the new community as hurried and pressured. There were concerns about how the knowledge and experience of staff who had worked with the child in his hometown could be transferred to his new team, to ensure that the structure that had worked for the child previously could be replicated in his new location.

When the child was discharged from the psychiatric unit at BC Children's Hospital on April 23, 2010, his hometown social worker transported him to his new group home.

A few days after she had placed him in his new home, the social worker received a telephone call from the staff. She could hear the child screaming in the background and staff told her he was breaking things and that they could not hold him. She advised them to call 911 and have him transported to hospital.

The social worker arranged for staff from the child's previous placement to travel with her to the new community on April 28, 2010 to provide training for the new staff. While she was driving them to the new community for this purpose, she received a telephone call from her team leader who told her she was no longer the child's social worker.

After receiving that call, the social worker continued to travel with the staff to the new community. They stopped at the CYSN office in the new community for clarification regarding the change to her status. She believed that it was important for her to introduce the new social worker to the child and so she visited the child with staff from his former residence, along with the new social worker. They all met with the child and she introduced his new social worker to him. The social worker and his former residential staff then returned to the child's hometown.

The social worker described the effect the child's departure had on her and other members of his care team as devastating. She felt personally as if her commitment to keep him safe, which she had often repeated to him, had been broken. She said she had seen the team working to build attachments for the child, only to witness those attachments being severed.

From the perspective of his new caregivers, the early weeks with the child in his new placement were challenging. Four staff members from the resource had travelled to Vancouver to shadow the professionals at BC Children's Hospital as they worked with the child. BC Children's Hospital staff demonstrated the need for the child to have a visual daily schedule – including pictures and simple words to help him understand when he was expected to do things such as brush his teeth, clean his room or put on his pajamas – and a routine that he could count on.

However, the Representative notes that this visual schedule was not implemented immediately in the child's new home, which was very different from the highly structured hospital environment from which the child had come. His new caregivers' previous experience working with street-entrenched youth had not prepared them for a child as complex as this. The senior manager now sought the help of the child's previous care team to assist in training the new team.

The child's previous caregivers made a second trip to the new community on May 12, 2010. But they were frustrated by the response they received when they tried to share their experiences with the staff at his new placement. After initially not being asked to liaise with the new contractor, they now felt that they were under considerable pressure to alter their schedules and make themselves available on very short notice. When these previous caregivers arrived in the new community, their program manager was dismayed that staff and managers in the new community only attended sporadically during the three days of training.

The child's new residence was in a suburban area. He was the only child housed in a basement suite. He had two staff with him at all times, and modifications made to the home included the construction of a "safe room."

Predictably, during his first few weeks in the new placement, the child was unsettled and frequently agitated. Three times during a one-week period, police or paramedics were summoned to take the child to hospital after outbursts during which he could not be calmed.

Gradually, however, the child and his new staff began to develop a relationship and the problematic behaviours decreased. One care worker in particular would become especially important to the child over the two years they were together.

## A New Care Team

Staff were supported by regular integrated case management meetings, which brought together all the professionals who were engaged in the child's care. This group included his psychiatrist, psychologist, a mental health counsellor from a contracted service agency, his ministry social worker, his ministry resource worker, and the residential resource manager and staff. This group met weekly to discuss what staff were seeing and to formulate strategies to deal with the child and his behaviours.

Some of those who participated in these meetings felt that there was a disconnect between the strategies developed by professionals who were not actually "hands on" with the child, and the care workers who were with him on a daily basis. One professional on the care team expressed frustration with what she perceived as a lack of feedback and accountability from the staff who worked in the child's home. She described a situation in which there was no way to determine if suggested strategies were actually being implemented.

The team of professionals involved with the child was unusual and reflected the real challenges in providing proper services and support to an 11-year-old child with developmental delay who was also displaying symptoms of a psychiatric disturbance. One medical professional observed that "everybody who was providing service to [the child] was not supposed to be providing service to [the child]." That same professional described the team as "cobbled together" and observed that many members of the team felt pressure from their supervisors because they were operating outside mandate in an effort to provide the best possible service to him.

The care workers who worked directly with the child put in long hours, often two or three 24-hour shifts in a row. Providing consistency and stability was often difficult because of staff turnover. Some employees of the contractor would work for short periods of time, decide they were not suited to the work, and resign. Staff during this period were earning between $226 and $275 for a 24-hour shift – not much in excess of minimum wage.

Female staff members were especially challenged by the child's inappropriate behaviours. As a result, staff hired to work with him were mainly younger males.

These young male staff members had diverse backgrounds, but were not drawn from social work or mental health career streams. The child's favourite worker had previously been employed by a cable television company. Another worker the child got along with had worked in a mill. Both of these workers, who formed close bonds with the child, had high school educations but had no formal training in the field.

One of the advantages of this staffing model was that the child was now surrounded by young staff who could keep up with his need to be busy and active. He loved to swim and ride his bike, and staff encouraged this as a positive outlet for his high energy. The child mimicked the behaviour and mannerisms of the staff he particularly liked, even styling his hair to resemble theirs. As the child had no opportunity to make friends his own age, these activities and interactions with staff met his need for play if not necessarily his therapeutic needs.

From the perspective of the professionals on the care team, this staffing model presented challenges in ensuring consistency in approach and required them to frequently "start from scratch" with new workers who lacked related training and would bring different attitudes and philosophies to the job.

The child's favourite care worker recalled his time as a period of real progress in the child's social and communication skills, his ability to self-regulate and in building some basic skills such as learning how to eat with a knife and fork rather than with his hands.

The child never returned to BC Children's Hospital during his two-year tenure with this favourite care worker, a fact that some of those associated with the child's care considered a major indicator of success. Professionals who observed their relationship noted that the care worker was highly attuned to the child's needs and felt that the child was doing far better than previously. One described the care worker as *"a bright, insightful person who got it – who could hear the message [from the professional team] and implement it. That's hard to hire."*

The child was registered at the local elementary school in the new community in time for the 2010-11 school year. The school resource teacher and classroom teacher met the child and visited him at his residence. According to his CPOC dated Jan. 4, 2010, the child's oversight team was to work on an IEP in which *"the school district would provide a resource teacher for [the child] who will oversee the education plan for [the child] which the resource staff can help implement."*

## A Hasty Move

After almost a year in his first residence in the new community, the child was moved on April 1, 2011 to a new location in the same community – his sixth group home placement. This decision was made by the owner of the residential resource and the local ministry manager of CYSN services. The reason behind the move was neighbourhood concern about the child's behaviour when he was outside the home.

In one incident, the child had broken a window at a local video store. He had also tried to run away several times, had climbed onto a neighbour's roof, and had even tried to hitchhike home to his family. A senior ministry manager described having to liaise with the local government to deal with complaints from neighbours.

One professional closely involved with the team told the Representative's investigators that she was under the impression things had been going well, and the decision to move the child came as a surprise. Another professional on his care team noted that the child's acting out coincided with times when less-skilled staff members were responsible for his care.

The manager believed that a move was necessary to avoid having a major incident with the child that would play out in public. There were also contractual concerns, as the house was moving from the control of the ministry to that of Community Living BC.

The plan was to move the 11-year-old child to a more rural location, where neighbourhood concerns would be reduced.

The management of this move, given the child's documented history of struggling with any change in his environment, was considered by many of the professionals involved with him as requiring extensive preparation and careful planning. Despite this, the move occurred very suddenly and with little warning to those involved. One social worker recalls the decision being made on a Thursday and the move happening on Saturday.

Six days after the move to the new location, the child was playing in his room in the late afternoon. His favourite care worker was not on shift. The child pushed his bed against

the door, preventing staff from entering, and then climbed out through his unsecured bedroom window. When staff ran to the front of the house to intercept him, he was gone. They immediately notified their program manager, the ministry, and a manager of the contracted resource company that ran the group home.

Staff located the child half an hour later in a travel trailer on an adjacent property. The child was stabbing the walls and upholstery with steak knives that he had found in the trailer. Staff could hear the child yelling that he wanted to call his mom. Staff were unable to verbally calm the child, who was not wearing his hearing aids at the time.

The child climbed out of the side window of the trailer and dropped to the ground, still clutching two knives. He threw one knife to the ground and then turned to climb a fence beside the trailer. The group home manager, believing both knives had been dropped, ran to the fence and the child stabbed him below his ribs.

The manager was taken to hospital, while other staff members continued to follow the child to a house on the property. They could see the child inside, but they had no way to communicate with him. Police were called and three officers arrived at the house.

Staff had called the child's favourite worker, who was on a day off, but he did not reach the scene until the confrontation was over.

Police tried to negotiate with the child, but their efforts to communicate with him failed and the child repeatedly showed a knife he was holding to the officers outside. When the child stepped outside the door of the house, one of the officers used a Taser to subdue him.

The child was transported to hospital in a police vehicle. The hospital was aware of the child's heart condition and a physician's assessment determined he was "physically fine with no concerns noted." The child spent the night in the pediatric ward with a security guard present and was taken back to his group home the next day.

When police attempted to interview the child, his response was that he wanted to go to the home where he was born.

Reflecting on this incident later, one professional working with the child made the observation that although the extreme nature of the event was shocking, the reasons for it were not surprising. The care team moved, in the words of one participant, "to try and pick up the pieces."

In the wake of the Tasering incident, the Provincial Director of Child Welfare tasked two senior staff at the Maples Adolescent Treatment Centre with doing a review of the residence the child was living in, focusing on the child's current and future care. The two senior staff spent two days at the residence collecting information.

In June 2011, the child was moved to another local elementary school. An introductory home visit was made by the school support teacher. The goal for 2011-12 was for the child to attend school on a weekly basis in a classroom setting. In July and August 2011, the child took part in craft activities and school work that the support teacher brought to his residence.

Although the child was enrolled in the new elementary school for the 2011-12 school year, he did not attend the school. An IEP dated April 13, 2011 said that *"[the child] has been out of the formal school system for a number of years. Special arrangements need to be put in place in order for his safety and the safety of other students."* Records show that during that school year, the child received academic instruction only once a week for between 30 and 40 minutes, from a special education teacher.

## The Maples Review

The reviewers were asked to assess a number of factors related to the quality of care being provided to the child. Their report stated, in part:

*"In summary, it was our observation that more often than not the staff working with [the child] do not 'bring to the job' the formal training or experience one would expect for working with complex needs and behaviour youth."*

The reviewers acknowledged that the residential resource contractor had historically been effective in working with an older conduct-disordered type of youth and that its workforce reflected this focus: *"As [the resource] moves into providing services for youth with neurodevelopmental challenges and complex behaviours their staff recruitment and training should accommodate to these new demands."*

The reviewers acknowledged the strong performance of the child's favourite care worker, despite his lack of formal qualifications, but also warned that long-term planning – recognizing the risk that this worker could move on – had to be put in place.

The reviewers also made a number of recommendations related to staff training and support, some of which, including additional training by a behavioural psychologist, was already underway.

The review also reflected the concerns voiced by the care team about follow-through on recommendations made by the care team to front-line staff, with clearer accountability around reporting back.

Looking to the future, the reviewers identified two opportunities to improve the outcome of future behavioural "presentations" including a better articulation of the long-term care plan for the child as he moved towards adulthood, and managing his relationship with his family.

On the use of the "safe room," the reviewers cautiously recommended its continuing use, despite the fact there was no policy providing authority to use such a room. They recommended enhanced documentation with use of the "safe room," including what kind of situations triggered the behaviours that necessitated its use.

The reviewers concluded:

*"This is not an ideal placement for [the child] but ideal is an unrealistic goal. In the tradition of "good enough parenting" as first articulated by paediatrician Charles Winnicot, we concluded that the ministry could continue to use this contractor. There is a good Care Team in place and the basis of a good working relationship with [the facility's] staff. [The child] is very attached to [his favourite care worker], his key worker, and a disruption to this relationship will have deleterious effects. Any change to his situation will inevitably have some negative effects on [the child]. We recommend that rather than wholesale change of caregivers, prompt improvement to services as described above will improve [the child's] quality of life and eventual outcomes."*

## Another Move, More Change

On April 19, 2011, ministry management decided during the weekly care team meeting that the child should be moved again because he continued to attempt to leave the home he was in.

But this time members of the child's care team made it clear that if the move proceeded in the same fashion as the previous one, they would quit the team. The result was a carefully managed transition process that gradually introduced the child to his seventh group home placement. The move was completed on July 20, 2011.

For approximately 10 months following the Tasering, there were no critical incident reports. A psychologist who had previously worked with the child was brought back into his care team to develop and implement new strategies to support his staff.

Unfortunately, the concerns expressed in the Maples Review about the potential loss of the child's favourite care worker came to pass. About a year after the Tasering incident, the care worker made the decision to leave his employment and move to a different part of the province. The care worker only gave two weeks notice, concerned that if he provided more notice his hours of work would be curtailed in advance of his departure. Everyone professionally involved with the child braced for his reaction to this unanticipated separation.

One medical professional closely involved with the child's care described how plans to begin to reduce the child's level of medication and to return him to a school environment were all put on hold in the wake of the care worker's departure.

In June 2012, shortly after his favourite care worker left, the child became verbally aggressive with staff. He smashed some windows and cut his arm as a result and was placed in the "safe room." Minutes later, he was taken out of the "safe room" and taken to hospital by police. Four security guards and police restrained him at the hospital so he could be given medication.

Three weeks after this incident, the child walked away from his staff at a movie theatre and made his own way to the local hospital, where he told the nurses he wanted to live at BC Children's Hospital. While at the hospital, the child became more agitated and physically aggressive with the staff there. He was again medicated and released.

Eleven days after this incident, the 13-year-old child ran away from staff at a local playground. When he saw that the staff members were following him in their van, he threw a rock at the vehicle, breaking a window and then further damaged the van with a garden tool he found in the backyard of a private home. He went on to break the windows of a vehicle parked in the driveway.

Police intervened and took him to hospital, returning him to his residence after more medication was administered.

For a child whose behaviour could include violent physical outbursts, police were relied upon to help contain and control that behaviour when it was at its most extreme. Front-line workers in the child's home were sometimes overwhelmed by his physical aggression and required assistance in restraining the child so that he could be transported to hospital. Although there were incidents where the mere presence of police had calmed the child enough so that no physical intervention was required, this was not always the case. When the child had been younger and was still living in his small hometown, the police knew him and had built a relationship with him and his caregivers. But after the child moved to a larger centre and as his physical strength increased, behavioural strategies became more and more dependent on police.

Two weeks after the incident above, the child became aggressive with staff. After he was placed in the "safe room," the child threatened to harm himself. This time, police attended and took him to hospital, where he was kept for two nights before being released.

The child was subsequently placed in a specialized living arrangement that is not normally used as a placement for children in care. He remains there today. The ministry is seeking a new long-term placement for him. The Representative continues to strongly advocate for a placement that matches the complex needs of this child.

## MCFD Case Reviews

The ministry completed two case reviews about this child. The first case review was a Deputy Director's Review Report (DDR) completed on June 15, 2005. The reviewer focused on the "*provision of guardianship services and the Ministry's response to historical allegations of abuse and neglect while the child was living in an approved foster home*."

The DDR was limited to a review of file information – no interviews with staff, family or caregivers were conducted. This hindered the reviewer's ability to adequately examine social work practice and how allegations were handled by the ministry. The reviewer concluded that "*a review of file documentation suggests that the Ministry's responses to care issues that were raised by the parent and by community members were appropriate*."

The reviewer did identify that *"information relating to the management of ongoing care concerns was not easily accessed or absent when the children's files were transferred to another case manager,"* but concluded the review by saying that *"the decision to close the caregiver home as a result of the protocol investigation has probably contributed to the impression that the children had been repeatedly abused or neglected by the caregiver during their stay in this foster home."*

The Representative notes that this first case review did not examine the ministry's practice when the child was living in the family home and therefore missed an important opportunity to review historical and current concerns with the family's ability to care for the child(ren). Further, the ministry did not review its practice in domestic violence situations.

The DDR resulted in recommendations for the regional Director of Child Welfare:

"1. *That the region's Community Service Manager (CSM) share and debrief the report with [ministry office] staff and review the need for staff to consider past history when assessing and responding to allegations of abuse and neglect in a foster home*
2. *That the CSM review the standards related to completing Annual Review on foster homes and the need for staff to document and address issues arising from allegations of abuse and neglect, protocols and quality of care reviews with the foster parent(s)*
3. *That the CSM ensure that a Comprehensive Plan of Care be developed and documented for [the child and his sibling]*
4. *That the CSM review the standards related to documentation and supervision across all program areas: guardianship, family services and resources*
5. *That the Director of Operations review with all CSM's the need to reassess the ability and capacity of foster parents when there is a significant change in the foster family constellation.*"

The second case review conducted by the ministry was in response to the Tasering of the child. The ministry ordered an integrated comprehensive case review with this purpose:

*"to promote excellence in case practice, as well as confirm good practice; to assess and examine case practice in relation to fulfillment of delegated powers, duties and functions under the Child, Family and Community Service Act (CFCS Act); to inform case practice at an individual case practice level and at a systemic level; to identify situations where additional services to a child or family may be required; to identify barriers to providing an adequate level of service."*

The MCFD reviewer was asked to answer the following two questions:

1) Did the ministry's service planning reflect an adequate understanding of the child's needs?
2) Did the ministry's service planning reflect the effective collaboration, integration and regular re-evaluation necessary to meet the child's needs?

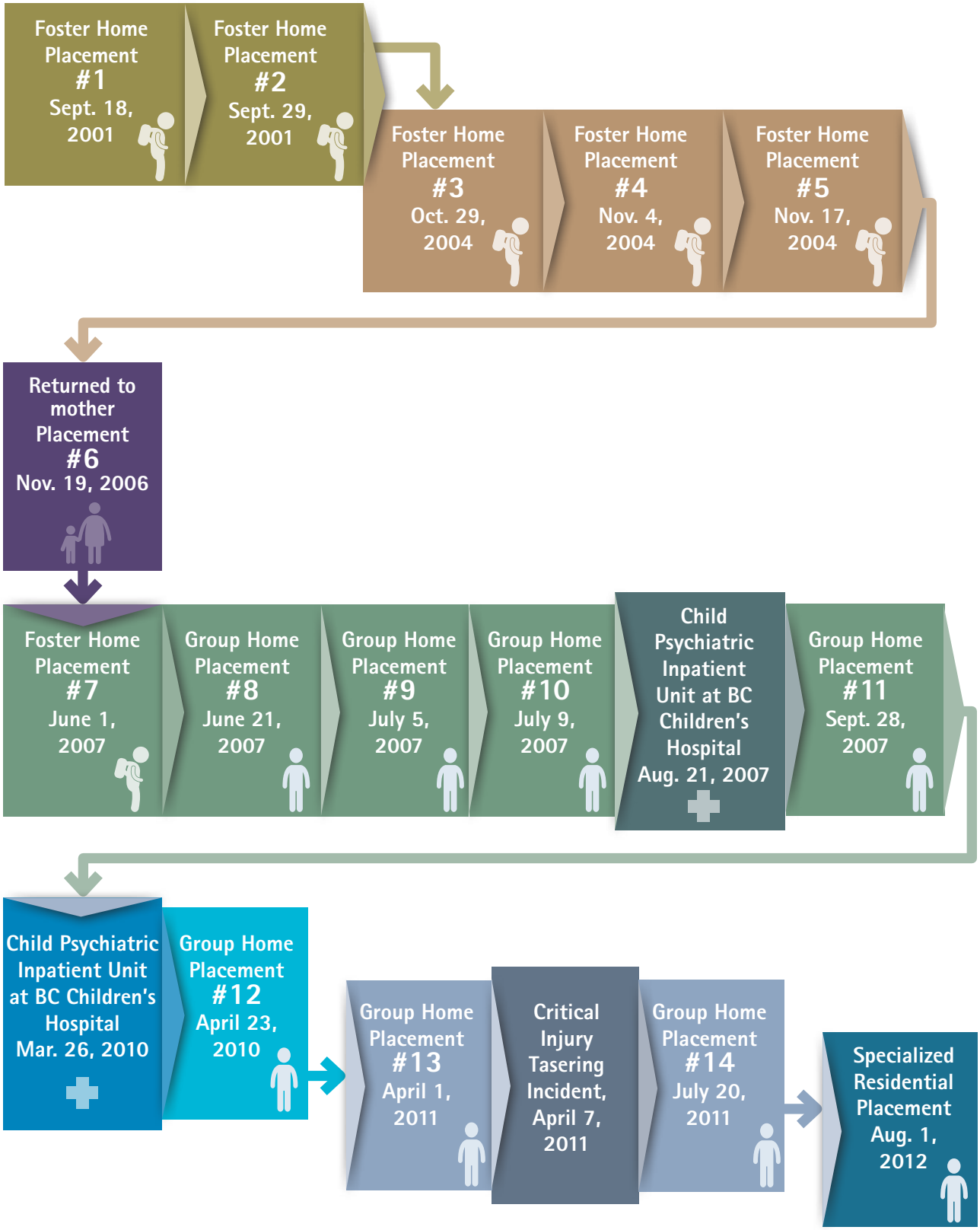
Although this review included a significant amount of factual detail about the child's early life, the time frame selected for analysis was limited to the period from Jan. 1, 2010 until April 22, 2011, because *"it was during this period that critical plans, assessments and decisions were made that may have been linked to the critical incident."*

In the Representative's view, this short time frame limited the ministry's learning in this case, especially since the child has been in the ministry's care since 2001. Such learning, in the Representative's view, can only be informed by a full understanding of the child's life and the challenges he faced both in and out of care.

For example, the reviewer demonstrated how the "safe room" issue was handled when the child first arrived in the new community:

*"Correspondence indicated that consultation took place with the MCFD, CYMH team leader in [the new community] regarding the use of a "safe room" [seclusion]. The team leader provided a number of guidelines and recommendations regarding defining the parameters of use and need to document, monitor and review the use of seclusion. It was noted that the MCFD Standards for Staffed Residential Resources expressly forbids seclusion/confinement as a behaviour management technique [Standard D.7.7e] and is considered a Reportable Incident."*

# Moves


Foster Home Placement #1 Sept. 18, 2001
Foster Home Placement #2 Sept. 29, 2001
Foster Home Placement #3 Oct. 29, 2004
Foster Home Placement #4 Nov. 4, 2004
Foster Home Placement #5 Nov. 17, 2004
Returned to mother Placement #6 Nov. 19, 2006
Foster Home Placement #7 June 1, 2007
Group Home Placement #8 June 21, 2007
Group Home Placement #9 July 5, 2007
Group Home Placement #10 July 9, 2007
Child Psychiatric Inpatient Unit at BC Children's Hospital Aug. 21, 2007
Group Home Placement #11 Sept. 28, 2007
Child Psychiatric Inpatient Unit at BC Children's Hospital Mar. 26, 2010
Group Home Placement #12 April 23, 2010
Group Home Placement #13 April 1, 2011
Critical Injury Tasering Incident, April 7, 2011
Group Home Placement #14 July 20, 2011
Specialized Residential Placement Aug. 1, 2012

# Police Involvement

**September 1998**
MCFD received domestic violence complaint, police attended the home.

**June 1999**
Child born and father charged with sexual assault.

**September 1999**
MCFD received domestic violence complaint.

**July 2001**
Domestic violence incident, police attended and arrested the father for assault.

**June 26, 2007**
Police called to escort child to hospital.

**August 2, 2007**
Police called to assist group home staff.

**January 30, 2008**
Police called to escort child to hospital.

**February 9, 2008**
Police called to escort child to hospital.

**February 20, 2008**
Police called to escort child to hospital.

**March 4, 2009**
Swimming pool incident, police called.

**March 24, 2009**
Police called to escort child to hospital.

**April 1, 2009**
Police called to escort child to hospital.

**January 28, 2010**
Police called – 3 officers restrained child and escorted him to hospital.

**January 30, 2010**
Police called to escort child to hospital.

**March 13, 2010**
Police called – no hospitalization.

**May 2, 2010**
Police called to escort child to hospital.

**May 4, 2010**
Police called – no hospitalization.

**November 18, 2010**
Child ran away from staff in a mall, police apprehended and returned home.

**December 6, 2010**
Child ran into neighbour's yard, police called.

**January 6, 2011**
Child ran away, police called.

**February 2, 2011**
Child broke a store window, store staff called police.

**April 7, 2011**
Tasering incident occurred.

**June 16, 2012**
Police called to restrain child so staff could administer medication.

**June 30, 2012**
Child left hospital and was returned by police to his residence.

**July 14, 2012**
Child ran away from staff, incident with property damage and police escorted child to hospital.

**July 28, 2012**
Child became aggressive with staff, police apprehended him.

**August 1, 2012**
Child placed in specialized residential resource.

# Education Timeline

## CHILD AGE 2–5 (SEPT 2001–JUNE 2004)

### Pre-School

**Pre-School**

- Attended pre-school 3 half days a week in local community
- Had a one-on-one aide
- Had a special education plan for hearing disability and a behavioural component

## CHILD AGE 6–8 (SEPT 2004–JUNE 2007)

### Kindergarten (Age 6)

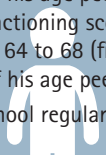
**School year 2004/2005**

- Child was designated as Aboriginal and special needs for hearing impairment by school district and had a teacher's aide and special needs teacher
- Child on an Individual Education Plan (IEP)
- No instruction documented for core subjects
- Attended school regularly

### Kindergarten (repeated) (Age 7)

**School year 2005/2006**

- Special needs were identified as hearing impaired, speech and language delayed and developmentally delayed
- Child was on an IEP
- Child assessed by school psychologist. IQ scores ranged from 67-75 (second percentile of his age peers). Adaptive functioning scores ranged from 64 to 68 (first percentile of his age peers)
- Attended school regularly



### Grade 1 (Age 8)

**School year 2006/2007**

- Child had the same full-time educational aide and teacher as last year
- Was placed in time-out room twice
- Attended school regularly

## CHILD AGE 9–10 (SEPT 2007–JUNE 2009)

### Grade 2 (Age 9)

**School year 2007/2008**

- November 2007 - the child's aggressive behaviour resulted in two support workers being injured
- As a result, child was not attending school
- Support worker delivered lessons at home two hours per day

### Grade 3 (Age 10)

**School year 2008/2009**

- On an IEP. Enrolled in Grade 3, but was working on Grade 1 academic outcomes
- Child was not attending school
- Lessons 2 1/2 hrs per day at home
- Assessment indicated that the child had the simple language of a 4 1/2-year-old



### Grade 4 (Age 11)

**School year 2009/2010**

- Attended class one hour per day and on an IEP
- Home care staff assisted child with homework 1 1/2 hr per day



### Grade 6 (Age 12)

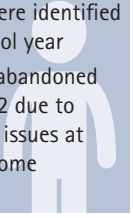
**School year 2010/2011**

- Sept. 2010 to March 2011 - The child received no instruction. He did not attend the classroom and did not meet a school support worker until March 2011

### Grade 7 (Age 13)

**School year 2011/2012**

- Home-schooled once per day/week for 30-40 min by a special education teacher
- Did not attend school
- Behavioural specialist attended bi-weekly meetings with MCFD to discuss transition planning to secondary school
- Child had difficulty with all areas of academics but goals were identified for the school year
- Plans were abandoned in June 2012 due to behavioural issues at the group home



**The Representative was not able to obtain the records for the child's school attendance.

# Analysis

The child who is the subject of this report was born into a home in which he was physically and emotionally abused and neglected.

Despite strong evidence – beginning well before the child was born – that his parents were unlikely to be able to safely care for him, the ministry failed to remove him from their care until he was two-years-old.

After the ministry took the child into care, it did not adequately nurture and protect him. A continuing series of child welfare practice errors, a failure to provide services to address his complex special needs and a string of inadequate living arrangements have compounded to severely compromise this child's long-term well-being and leave him increasingly isolated.

## Overall Finding

*In multiple instances, the ministry ignored child welfare practice standards that, if followed, could have spared this vulnerable child from physical and emotional abuse and neglect, and fulfilled its duty to protect him from obvious harm. The ministry did not provide an appropriate home or services to meet this child's needs, nor did it adequately oversee his health and education. Moreover, his basic civil and human rights were disregarded under the guise of managing his behaviour. The incident involving the Taser and indeed most of the 22 reported critical incidents and injuries could have been prevented had a system of support been available to meet his needs. Instead, the techniques and approaches resembled incarceration and isolation and hampered his development.*

Shortly after taking the child into care as a two-year-old, the ministry placed him in a foster home, where he again suffered physical and emotional abuse and neglect for more than three years.

Following his removal from that abusive situation, the ministry failed to offer supports that might have kept the child in a positive foster home setting where he was making progress. The ministry later failed to follow through on a potential adoption opportunity for the boy. Instead, inexplicably, the seven-year-old child was returned to his mother – from whose care he'd been removed five years earlier – even though there was no evidence to suggest that her ability to parent had improved.

Rather than follow the advice of professionals who recommended that the child be placed in a supported therapeutic foster home, the ministry instead placed him in a series of staffed residential facilities that continually failed to address his special needs or his past trauma. In many instances, it is likely he was re-traumatized by the use of a "safe room" to manage his behaviour, despite the fact no policy or legislation exists in B.C. to permit this measure under these circumstances.

This child has very complex needs as a result of developmental disabilities, hearing loss, a heart condition and mental health problems. The Representative acknowledges that finding a suitable, nurturing residential placement for him is a challenge. But such a challenge is the core business of the ministry – to protect and nurture B.C.'s most vulnerable children. The duty to meet the needs of this child and others like him is a statutory responsibility of the ministry, not a discretionary service.

Group home care for a child such as the child who is the subject of this report can be very expensive. In his case, the child's most recent placement cost $400,000 per year. This was negotiated as part of a five-year contract that included a one-year cancellation clause. Even though the child has not been residing in his group home since August 2012, that empty bed continues to be paid for by the ministry.

## Child Protection

**Finding:** *Ministry staff, including social workers, supervisors and managers involved with the child, failed to adequately follow the ministry's practice standards and placed the child in situations where he experienced repeated emotional and physical abuse. Despite compelling evidence gathered in their own risk assessments, ministry staff failed in their primary responsibility to protect the child from harm. They even returned the child to his family, despite repeated professional assessments that concluded the parents lacked the fundamental capacity to care for him.*

Child welfare legislation permits the state to become involved in the lives of families, to engage in interventions ranging from offers of support to the removal of children. Legislation in British Columbia – the *CFCS Act* – sets out in Section 2 the guiding principles under which such decisions are to be made. These guiding principles ground practice standards, directives and the professional judgement expected of those within the child-serving system, and are premised on the recognition that children have human rights and are entitled to special protection because of their vulnerability:

*S. 2 This Act must be interpreted and administered so that the safety and well-being of children are the paramount considerations and in accordance with the following principles:*

*(a) Children are entitled to be protected from abuse, neglect and harm or threat of harm;*

*(b) A family is the preferred environment for the care and upbringing of children and the responsibility for the protection of children rests primarily with the parents;*

*(c) If, with available support services, a family can provide a safe and nurturing environment for a child, support services should be provided;*

*(d) The child's views should be taken into account when decisions relating to a child are made;*

*(e) Kinship ties and a child's attachment to the extended family should be preserved, if possible;*

*(f) The cultural identity of aboriginal children should be preserved;*

*(g) Decisions relating to children should be made and implemented in a timely manner.*

MCFD's first investigation regarding the child who is the subject of this report – conducted in September 1999 – led the social worker to conclude that the three-month-old boy was in need of protection. The practice standards in place at the time directed the social worker to then complete a CRA.

The CRA of Oct. 20, 1999 found that:

- there was ongoing domestic violence occurring in front of the child
- both parents failed to recognize that the father throwing the baby in the air and roughly bouncing him on the couch could result in injury
- the parents strapped the boy into a car seat and left him in the bathtub while they were in another room
- parental responses to the baby's needs were inconsistent, and
- the parents did not consistently attend parenting classes.

Because the CRA concluded that the child needed protection and was at high risk of future abuse, practice standards called for the social worker to determine appropriate measures to ensure the child's protection, based on the level of risk identified. The steps taken to reduce risk were to be reflected in the Risk Reduction Service Plan and the plan had to be approved by the social worker's supervisor.

Practice standards outline a continuum of measures that can be used by social workers to protect a child. The least disruptive measure is to provide protective services to the child in the family home under an SSA. The most disruptive measure is the removal of the child from the family home and subsequent placement in a foster home. According to practice standards, the only measure available to the social worker in this case – when this child was found to be in immediate risk of harm in the fall of 1999 – was removal and placement in a foster home.

Inexplicably, the social worker, with supervisory approval, entered into an SSA with the parents, which left the three-month-old child in their care. This measure was not in compliance with the practice standards for a child who was at immediate risk. The Representative notes that, based on the risk factors identified in the assessment, the ministry could not have reasonably concluded that the parents could provide for the child's care and safety with support services. The decision defied common sense.

The goals of this SSA were for the parents to cease the ongoing domestic violence they were engaged in, attend a parenting program and for the father to *"address alcohol and drug related problems."* As previously noted, the parents' older child was already in the care of a relative due to child safety concerns.

The file includes no documentation to suggest that the SSA was renewed upon its expiry on Nov. 8, 1999. There is also no evidence to suggest that any of the risk factors identified in the assessment had diminished.

Practice standards require social workers to complete a CRA and review the Risk Reduction Service Plan during regular case reviews every four months. Another assessment should have been conducted in February 2000. In fact, the next CRA was not completed until June 1, 2001 – 20 months after the original assessment which found the child to be at high risk.

Another SSA was signed with the parents on Feb. 21, 2001, again stating goals that included both the mother and father attending parenting classes and for the father to seek anger management as well as drug and alcohol counselling. This was renewed in May 2001.

A CRA was completed in June 2001 following another call to the ministry about the parents neglecting the child. The investigation determined that the father continued to misuse alcohol and noted that the mother had multiple bruises on her body. The risk assessment concluded that the boy and his older sibling were at high risk of abuse. The Representative notes that, although the SSA was clearly not working, the ministry continued to leave the children in the care of their parents. As noted earlier, the ministry extended the agreement despite knowing that the parents were not engaging in services and were seen as resistant.

On July 8, 2001, one month after the SSA had been extended, the social worker was informed that police had arrested the father for assaulting the mother. The children were finally removed from their parents' care on Sept. 13, 2001. The Representative notes that this removal occurred almost two years after practice standards had actually called for this step to be taken.

The Representative also notes that the Risk Reduction Service Plan following the June 2001 assessment was not completed until Oct. 15, 2001. That plan also failed to address substance misuse, although that issue does not appear to have disappeared in the meantime. The father was referred to an anger management program by his probation officer and was placed on a wait list.

On Sept. 29, 2001, having finally removed the children from the parents' care, the ministry placed them in an over-capacity foster home. The foster home exceeded its allowed capacity of six children, with eight children residing there for a six-month period. The social worker received management approval to place the children in this foster home with six other children, but failed to adequately monitor the foster parent's ability to provide quality care to all eight children in the home.

The ministry's reason for placing the children in an over-capacity home was a desire to keep two sibling groups together. The social worker believed that this foster parent was able to meet the children's needs, but the worker rarely visited the children in the home to ensure that their needs were being met.

By March 2002, the home was no longer over-capacity because the other sibling group had been moved out. This did not mean that the quality of care to the child who is the subject of this report improved, however. In fact, the ministry received 16 reports raising concerns about this foster home from members of the public between 2001 and 2004.

The ministry addressed the concerns with the foster parent, but when the foster parent did not follow through on the suggestions for improvement, the ministry did not investigate the concerns any further. The ministry did not launch an investigation until 2004 even though many of the previous concerns were related to physical harm, emotional harm and neglect by the foster parent towards the child.

The investigation revealed concerns far greater than the issue of over-capacity, and concluded that the child had been abused by his foster parent and other children in the home, while his needs for crucial therapeutic interventions and basic medical care had been neglected.

The child endured three years in this foster home before the ministry took action to keep him safe. In 2004, the recommendations from the ministry's investigation into the foster home stated: *". . . that this resource be closed given that [the child] has been physically abused by the [foster parent] . . . "*

By failing to maintain meaningful contact with the child while he was in foster care, the ministry added to the child's already significant burden of trauma. The ministry closed the foster home without reporting the abuse to police and without notifying the Public Guardian and Trustee, who has responsibility for reviewing and seeking civil redress for injuries that occur to children in care.

As noted earlier, the mother underwent a court-ordered psychological assessment in March 2002, and the ministry requested a follow-up assessment in September 2003, which included her new partner.

The second assessment concluded that the mother had *"persistent mental disorders that will compromise stability and judgement as a parent."* She continued to *"overestimate her competencies as a parent, and minimize the challenges of caring for two children with special needs. She is easily overwhelmed by stress, and has admitted to foreseeing the return of the children as overwhelming, which is in part a function of cognitive deficits, but also because of depressive mood, anxiety, and enduring personality deficits."*

While the mother was noted to have improved in functioning because she had stopped abusing substances, she presented *"with many of the same, chronic deficits that pose a serious risk to the children."*

The mother's new partner was found to have a lack of insight and *"minimized the extent and severity of anger discontrol (sic),"* although it was noted that he had no known convictions for violence, and there had been no reports of violence in his relationship with the mother.

On Dec. 17, 2003, a judge granted the ministry a CCO for the boy and his older sibling. The judgement recognized that the mother was clearly attached to her children and that she had attended parenting programs, adding *"the problem is not attendance, but application."* The judge also stated that the social worker's reduction of access between the mother and her children seemed *"to be directed more at disciplining the mother, rather than*

*considering the children's interests. It also seems to be aimed at the director's ultimate goal of severing contact between the children and the mother."* The judge ordered the parents have access to the children.

A year-and-a-half later, in July 2005, the CCO was rescinded with the consent of the Director. The Representative notes that this occurred despite a complete lack of evidence to suggest that the parents were any more capable of caring for the children than they had been at the time the original CCO was granted. The older sibling was returned to the parents while the boy remained in his foster home under a Special Needs Agreement that was signed in July 2005 and renewed for another year in January 2006. All available evidence indicates that rescinding the CCO was driven by the philosophical stance of an individual social worker, rather than any relevant change in the circumstances of the child or his family.

The social worker completed another CRA four months later, in November 2005. This risk assessment, which was updated in January 2006, concluded that the family had stabilized and was *"currently functioning quite well."* It found the older sibling was at low risk, while the boy was at medium risk of future abuse.

On June 27, 2006, the ministry received a report that the boy's older sibling had been physically injured by the stepfather. The finding from the ministry's investigation was that there was "no physical harm" but it also noted that the parents *"do not have the skills to deal with a special needs child."* The investigation resulted in the older sibling returning to the care of the ministry that same month.

Despite this, just five months later on Nov. 19, 2006, both the child who is the subject of this report and his older sibling were returned to the care of their parents. The Representative considers it inconceivable that the ministry could reasonably conclude that anything had significantly changed in the parents' capacity to parent their children. The only rationale found by the Representative's investigators for the return came in an interview with the social worker who stated that the long-term goal was always to return the children to their parents' care.

A change in ministry practice standards, which took effect in November 2003, meant that a CRA was no longer required prior to the ministry returning a child to the care of a parent. The new standards stipulated that the social worker must review the reasons why the child came into care; and must review the child's plan of care to ensure that objectives relating to the safety and well-being of the child had been achieved.

The Representative notes there is no indication on file that these reviews by a social worker actually occurred. In fact, had the social worker reviewed the reasons the children were in care, the only logical conclusion would have been that they should remain in care. The parents could not cope with the older sibling, and social workers had already determined that the parents did not have the skills to parent a special needs child. There is no evidence on file that the parents had gained these necessary skills during the five-month period since the last protection investigation in June 2006.

Yet the social worker nevertheless concluded in a new CRA completed in December 2006 that both children were at low risk of abuse. The social worker made this conclusion despite the loss of the extensive parental support the mother had been receiving from the foster parent, who had moved to another community, and despite there being no significant change in the skills of either the mother or father.

Given the history of the parents and the repeated professional assessments of their lack of capacity, it is not surprising that the child's mother and social worker eventually concluded in May 2007 that the child could not remain in the family home. The Representative believes that had this decision been made by the ministry much earlier – as practice standards dictated – the child's life might well have taken a different path.

The guiding principles of the practice standards in place when the child first came in contact with the ministry explicitly stated that *"any doubts about a child's safety and well-being, a child's need for protection, or the ability and willingness of a child's parent to care for and protect the child must be resolved in favour of protecting the child."*

This guiding principle was repeatedly ignored to the detriment of the child.

The obvious question that arises is whether the deficiencies in practice identified in this report were occurring in other cases in the region. In 2006-2007 the ministry audited 21 closed and nine open family service files in the child's home community. Of the 21 closed files, 80 per cent were compliant for the critical measure of conducting a child protection investigation. On the nine open family service files, only half were compliant for that same critical measure.

These audit results were comparable to the other eight offices that were audited in the region. The child protection practice audit compliance rate in this region was 69 per cent in 2006, declining to 52 per cent in 2007. The 2006 compliance rate for reassessing risk was 59 per cent, declining to an alarming 16 per cent the following year.

It is difficult to know whether or not the compliance with critical measures has improved or declined in the region, because fewer and fewer files have been audited in recent years.

## Planning and the Prudent Parent

**Finding**: *The ministry repeatedly failed to provide a safe, stable, and nurturing home for this child. Rather than providing supports for foster parents, or pursuing the option of adoption, the ministry moved the child into a group care setting that could not provide security, stability or long-term sustaining relationships for the child. Poorly planned changes to the child's living arrangements created a situation of isolation and anxiety and contributed to the incident in which he was Tasered. His educational attainment is very low and insufficient effort has been made to school this child. His identity as an Aboriginal child was not preserved or supported as required by legislation.*

Following the move from the abusive foster home, the child and his older sibling were moved twice in less than three weeks into two different foster homes, both of which were

either over-capacity or poorly matched to the children's needs. When these placements ended, the children were moved to another foster home, their fifth, with a woman who had known the children for years through her work in the local CDC.

This report has already detailed the extraordinary lengths this woman went to in ensuring that the child felt safe in his new home. He flourished in this environment, but the demands on his foster parent were high, and she was given little support beyond respite care. Her requests for additional assistance during her workdays went unmet.

At the same time that the child was finding success and safety in this foster placement, the ministry had identified an Aboriginal adoptive home that possessed the skills necessary to support the child and his older sibling. This opportunity for the child and his sibling to finally find permanency was lost when the ministry consented to abandon its continuing custody of the children in July 2005, foreclosing the option of adoption.

When the child's fifth foster parent moved to a new community in November 2006, there appears to have been no consideration given to how the ministry could have supported her to allow the child to remain in her care. Instead, in the face of all the evidence to the contrary, the ministry returned him to his mother.

When the mother was again unable to cope with the child's needs, he was removed from her care and placed with another set of foster parents. Predictably, the child struggled with this change and, in June 2007, he began to act out aggressively. The foster mother, a ministry social worker, knew that the child psychiatrist in charge of the child's care was at the MCFD office and she brought the child to the office, where he was seen and subsequently admitted to the hospital in his hometown.

Following this, the child was assessed at BC Children's Hospital. The discharge summary states: *"[the child's] attachment needs are both crucial to his functioning and challenging to provide. He has extreme difficulty with uncertainty and change, and it will be essential for caregivers to 'hang in there' with him as he adapts to changing circumstances."* There was no recommendation regarding the type of placement for the child, but it was recommended that there be two adults present during the day to ensure safety.

MCFD's Caregiver Support Service Standards 10 states: *"the Director uses staffed children's residential services only when an assessment of the child's needs and best interests determines that placement of a child in a family care home is neither appropriate nor possible. The Director considers all other placement options first, and uses staffed residential resources only when the child's needs cannot be met within a family care home, or as a last resort."*

The Representative's investigators found no indication on the ministry files that any discussion took place about leaving the child in his foster placement and offering the kind of support his foster parent would require. The child psychiatrist told investigators: *"I think there would have been a fighting chance at that time perhaps, if [the foster parent] had had enough support."* This could have been the child's best hope. In this case, it appears the "last resort" became the first choice for the ministry with no analysis of how the child could have stayed in a more home-like setting.

The ministry asked a mental health specialist for input on an optimum placement for the child. The specialist suggested a foster home with excellent supports, based on the specialist's review of the literature and personal experience with previous successes using that model.

The mental health specialist stated that *"best for [him] would be a family home, very supported, with respite and access to professionals. He deserves to be in a school setting and he deserves to be with other children."* The ministry rejected this advice.

Once the child had moved from foster care to group home care there were ongoing challenges in providing him with stability and security. These challenges are perhaps best illustrated by the events that occurred in the days prior to the Tasering, when the decision was made to move the child from his suburban group home setting to a more rural location.

In this instance, the ministry was clearly operating in a crisis mode when it moved the child hastily, with no time allowed to prepare him for the transition to the new home.

Neighbourhood concerns about the child's behaviour and changes to his group home's contractual status might have justified a move. However, there was no justification for the rushed manner in which this move took place. When ministry management informed the care team that the child would be moved, the team advised that he would require significant time to accept the idea and that staff would need to gradually transition him to the new environment. The team was told that they would have one week to prepare him for the move. In fact, he was moved two days later.

Group home staff scheduled his primary worker to be with him for several days following the move because they understood how difficult this transition would be. In those early days after the move, the child's behaviours were managed. But when his primary worker took a day off, the child was paired with a worker that he didn't like and his behaviour escalated to the point that he stabbed a staff member and was subsequently Tasered by police.

Decision-makers ought not to have disregarded the advice of his care team and the experience gained by everyone who had previously worked with the child. The child was hyper-vigilant with respect to his attachments, rejection and safety, as a result of the abuse and neglect he had suffered. His psychologist described how vulnerable the child was to experiencing profound emotional dysregulation and that the preferred strategy once he escalated was to back off, say less, do less and let it work through. A child in this state is not amenable to being "talked down" as the child's ability to act rationally is extremely compromised.

During the Tasering incident, police attempted to reason with the child but, in his elevated state and without his hearing aids, his only response was: *"I want my Mom."* One can only imagine how confused, alone, frustrated and fearful the 11-year-old child must have felt in this situation.

In the aftermath of the Tasering incident, when it was being reviewed by an outside police agency, the Representative strongly urged that the child be provided with legal counsel so that his rights could be protected. The ministry refused to do this. The result was that there was no one to speak for the child or represent his interests as this process unfolded. This raises fundamental questions of fairness and commitment to the civil rights of the child, all of which went unaddressed by the child's legal guardian.

CIC Standard 12 states: *"When a child in care changes living arrangements, prepare the child before the move and support him . . . throughout the transition . . . This standard reflects the fact that a change in a child's care arrangements may be disruptive and emotionally destabilizing. All efforts are therefore made to prevent and mitigate the trauma that a child may experience when making this transition."*

Caregiver Support Service Standard 13 states: *"A director works with a caregiver and all members of a child's team to plan for the child and promote stability in the child's living arrangement . . . In order to ensure that the child . . . [is] well prepared for the change, the director participates in developing a plan that addresses the activities and supports needed to promote a positive transition experience for all concerned."*

In this child's case, there was a dramatic failure of ministry management to follow ministry standards. Community Living BC was taking over the contracted group home in which the child was living, and the ministry allowed this to supersede the complex needs of a child who was extremely vulnerable. The decisions by ministry management did not mitigate trauma to this child, but instead led to further traumatization. As one of his mental health workers stated: *"We need to be concerned that the care we're giving is actually causing the mental health issues."*

The Representative is dissatisfied that the ministry did not carefully consider the impact of its decisions. There is no doubt a connection between this poorly handled move, the child's emotional dysregulation and police involvement leading to the child being Tasered.

Following the Tasering, when ministry management informed the care team that he would be moved once again in one week, members of his team stated that they would resign unless a more appropriate plan was followed. Ministry management acquiesced and the team prepared a detailed five-week plan. This time, the move was successful. Clearly, a carefully planned transition and time for the care team to prepare the child for a significant change can positively influence outcomes for this child.

The crisis-orientation and decision-making in this case resulted in disruption and instability in this child's life. This child has been subject to a parade of ever-changing caregivers, living in 15 different foster or residential placements, not including hospitalizations, since 2001.

The pattern of multiple moves for this child is consistent with findings in the Representative's report, *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm*. In that report, 89 self-harm and suicide incidents were examined and a common circumstance in the lives of many of the children was a lack of stable living arrangements, with just over half of youth experiencing between 10 and 20 moves while in care.

Again, the number of placement changes is noteworthy because frequent moves can have serious consequences such as further traumatizing already vulnerable children, higher levels of anxiety, feelings of loss and depression, and negative impacts on social and emotional development *(O'Neil, Risely-Curtis, Ayon, and Williams, 2012)*.

In the Representative's report, *Kids, Crime and Care: Health and Well-being of Children in Care: Youth Justice Experiences and Outcomes* (February, 2009), she recommended that whenever a child or youth in care has more than three changes in placement outside of the parental home within a year, a report is made to the Regional Director of Integrated Practice. To this date, the ministry still has not fully implemented this recommendation.

The ministry and caregivers need to do more to ensure that children in care with complex needs are receiving care that is aimed at improving their well-being and that the match between a child's home and needs is carefully considered when planning for a child. The responsibility of the ministry is to serve as a prudent parent for every child in its care.

A prudent parent fosters a child's well-being, assists a child in developing valuable life skills, promotes good relationships, physical health, cultural identity and connection to community, and provides a reasonable level of stability in a child's life. As we assess the life of the child who is the subject of this report, it is important to pause periodically and ask: "If this were my child, would I have done the same thing?"

The responsibilities of a prudent parent are amplified when the child has complex medical, physical or emotional needs. If we apply that standard to the care received by this child from MCFD, it is clear that the ministry repeatedly fell short in its efforts, despite the passionate and committed work of some of the individuals who were responsible to care for him.

The focus dominating the decision-making process throughout the most recent stages of the child's life is on ensuring safety for the child and those who work around him. That focus on safety has meant that the child has lived a life of increasing isolation.

When neighbourhood concerns in his first suburban placement arose, the response was to move him to a rural setting – even though some of those around him worried this would re-ignite the trauma he experienced in the rural foster home where he was abused.

When the child became verbally aggressive and sexually inappropriate with female members of his staff, the response was to remove those workers from his care team and replace them with young male staff, rather than to teach him how to more appropriately manage interactions with women. Although the child enjoyed the activities he shared with his young male staff and formed deep attachments with them, part of the challenge now for staff where he currently resides is teaching him how to manage interactions with women more appropriately, an important life skill.

One of the professionals involved in the child's care observed that, in the wake of the Tasering incident, many of those working closely with the child feared for their jobs.

The professional told the Representative's investigators that this fear meant choices were made based on the minimization of risk, rather than the optimum outcome for the child. In his view, even though adverse events were not to be welcomed, they did provide valuable learning opportunities that could help develop better overall care strategies.

In *Kids, Crime and Care: Health and Well-being of Children in Care: Youth Justice Experiences and Outcomes*, the Representative recommended that upon each new occurrence of a youth in care having involvement with the youth justice system, including police, the youth's plan of care be reviewed within 30 days with youth justice professionals and service providers, and modified as required to address the criminal behaviour. In this child's case, the youth had multiple and significant contacts with police and the ministry did not review the youth's plan of care to ensure that the services being provided to this child were appropriate and adequate.

It would appear that the same concerns about safety meant that the child's education was neglected, because of fear he might act out and the feeling that it was too risky to expose him to a school environment, even during those extended periods of time when he was perceived to be doing well. This was particularly devastating in this child's case because speech and language therapy which could have been of obvious benefit to him are provided through the school system.

The lack of focus on education was described to the Representative's investigators as being a common problem for children and youth with behavioural challenges. One professional described working with six youth who together were attending school a half-day per week. The practice of excluding children from a school setting based on behaviour they cannot control raises significant concerns for the Representative, and the apparent unwillingness to even attempt to place this child in a school in the new community seems a blatant example of this sort of exclusion.

The result is a child who has not been in a school setting for many years and whose skills are far below those of other children his age. His learning needs have been so neglected that it will require an immediate and intensive intervention to support his learning, although many years of potential growth have now been irrevocably lost. The gaps in his education include the loss of opportunity to address behavioural, mental health and learning needs, particularly speech pathology to assist him in forming clear sentences.

The child's ability to form peer relationships was also impacted by his move to a remote location and the fact he didn't attend school. He occasionally had opportunities to play with other children when he and his staff visited public parks, but his behavioural challenges and developmental delays made it frustrating for him to understand how to behave around other children, particularly strangers. His only contact now is with other children where he is living. Outside of that, his only contacts have been with paid staff, either in a hospital setting or in a rural resource where he is the only "client." This abnormal model has left him even more ill-equipped to develop appropriate social behaviours and opportunities for broader interactions.

Another part of the child's life that has been left unexplored is his Aboriginal culture. Those involved with his care seemed content to wait until he expressed an interest, highly unlikely for a young boy who would have had no way of knowing about this dimension to his life.

One witness told the Representative's investigators she believed there was "a group home mentality of hopelessness" about the prospects of the child developing greater skills and abilities. Another professional described group home care as "warehousing" children until they aged out of the system.

Although the child made some significant gains during his time in group care in the new community, it is clear that "getting through the day" was more important than equipping the child with the skills to interact with people other than paid caregivers.

Children in B.C. with a developmental disability can receive services from birth to age six through their local CDC. After age 14, they can receive services through dedicated Developmental Disability Mental Health teams that provide consultation and assessment for those working with the youth, but no case management or treatment. There is a serious and chronic gap in services for children with developmental disabilities between the ages of six and 14, particularly for those with a concurrent mental health issue.

CYMH is the program funded to treat the mental health of children and youth in the province, yet it often doesn't have specific expertise in developmental disabilities. The ministry has undertaken some specific training for CYMH staff, but much remains to be done to address service demand.

The result of the lack of dedicated mental health services for children and youth with developmental disabilities is that when they are in a crisis, they end up in the Emergency Ward of their local hospital.

In his home community between the ages of eight and 10, this boy was admitted to the hospital 12 times when his behaviour was aggressive and resource staff were unable to calm him. Although he was eligible for mental health services, there were no therapeutic programs available to the child as a result of him having a developmental disability and mental health issues. This continues to be a systemic barrier for other children such as him. The hospital staff did not feel equipped to deal with him, and his doctor eventually informed MCFD that he could no longer admit the boy when he had a behavioural crisis. He recommended the boy be relocated to a community with full pediatric and adolescent psychiatry to manage his behaviour.

MCFD eventually moved the child to a community better equipped to deal with him. But the hospital adolescent psychiatric unit in the new community wouldn't accommodate him because he was under 12. The mental health worker tried to set up protocols with the hospital but was unsuccessful. The pediatric floor wouldn't take him, either. Regarding the refusal to enter into a protocol for the child, a pediatric nurse told the mental health worker: "We cure kids, and we can't cure mental health."

## "Safe Room" Use/Punitive Aspects of Confinement

**Finding**: *The use of a "safe room" is not authorized by any ministry policy or British Columbia legislation. Assigning low-wage and unskilled staff the power to confine raises fundamental issues about the rights of children with special needs. Frequent isolation in the "safe room" was not effective in positively changing this child's behaviour, and has most likely resulted in harm as a result of repeated re-traumatization.*

The Representative has determined that every residential facility in which the ministry has placed this child since the age of eight has included a "safe room."

At various times, the child was locked inside these rooms, which have varied in construction from drywall to plywood walls, some including windows and some not.

It appears to the Representative that such rooms were used to keep both the child and the staff safe, but at times it appears that they were also used as a punitive measure in an attempt to control his behaviours.

The effectiveness of these rooms to control his behaviours is highly doubtful. The Representative has determined that nine of the 22 reportable incidents involving this child occurred after he had been confined in such a room.

It is inconceivable to the Representative that the ministry would condone use of such confinement, particularly given this child's prior experience with being confined. The boy was locked in his room at the age of two by his parents when they became frustrated by his behaviours. He was then reportedly locked in a shed by the abusive foster parent with whom he lived for three years. Ironically, in June 2007, the ministry social worker learned that the school the child was attending used a seclusion room to manage his behaviour and questioned the legality of this approach under the provincial *School Act*.

Not only was use of such a room unquestionably traumatic for the child, there is also no policy or legislation in existence to justify its use in this circumstance.

The only legally authorized use of confinement rooms in British Columbia occurs in the youth justice and mental health sectors, where such use is carefully regulated by policy and procedure administered by a branch of government, not a private contractor. In the case of this child, private contractors and their employees – some of whom had no formal training – were administering this measure.

A psychologist working for the ministry expressed concerns in 2010 about using such a room for this child because it could be perceived as punitive.

"*I would caution you on this whole 'calm down room' concept for the following reasons*," the psychologist wrote in an email to a social worker. "*The bigger issue is what purpose does the room serve? Will it be used as a planned time out [from positive reinforcement] area . . . as a crisis intervention in which case that would be considered a seclusion room . . .*"

Seclusion is defined by BC Children's Hospital seclusion room protocol as the involuntary placement of an individual in a locked room. It is considered a high-risk intervention that utilizes a room with reduced sensory stimulation and a secure, safe environment. The room becomes a seclusion room once the door is locked.

In a later 2010 email to a different social worker involved with the child who is the subject of this report, the ministry psychologist wrote: *"Any use for Time-Out or for seclusion needs to be part of a much larger clinical plan of care. Use of such rooms is considered highly restrictive and ethically there are actually very few circumstances that can justify such use. The risk of harm to a client is considered quite high when use of seclusion is allowed. The risk of institutional abuse is also considered quite high. I would strongly urge caution."*

The Representative's investigators could find no evidence that use of "safe rooms" was part of a larger plan of care for this child. In fact, documentation of use of "safe rooms" with the child ranged from inconsistent to nonexistent.

Ministry Standards for Staffed Residential Services expressly forbid the use of seclusion or confinement. Standards state the use of "time outs" is acceptable, but this policy does not address circumstances in which a child is locked in an isolation room.

The residential setting in the new community was subject to the scrutiny of an accreditation body. The accreditation standards allow for the use of seclusion only as a last resort. It is used only after an assessment that the child's behaviour has become so dysregulated that it poses a risk to the residents' safety or to the safety of others. This requires skilled assessment to ensure that the room is used therapeutically and not punitively. Seclusion is considered a high-risk intervention because, each time it is used, it *"creates potential physical and psychological dangers to the persons subject to the interventions."*

This same accreditation agency said that *"each organization still utilizing seclusion or restraint should have the elimination thereof as an eventual goal."* The plan is directed to include various components, including a debriefing process.

A second accreditation agency for service providers said that research indicated *"for individuals with a history of abuse or other trauma, undergoing a restrictive behaviour management intervention [being placed in seclusion] can be extraordinarily retraumatising."* It also noted that *"when staff are trained and supported in the use of alternate methods in crisis situations, the use of seclusion and restraint is reduced dramatically."*

The ministry file states the medical community recommended seclusion as part of a behaviour management plan, though documentation of this could not be found by the Representative's investigators. Despite the prohibition of seclusion in the ministry's own standards and the fact the boy had been traumatized by seclusion in previous living environments, a senior ministry manager granted an exemption to this prohibition in 2010. Seclusion had already been used for three years in the child's residential setting prior to this exemption being granted with no senior management approval found on file. Where a senior ministry manager would derive the lawful authority to authorize such an exemption is both unclear and likely non-existent.

Some members of the child's care team in the new community became concerned that they were not receiving accurate reporting about the use of the "safe room," although there was a log book in which to enter details about every use of the room. These care team members were surprised when they were told by the senior ministry manager that the rationale for the child's move from a suburban to rural location was his escalating behaviour and increased use of the "safe room," as they were under the impression it was being used only rarely.

A plan to eliminate the use of seclusion would be impossible if there was inaccurate reporting and therefore inadequate debriefing following use of the tactic.

Following the Tasering incident, a new "safe room" protocol for this child was developed that included higher levels of professional oversight by a psychologist and child psychiatrist. Nevertheless, four of the nine reportable incidents involving the child that occurred after the tasering in April 2011 came after use of the "safe room" at his residence.

Some professionals associated with the child's care have pointed out that the more a "safe room" is used, the less likely it is that the child will learn to independently regulate his own behaviour. Ministry standards dictate that care to a child be provided in such a way that the child develops and enhances his or her skills and presentation. In this case, a plan that focused on decreasing and eventually eliminating "safe room" use should have been an important part of that developmental learning.

# Recommendations

## Recommendation 1

**That MCFD urgently create a comprehensive plan to develop a continuum of residential services for children and youth in B.C. with complex needs that cannot be met in traditional foster home or group home settings, and fully fund and support that plan to ensure that these vulnerable children have access to residential care to support their optimal development.**

### Detail:

The plan should include:

- detailed analysis of needs, completed by April 2013
- detailed plan for service requirements, including facilities, operating and staffing costs, and specialized mental health and behavioural resources to support treatment needs, completed by June 2013
- detailed implementation plan and timelines, completed by October 2013.

**Full implementation should begin in April 2014.**

## Recommendation 2

**That the Office of the Provincial Director develop policy and standards to ensure that active oversight is in place at a senior management level in each region to provide effective accountability in planning and delivering services, including guardianship for children with complex special needs.**

### Detail:

The following features are required:

- a robust system of flagging and identifying exceptional cases that require active oversight. Examples of indicators might include, but not be limited to:
  - number of moves
  - use of police to manage behaviour
  - a Continuing Custody Order is rescinded
  - a child is not receiving educational instruction
  - medication profiles
- a robust system for tracking planning of cultural continuity for Aboriginal children, and implementation of the activities outlined in those plans
- periodic reporting to the Provincial Director.

**The policy should be in place and implemented by Sept. 30, 2013.**

## Recommendation 3

**That MCFD develop an internal clinical unit to provide consultation, training and clinical support to residential care staff, social workers and policy makers who are dealing with children and youth with complex needs.**

### Detail:

The unit should have the following characteristics:

- dedicated staff and sufficient financial resources to meet demand
- multidisciplinary team approach
- quick response.

**The unit should be implemented by Sept. 30, 2013.**

## Recommendation 4

**That MCFD immediately discontinue use of isolation and restraint as behaviour management strategies for children in residential care, and develop trauma-informed approaches, including positive and pro-social behavioural supports.**

### Detail:

- all behaviour management plans and plans of care for all children and youth in residential settings that include use of isolation or restraint should be reviewed and updated to reflect that those techniques are discontinued
- beginning March 1, 2013, all instances in which restraint is unavoidable in a crisis to protect the safety of the child or others must be reported to the Representative as critical injuries
- following any use of restraint, the plan of care must be reviewed by senior staff.

# Conclusion

From the perspective of most British Columbians, this child's story began and ended with the incident that culminated in police Tasering him. This incident resulted in widespread media coverage, and the Representative's investigators heard repeatedly from people who referred to the child as the "Taser kid" – as if this was the defining event in his young life.

But when the circumstances of this child's life are more fully understood, it is clear that the events of that day in April 2011 were the result of a lifetime of trauma and complex challenges. His complex needs repeatedly overwhelmed those responsible for his care, including his biological parents, numerous foster parents and even professionally staffed residential resources.

His earliest years were shaped by his developmental disabilities, his hearing loss and an environment of domestic violence, substance abuse and poverty. His young parents struggled with their own challenges as they tried to raise the child and his siblings. Some professionals who knew the family doubted from the very beginning that his mother and father would ever be able to care for the child.

When the child was finally moved from his family home to live in foster care, the outcome was not an improvement in his life and health, but instead repeated traumatization.

His placement in foster care in a rural location away from his hometown resulted in the child being abused – not just by his foster parents, but also by other children living in the overcrowded home. This abuse occurred over a period of more than three years, raising obvious questions about the level of oversight being provided by ministry workers tasked with the care of the child.

Efforts to place the child with new caregivers resulted in more turmoil, as some found him too challenging and lasted only a few days before refusing to continue caring for him. In addition to submitting him to a string of residential placements, the ministry failed to support the child's Aboriginal identity or encourage positive connections to his culture.

But along with the legacy of abuse and disrupted connections, there were also people, many working for the ministry, who clearly cared deeply for the child and worked diligently in an attempt to build new homes and new, safe relationships that would support him. It was clear to the Representative's investigators that many of the professionals who had been responsible for the child during his life had a deep and continuing commitment to his well-being that cannot go unrecognized.

A caregiver who must be acknowledged is the woman who provided foster care for the child after he was moved from his first foster placement. Having previously known the child through her work with the local CDC, she was under no illusions as to the magnitude of the challenge. Her efforts to make the child feel secure, including removing all the internal doors in her home to overcome his fear of confinement, resulted in what was undoubtedly one of the best periods of the child's life to date. Had the ministry been able to support and sustain that relationship for the long-term, it is unlikely this report would ever have been written.

But at the core of this report is the inability of the system to nurture and sustain the relationships that mattered most to the child. If his attachment issues were obvious to everyone who worked with him, the repeated severing of ties to the people closest to him and his continual retraumatization are inexplicable. The apparent inability or unwillingness of the system to provide him with stable, caring connections to others is the failure that must be addressed.

One of the systemic issues that contributes directly to that failure is the model of group care that this child's psychiatrist described as placing "the most difficult kids with the people least able to care for them." There is no question that the child was able to form at least one very deep attachment to his primary worker in the new community, but the structure within which that worker functioned was a recipe for transience and instability.

Paying people at or just above minimum wage, while asking them to work long shifts with difficult and challenging youth, is a model that places no emphasis on staff retention or stability. It was difficult enough for the child's constantly changing staff to adapt to his model of care, but imagine the challenge for the child himself to deal with this constant parade of new and unfamiliar faces.

Although the child, with his complex needs and history of trauma, is exceptional, he is by no means unique. People throughout the system told the Representative that there are other children like him in B.C., struggling to find stability and permanency. The Representative is aware that there are many other children in this province requiring similarly intensive support.

The Representative urges the ministry to learn from this child's case so that mistakes made are not repeated. How well the child-serving system is able to learn will greatly affect the life trajectory of this child and others like him.

# Appendix A: Representative for Children and Youth Act

**Part 4 – Reviews and Investigations of Critical Injuries and Deaths**

**Section 11 – Reviews of critical injuries and deaths**

(1) After a public body responsible for the provision of a reviewable service becomes aware of a critical injury or death of a child who was receiving, or whose family was receiving, the reviewable service at the time of, or in the year previous to, the critical injury or death, the public body must provide information respecting the critical injury or death to the representative for review under subsection (3).

(2) For the purposes of subsection (1), the public body may compile the information relating to one or more critical injuries or deaths and provide that information to the representative in time intervals agreed to between the public body and the representative.

(3) The representative may conduct a review for the purpose of identifying and analyzing recurring circumstances or trends to improve the effectiveness and responsiveness of a reviewable service or to inform improvements to broader public policy initiatives.

**Section 12 – Investigations of critical injuries and deaths**

(1) The representative may investigate the critical injury or death of a child if, after the completion of a review of the critical injury or death of the child under section 11, the representative determines that

(a) a reviewable service, or the policies or practices of a public body or director, may have contributed to the critical injury or death, and

(b) the critical injury or death

(i) was, or may have been, due to one or more of the circumstances set out in section 13 (1) of the *Child, Family and Community Service Act*,

(ii) occurred, in the opinion of the representative, in unusual or suspicious circumstances, or

(iii) was, or may have been, self-inflicted or inflicted by another person.

(2) The standing committee may refer to the representative for investigation the critical injury or death of a child.

(3) After receiving a referral under subsection (2), the representative

(a) may investigate the critical injury or death of the child, and

(b) if the representative decides not to investigate, must provide to the standing committee a report of the reasons the representative did not investigate.

(4) If the representative decides to investigate the critical injury or death of a child under this section, the representative must notify

(a) the public body, or the director, responsible for the provision of the reviewable service, or for the policies or practices, that may have contributed to the critical injury or death, and

(b) any other person the representative considers appropriate to notify in the circumstances.

# Appendix B: Documents Reviewed and Interviews Conducted

**Police and RCMP records**

- Police files for one detachment
- RCMP files for two detachments

**Ministry of Children and Family Development records**

- Family Service files (Volumes 1-10)
- Child Service files (Volumes 1-15)
- Child and Youth Mental Health File and CARIS notes (Volumes 1-2)
- Child and Youth with Special Needs FH file (Volume 1) and PARIS notes
- Resource files for all of the child's placements (16 volumes)
- Contract files
- Provincial office file (Volume 1)
- Regional office file (Volume 1)
- Regional practice audits
- Child's Critical Incident file (Volumes 1-12)
- Deputy Director's Case Review, 2005
- Comprehensive Case Review, 2012

**Contracted service agency records**

- Child's placement files
- Child's Child Development Centre files
- Child's Developmental Disability and Mental Health files

**Medical records**

- Child's files from three hospitals
- Psychologist, psychiatrist and pediatrician's files for the child
- Child, mother and father's psychological assessment reports

**Ministry of Education**

- Child's files from two school districts

**Maples report**

- Review of residence for the child conducted by the Maples Adolescent Treatment Centre May 3, 2011

**Ministry of Children and Families/Ministry of Children and Family Development – Policy, Standards and other documents**

- Caregiver Support Service Standards, 2006
- Quality Assurance Standards, 2004
- Child and Family Development Service Standards, 2003
- Child and Youth Mental Health policies, 2002
- Practice Standards for Guardianship, 1999
- Protocols for Foster Homes, 1999
- Standards for Staffed Children's Residential Services provided under the *CFCS Act* 1998
- Standards for Foster Homes, 1998
- Practice Standards for Child Protection, 1998

**Legislation**

- *British Columbia Representative for Children and Youth Act* (2006). Victoria, BC: Queen's Printer.
- *British Columbia Child, Family and Community Service Act* (1996). Victoria, BC: Queen's Printer.

**Interviews conducted in this investigation:**

- 10 Ministry of Children and Family Development staff
- 16 health/medical professionals
- 3 Ministry of Education staff
- 1 police officer
- 10 contracted service agency staff
- 1 family member

# Appendix C: Multidisciplinary Team

Under Part 4 of the *Representative for Children and Youth Act* (see Appendix A), the Representative is responsible for investigating critical injuries and deaths of children who have received reviewable services from MCFD within the 12 months before the injury or death. The Act provides for the appointment of a Multidisciplinary Team to assist in this function, and a Regulation outlines the terms of appointment of members of the Team.

The purpose of the Multidisciplinary Team is to support the Representative's investigations and review program, providing guidance, expertise and consultation in analyzing data resulting from investigation and reviews of injuries and deaths of children who fall within the mandate of the Office, and formulating recommendations for improvements to child-serving systems for the Representative to consider. The overall goal is prevention of injuries and deaths through the study of how and why children are injured or die and the impact of service delivery on the events leading up to the critical incident. Members meet at least quarterly.

The Multidisciplinary Team brings together expertise from the following areas and organizations:

- Ministry of Children and Family Development, child protection
- Policing
- Coroners Service
- BC Injury Research Prevention Unit
- Aboriginal community
- Pediatric medicine and child maltreatment/child protection specialization
- Nursing
- Education
- Pathology
- Special needs and development disabilities
- Public health

## Multidisciplinary Team Members at the Time of This Review

**Dr. Evan Adams** – Dr. Adams is the Aboriginal Health Physician Advisor for the Office of the Provincial Health Officer, as well as a family physician. He is a Masters candidate at the Johns Hopkins Bloomberg School of Public Health, a past-president of the Rediscovery International Foundation, and a Youth Advisory Committee member at the Vancouver Foundation. He is a member of the Coast Salish Sliammon First Nation.

**Lucy Barney** – Lillooet Nation, RN, completed her Masters of Science in Nursing from the University of British Columbia, and is currently employed as a perinatal nurse consultant with the BC Perinatal Health Program. She is the vice president of the Native and Inuit Nurses' Association of BC, and is a member of other advisory committees. Ms. Barney has assisted in investigations with other provincial and national agencies. Ms. Barney's expertise is Aboriginal health and she developed the braid theory which looks at the mind, body and spirit, and demonstrates a holistic view on health.

**Randy Beck** – A/Commr. Beck is the RCMP "E" Division Officer in Charge (OIC) Criminal Operations – Core Policing. He is responsible for the operational oversight of the over 150 RCMP detachments in the Province of British Columbia. A/Commr. Beck has a broad policing background in General Duty, plain clothes investigations (GIS & Major Crimes) and Federal Policing throughout his career across the western provinces of Canada.

**Beverley Clifton Percival** – Ms. Percival is from the Gitxsan Nation, and is a negotiator with the Gitxsan Hereditary Chief's Office in Hazelton. She holds a degree in anthropology and sociology and is currently completing a Master of Arts degree at UNBC in First Nations Language and Territory. Ms. Percival has worked as a researcher, museum curator, and instructor at the college and university level.

**Dr. Jean Hlady** – Dr. Hlady is a clinical professor in the Department of Pediatrics at the University of British Columbia's Faculty of Medicine. She is also a practising pediatrician at BC Children's Hospital and has been the Director of the Child Protection Service Unit for 21 years, providing comprehensive assessments of children in cases of suspected abuse or neglect. Dr. Hlady also served on the Multidisciplinary Team for the Children's Commission.

**Doug Hughes** – Mr. Hughes is currently the Provincial Director of Child Welfare for the Province of British Columbia. He has 26 years experience in child welfare as a child protection social worker, community development worker, community services manager, regional executive director and finally as an Assistant Deputy Minister. He graduated from the University of Calgary with Master of Social Work in 1992.

**Norm Leibel** – Mr. Leibel is the Deputy Chief Coroner for the BC Coroners Service, who has 25 years of policing experience and 17 years as a coroner. Mr. Leibel has examined the circumstances around child deaths in criminal and non-criminal settings, with the goal of preventing similar deaths in similar circumstances in the future. Mr. Leibel was a member of the Multidisciplinary Team for the Children's Commission.

**Sharron Lyons** – With 32 years in the field of pediatric nursing, Ms. Lyons currently works as a Registered Nurse at the BC Children's Hospital, is past-president and current treasurer of the Emergency Nurses' Association of BC, and is an instructor in the provincial Pediatric Emergency Nursing program. Her professional focus has been the assessment and treatment of ill or injured children. She has also contributed to the development of effective child safety programs for organizations such as the BC Crime Prevention Association, the Youth Against Violence Line, the Block Parent Program of Canada and the BC Block Parent Society.

**Dr. Ian Pike** – Dr. Pike is the Director of the BC Injury Research and Prevention Unit and an Assistant Professor in the Department of Pediatrics in the Faculty of Medicine at the University of British Columbia. His work has been focused on the trends and prevention of unintentional and intentional injury among children and youth.

**Dr. Dan Straathof** – Dr. Straathof is a forensic pathologist and an expert in the identification, documentation and interpretation of disease and injury to the human body. He is a member of the medical staff at the Royal Columbian Hospital, consults for the BC Children's Hospital, and assists the BC Coroners Service on an ongoing basis.

# Appendix D: Advisory Committee on Services to Special Needs Children and Youth

The Advisory Committee on Services to Special Needs Children and Youth is comprised of individuals from across the province who have specialized knowledge or experience with services to children and youth with special needs. The membership is drawn from a variety of backgrounds, including individuals with experience in child development, pediatrics, social work, education, mental health, alcohol and drug addiction, policing and public policy, and from agencies that provide services to children and youth with special needs and developmental disabilities. The Committee provides invaluable advice to the Representative about current issues and helps inform the Representative's reports on related matters.

**Faith Bodnar**, Executive Director, B.C. Association for Community Living

**Jennifer Charlesworth, PhD**, Director of CoreBC, Federation of Community Social Services of B.C.

**Dr. Jonathan Down, MB, MHSc, FRCP(C)**, Developmental Pediatrician, Queen Alexandra Centre for Children's Health, Victoria, B.C.

**John Gotowiec**, Coordinator of Development for Education Programs, Pacific Community Resources Society

**Bev Gutray**, Chief Executive Officer, Canadian Mental Health Association, B.C. Division

**Angela Kwok, MSW, RSW**, Executive Director, B.C. Centre for Ability Association

**Dr. Christine A. Loock, MD, FRCPC, DABP**, Associate Professor, UBC Developmental Pediatrics, B.C. Children and Women's Health Centre, Sunny Hill Health Centre for Children

**Kim Lyster**, Community Consultant experienced in disability issues

**Dr. William McKee**, Director, Psychoeducational Research and Training Centre Faculty of Education, University of British Columbia

**Nella Nelson**, Aboriginal Nations Education Division, Greater Victoria School District

**Paul Pallan**, Consultant to the Advisory Committee for Children and Youth with Special Needs

**Inspector Ralph Pauw**, Youth Services and Mental Health Units, Vancouver Police Department

**Dr. Bruce Pipher**, Child and Adolescent Psychiatry, Medical Director Interior Health Children's Assessment Network

**Dr. Nancy Poole**, Director, BC Centre of Excellence for Women's Health

**Michael J. Prince**, Lansdowne Professor of Social Policy, Faculty of Human and Social Development, University of Victoria

# Glossary

"**Aboriginal**" is a broad term which, according to the *Constitution Act* of 1982, includes the Indian, Inuit and Métis people of Canada. However, the term "Aboriginal" is generally more broadly interpreted as including people who are registered status Indians, non-registered Indians, Inuit and Métis. Non-registered Indians are generally people who self-identify as having Aboriginal heritage, but who are not eligible to be registered under the *Indian Act*.

**Child protection report**: a report received about a child's need for protection due to abuse or neglect. Every report received is assessed to determine the most appropriate response. Responses include: taking no further action, referring the family to support services, providing a family development response, providing a youth response if the child is a youth, or conducting a child protection investigation.

**Comprehensive Plan of Care**: an action-based planning tool for children in care, used to identify specific developmental objectives based on continuous assessments of the child's evolving needs and the outcomes of previous decisions and actions. Care plans are completed by the child's worker with the involvement of the child, the family, the extended family and Aboriginal community if the child is Aboriginal, the caregiver, service providers and significant people in the child's life.

**Comprehensive Risk Assessment**: a process and document that describe the risk of harm to a child and the mitigating strengths of the family. Risk assessment includes a review of previous child protection reports regarding the family, identification of risk factors and the potential for future harm to the child. A Comprehensive Risk Assessment is completed whenever a child is found in need of protection.

**Continuing Custody Order**: is a court order under section 41 (1)(d), 42 (3)(b), 49(4) or (5) or 60 of the *CFCS Act*, placing a child in the continuing custody of a director. Custody includes the care and guardianship of a child. The court grants a Continuing Custody Order when it is satisfied that the child cannot return to the family. The social worker responsible for the child must address the long-term need for permanency and consistency when planning for the child. In some cases, the court may approve continued contact between the child and the parents or guardians, despite the fact that the child will not be returning to their home. This provision recognizes the significance of the child's natural family, regardless of their ability to live together.

**Director**: means a person designated by the minister under section 91 of the *Child and Family Community Service Act (CFCS Act)*.

**Individual Education Plan**: is designed for a student 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,

**Intake**: the process by which child protection reports and requests for service are introduced into an office. These reports and requests for service are assessed and assigned to social workers for follow-up.

**Respite Care**: the Respite Program is intended to provide a "safety valve" function in order to prevent placement breakdowns, to preserve relationships, and to build a sense of competence and belonging in the family rather than failure and rejection. Periods of respite can range from a few days to two weeks.

**Reactive Attachment Disorder**: by definition, the condition is associated with grossly pathological care that may take the form of persistent disregard of the child's basic emotional needs for comfort, stimulation and affection, persistent disregard of the child's basic needs, or repeated changes of primary caregiver that prevent formation of stable attachments. The essential feature of Reactive Attachment Disorder is disturbed and developmentally inappropriate social relatedness in most contexts that begins before the age of five.

**Risk Reduction Service Plan**: a portion of a service plan that outlines how specific risks to the child will be addressed and reduced.

**Special Needs Agreement**: is a voluntary care agreement for a child who has special needs. A child with special needs has documented significant impairment associated with an ongoing physical, cognitive, communicative, and/or emotional/behavioural condition that requires specialized care and support. This is determined through assessment completed by a qualified professional in the area of child development.

**Supervision Order**: is made by the court that allows the social worker to supervise the child in the family home. A director may apply to court for an order that the director supervise a child's care if the director has reasonable grounds to believe that the child needs protection and that a supervision order would be adequate to protect the child. A supervision order usually has a provision for removal of a child if the parent is unable to follow the court-ordered expectations of the order.

**Temporary Custody Order**: is a court order under section 41(1)(b) or (c), 42(3)(a) or 60 of the *CFCS Act*, placing a child for a specific period of time in the custody of a director or another person, and includes any extension of or change to that order. A temporary custody order is granted when a child is removed from a parent or guardian because the child needs protection beyond what is currently provided. The plan is for the child to return home.

**Voluntary Care Agreement**: is an agreement negotiated between the ministry and a parent for providing care for a child for a limited period of time, in an approved foster home. This agreement is used when a child temporarily cannot live at home and support services and informal kinship care are unavailable or inadequate to meet the child's needs. They can only be used if reunification with the parents is expected. If a child needs protection, a VCA may be used as means to keep the child safe when the parent agrees to services and a plan of care to assist in resolving the circumstances that cause the child to need protection.

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