NOVEMBER 2019

CAUGHT IN THE MIDDLE

REPRESENTATIVE FOR
CHILDREN AND YOUTH

The cover image of this report was created by Chloe de Beeld of Reber Creative. RCY Investigators chose the theme of the cover to honour Romain's love of comic books and super heroes.

Nov. 26, 2019

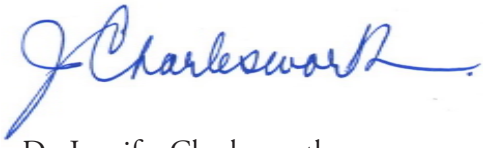
The Honourable Darryl Plecas
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting the report *Caught in the Middle* 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 critical injuries and deaths of children receiving reviewable services.

Sincerely,



Dr. Jennifer Charlesworth
Representative for Children and Youth

pc: Ms. Kate Ryan-Lloyd
Acting Clerk and Clerk of Committees,
Legislative Assembly of British Columbia

Contributors

Dean Campbell, Lead Investigator

Alysha Hardy, Senior Investigator

Carly Hyman, Chief Investigator

Joanna Lee, RCY Co-op Student

Jeff Rud, Executive Director, Strategy and Communications

The Representative would also like to acknowledge the many other RCY staff who were involved in the planning, preparation and distribution of this report.

Contents

Executive Summary

When he was just 11-years-old, the boy wearily told social workers that it felt as though he had been *"passed around for 20 million years."*

Such was the level of instability for Romain who, by this age, had already experienced significant trauma and upheaval in his life. But instead of providing stability and appropriate care and services to address that trauma, the child-serving systems in two provinces continued to pass him around until his tragic death six years later.

This report tells the story of Romain, a pseudonym chosen by the boy's family who loved him but struggled to meet his complex needs and was never properly supported to care for him. It is the story of a boy who desperately sought connections and permanency in his young life but never received those things on a consistent basis as he was bounced between dozens of inadequate placements in Alberta, British Columbia and beyond.

The Representative chose to investigate Romain's case because it illustrates what can happen when children in government care or receiving designated services are moved between provinces and territories. Despite an established Interprovincial Protocol designed to facilitate the provision of *"seamless"* services to children and youth in these circumstances, there remain, in fact, significant gaps. The gaps are effectively widened in B.C. due to ineffective oversight of the cases of "interprovincial children" by this province.

In Romain's case, those gaps were too significant to escape. A young man with a magnetic smile, compassion for others and a deep desire to be with family, he died of a fentanyl overdose in May 2017 while placed in an emergency staffed residential resource in B.C.

This final placement was obviously inappropriate for a teen with Romain's history and significant needs and yet nothing more suitable was arranged because the Alberta and B.C. child-serving systems didn't communicate or work together well enough to develop an appropriate resource.

Born in Alberta, Romain first moved to B.C. as a 13-year-old when Alberta Children's Services (Alberta CS) placed him with his eldest maternal sister. However, Alberta CS didn't follow the Interprovincial Protocol, failing to provide MCFD with notice about the move and not formally requesting MCFD's help until two months after Romain had arrived in this province.

This was the first of a string of miscommunications and dropped handoffs between the two provinces that culminated when, despite Alberta's informal agreement to fund a highly specialized residential resource for Romain four years later, this was never confirmed in the Interprovincial Agreement. No action was taken by B.C. to create that resource, leaving the teen in a predictably precarious situation and contributing to the events that led to his death.

Romain's time in care could best be described as chaotic. Although RCY investigators had limited access to information about his time in Alberta, they estimate he moved more than 40 times during his time in care in Alberta and B.C. He lived with family members in both provinces as well as two different brief stints as a young boy with his father in the small Caribbean nation of Belize. In Alberta, he was also placed in group homes, treatment centres, residential treatment homes and he had numerous secure care placements. In B.C., he also spent time in youth custody, hospitals and emergency bed homes.

Romain disclosed physical abuse he experienced as a young boy in Belize. He was also sexually assaulted at 13 while he was placed in a residential treatment facility in Alberta. After a placement with a sister in B.C. broke down, MCFD child welfare staff decided to send him back to Alberta. Romain was sent back against his will and, despite his trauma from the assault and an explicit promise from a case worker, he was later returned to the same cluster of residences in which he had been victimized. And shortly before his death, he was the suspected victim of a similar assault by a co-resident in his B.C. emergency bed home, despite warnings from staff at the home that Romain was at risk there due to the other resident's history. Romain never received appropriate mental health services to help him work through these experiences.

In addition to the trauma he endured, Romain was a boy with complex needs. During his tumultuous life, he was diagnosed and medicated for a number of psychiatric disorders. He began misusing substances when he was 10, was placed in secure care in Alberta an estimated eight times, exhibited suicidal and violent behaviour on a number of occasions and spent significant time in B.C.'s youth justice system.

Romain's placements with family members were not adequately supported by the child-serving systems in either province, contributing to his constant shuttling through various residential facilities. While family connections were not supported by services that might have made a difference, neither were cultural connections. Neither the protective factor that connection to Romain's black Caribbean cultural heritage might have provided nor the potential impacts of racialization were explored by those whose job it was to help him find a sense of belonging.

Through this investigation, the Representative found a link between the inadequate services provided to Romain in B.C. and his death by overdose. Factors that contributed to those services being inadequate included shortcomings in the current Interprovincial Protocol, a lack of provincial coordination and oversight of such cases in B.C., a lack of training and policy to guide MCFD employees in working with interprovincial cases, and the B.C. child-serving system's inability to house and wrap responsive supports around children and youth who have experienced trauma.

It is beyond the Representative's scope to make findings about the role of Alberta CS in Romain's life and death. But the Representative recognizes that the Alberta ministry shares responsibility for his tragic outcome. MCFD did not receive adequate notification and information from Alberta each time Romain was placed in this province and the ineffective oversight of Romain's well-being was not limited to B.C.

RCY investigative reports are not meant to place blame on individual front-line staff and their supervisors. And, in fact, the Representative notes that Romain did receive some exemplary service in B.C., particularly from his Youth Probation Officer and a school outreach program.

Overall, however, the services and supports for Romain and his family were inadequate. And the purpose of RCY reports is to point out the systemic deficiencies and make recommendations for improvement so that other children and youth can be spared from similar experiences.

First among the recommendations in this report is for MCFD to take a leadership role in making improvements to the Interprovincial Protocol that is supposed to ensure children and youth moving between provinces and territories receive timely and appropriate services.

This investigation pointed to a child falling through the cracks and his best interests getting lost in confusion, miscommunication and discord between provincial child welfare authorities. Those cracks must be filled. As B.C.'s Deputy Director of Child Welfare told RCY investigators: *"We've taken our eye off the ball, I think, to some degree, with the [Interprovincial Protocol] . . . Likely this report will put it back on the front burner again."*

The Protocol will next be reviewed by provincial and territorial directors of child welfare in 2021. The Representative calls on MCFD to push during that process for the addition of cultural planning to the Protocol as well as clarification about the delegation of guardianship responsibilities and about how disputes can be resolved when children arrive in a province or territory without notice. In addition, the Representative recommends MCFD seek an amendment to Interprovincial Agreement forms to include details on financial expenditures and payment mechanisms.

The Representative also recommends that MCFD fully dedicate an Interprovincial Coordinator to work together with an adequately resourced network of regional analysts to support, track and monitor interprovincial cases – both those involving children who arrive in this province and those who move from B.C. to other provinces and territories. Currently, the Interprovincial Coordinator is not a full-time dedicated role and the knowledge among MCFD staff about this position varies widely among workers.

In order to improve how MCFD deals with such cases, the Representative also recommends that the ministry create provincial practice guidelines or policies and develop a mandatory online training course for staff specific to these cases. The staff who were involved in supporting Romain had never received training in managing interprovincial cases.

With regard to the cultural planning that might have helped Romain, the Representative recommends that MCFD direct its staff to speak with all children in care about their ethnicity and desired connections and record that self-identified ethnicity in the ministry's case management system. At this time, social workers are compelled only to record ethnicity in the case of Indigenous children in the ministry's case management

system. The Representative believes that cultural protective factors can benefit children of any ethnicity.

Two other recommendations address current shortcomings in B.C.'s system of services to care for children and youth who have experienced trauma. First, the Representative recommends that MCFD take steps to ensure that a trauma-informed method is implemented for making decisions about resourcing for children in its care who have experienced multiple adversities in their lives.

Finally, the Representative calls on MCFD – as part of its current overhaul of residential services – to assess the need for residential care and treatment resources across the province to accommodate children with complex needs and to create sufficient resources to meet those assessed needs in a timely way.

About Romain

Romain is remembered by family members as a sweet and loving child whose infectious smile and engaging personality were evident from the very beginning.[1] His mother recalls that Romain had a special presence as a newborn, describing him as a sweet baby who was her *"king of the world"* and who touched everybody's heart. As a child, she said he was loved by his whole family for his way of being and his big smile.

Another relative described young Romain as fast-paced and thinking about everything, but very sweet and seemingly destined to do great things as he got older. He was always active and extremely affectionate. He had *"the most awesome curly hair"* with *"very, very big prominent eyebrows"* which became animated when he talked or interacted with others, further adding to his aura. One family member said: *"anybody who's heard [his] laugh will never ever get that out of their heads and hearts . . ."*

Romain's father is Albertan, of European descent. Romain's mother self-identifies as a multi-generation Nova Scotian, of Barbadian descent who also has Indigenous ancestry through her paternal grandmother who was Mi'kmaq. According to Romain's mother, he began self-identifying as being of *"Jamaican"* descent from an early age, something she believed was due to his exposure to pop culture. She corrected Romain, telling him that his heritage was not Jamaican. One family member described Romain as being culturally lost.

> *"Romain was this tall, beautiful boy … Romain [was] very beautiful, like very tight, curly hair, very tall . . . [He] tended to be more quiet, more reserved."*
>
> —Social worker

Romain was described by family members as very devoted to all of them, choosing to spend his free time with family. As one put it, *"He loved everybody no matter what, and no matter what everybody threw at each other . . . There was so much unwavering love and loyalty [from] that kid."* They also recalled that he was extremely intelligent. He read at a young age and loved to discuss what he learned with his family. He was also *"tech-savvy,"* fixing his family's electronics, phones and computers.

Romain had a life-long interest in comic books and movies. As a young child, a relative said he was *"constantly re-enacting Hulk and [other] superheroes . . . he really liked to embody those characters."* Another relative added to this, recalling that as a child he *"always had to have a superhero shirt."* His favourite superheroes were Spiderman and the Hulk.

Family and the professionals who worked with Romain pointed to his love of music, particularly rap. He expressed his creativity by writing song lyrics. As one school professional told RCY investigators, *"[He was] hilarious, witty [and] really musical … He was super cool, just a really fun kid. If you wanted to do anything, he's the guy you ask, whether it's to help you or join you in the fun … He was always wanting to impress everybody … just a total performer."*

1 Romain is a pseudonym chosen by the maternal family for the purpose of this report.

As a whole, emergency bed home employees, school support staff, and other professionals who worked with Romain in B.C. described him as polite, kind and a *"gentle soul."* They often mentioned Romain's infectious smile, large personality and devotion to his family.

This investigation examined relevant events in Romain's short life, why they happened, and how those events impacted him. The Representative wanted to ensure that Romain was not forgotten in this process. He was loved and cared about. He was unique, and he had potential that, tragically, went unfulfilled.

Chronology

Alberta Birth and Family

Romain was born in Edmonton in June 2000. His mother was 33-years-old when he was born and already had two daughters, ages 12 and nine, from a previous relationship. Romain's mother told RCY investigators that he was a *"sweet child and a happy baby."*

His mother is the second-youngest of 11 siblings and recalls a challenging childhood in Nova Scotia while being raised by a single mother with substance use issues. Like many of her siblings, Romain's mother left the family home at a young age, relocating to Alberta when she was 17.

Romain's parents were not a couple when he was born and there was never a formalized custody arrangement between them. His father moved to the U.S. when Romain was two-months-old, and there was only sporadic contact between them during his first few years. In addition to Romain's two older maternal sisters, he had five paternal siblings. Throughout his life, Romain's family was deeply connected with him and tried to stay involved and attached to him. They acted as supports for him. Regardless of whether he was in the care of child services or in their care, they provided him with love and affection.

Alberta, the Early Years

Alberta Children's Services (Alberta CS) was involved with Romain's family since his birth, providing services to his mother, who had ongoing struggles with depression and felt overwhelmed by the demands of parenting three children.

In 2003, when he was three, Romain's mother sent him to live with his father, who had returned from the U.S. and was again living in Alberta. This arrangement was organized informally between his parents. Romain lived with his father for four years while still regularly visiting and maintaining a relationship with his mother. He was close with his maternal and paternal family at this time.

In 2006, Alberta CS assessed allegations of physical abuse of Romain by his father. The Alberta CS file was closed with *"a caution to the father that he is not to use a belt to discipline his child."* In December of that year, six-year-old Romain moved with his father and grandmother to Belize. Family members described this move as *"unsettling"* for Romain, who struggled to adjust to the new culture, environment and school system in the Caribbean country. Eight months later, in August 2007, Romain returned to Alberta and moved back in with his mother.

By the end of 2008, Romain's mother was again feeling overwhelmed with caring for him. She planned to send Romain back to Belize to live with his father. A friend of Romain's mother took eight-year-old Romain to Mexico, where his father was supposed to meet them. This connection did not take place, however, and Romain was placed alone on a bus from Mexico to Belize to live with his father. RCY investigators

found little information about what happened to Romain during this stay in Belize, although later in life Romain reported that he experienced physical abuse, parental substance misuse, peer bullying and that he was left alone for long periods of time. RCY investigators could not verify these reports. Six months later, in June 2009, Romain again returned to Alberta to live with his mother. He turned nine that same month.

Romain's mother told RCY investigators that, following his return home from Belize in 2009, he seemed withdrawn. A school assessment completed in November 2009 in response to problematic school behaviours identified Romain as exhibiting *"poor self-esteem, sexualized behaviours, and physical aggression towards his peers such as hitting, fist fights, and kicking."* The assessment suggested Romain's behavioural responses came from feeling *"powerless and inadequate"* and recommended counselling and behavioural interventions for him. Alberta CS was not involved with the family at the time of the school assessment and it is unclear to RCY investigators what follow-up occurred after this assessment.

In June 2010, Romain's mother called Alberta CS saying that she was struggling to parent 10-year-old Romain. She reported that he was damaging property and posing a significant challenge at school. According to his mother,[2] Romain had been diagnosed with attention deficit hyperactivity disorder (ADHD),[3] depression and oppositional defiant disorder[4] and was prescribed the medications Risperidone[5] and Dexedrine[6] managed by a psychiatrist through the Alberta Child, Adolescent and Family Mental Health (CASA) services.[7]

Romain's mother was dissuaded by an Alberta CS worker from having him placed in care and was instead referred to community services including a mental health assessment for Romain. It is unclear to RCY investigators if a mental health assessment was completed.

A family member offered RCY investigators the following recollection of him at this time:

> *"He was totally like Mowgli [from the Jungle Book]; he was a big boy now, and so he kinda just wanted to do his free reign and call the shots, and [his mother] let him, and so it was kind of just like a bit of disarray. I went and saw him, and I expected to see this, like, erratic, psycho kid and it was like no, he just clearly does not have any coping mechanisms and lashed out and has no concept of … the impact of his actions. I think he was just sort of … not really familiar with how to behave socially."*

2 RCY could not obtain records from Alberta and could not verify this early diagnosis although a diagnosis of ADHD was confirmed in later years.
3 ADHD includes a range of behavioural disorders occurring primarily in children, including such symptoms as poor concentration, hyperactivity, and impulsivity.
4 Oppositional defiant disorder is a childhood mental health disorder that includes frequent and persistent anger, irritability, arguing, defiance or vindictiveness toward parents or authority figures.
5 Risperidone, sold under the brand name Risperdal among others, is an antipsychotic also used for the short-term treatment of behavioural problems (such as verbal or physical aggression, suspiciousness, and agitation).
6 Dexedrine belongs to the family of medications known as stimulants. This medication is used to treat ADHD.
7 CASA offers services for infants, children and adolescents and their families.

In April 2011, Romain was treated and released from a hospital in Alberta after he swallowed an entire bottle of melatonin. He told professionals at the hospital that he was not suicidal. Romain disclosed at this time that, while he had lived in Belize, he had been assaulted by his father and had experienced both neglect and exposure to his father's substance misuse.[8] According to his mother, the family received ongoing support from a counsellor after this incident.

In June 2011, Romain's mother called Alberta CS requesting that Romain be removed from her care due to his behaviours including suicidal ideation. Alberta CS initiated a safety plan for the family that included referring Romain's mother to two programs that provided support and services to children with special needs, even though Romain was not identified in any of the Alberta CS or subsequent MCFD case records as having special needs. The Alberta CS file was subsequently closed, stating that concerns had been addressed and there were no further grounds for involvement.

In mid-June 2011, Romain was admitted to a hospital child and adolescent psychiatric ward for two weeks, marking his first time in secure care in Alberta. As he was being prepared for discharge at the end of the month, his mother contacted Alberta CS again requesting that he be removed from her care, citing fear that she may injure him as well as her inability to manage his behaviours. This removal did not occur, and he was discharged instead to the care of a sister in an informal family arrangement. This sister promptly called Alberta CS to express her concerns for Romain's mental health, stating that he was attacking family members, had tried to light himself on fire and had caused property damage.

On July 3, 2011, the sister told Alberta CS that *"she could no longer care for Romain as his behaviour became out of control."* Romain returned to his mother's care and an Alberta CS worker provided support services to the family. Meanwhile, Alberta CS identified Romain's eldest sister, by this time living in B.C., as a possible long-term placement option for Romain if he was to come into government care.

Alberta Care History

On July 7, 2011, his mother drove now 11-year-old Romain to an Alberta CS office and told staff she could no longer care for him. According to written Alberta CS records, Romain told case workers[9] that he felt *"cracked like an eggshell … passed around for 20 million years,"* and that he wanted to die. Romain and his mother were placed in separate rooms when he was told he was being removed from his mother's care. He reacted violently, damaging property in the Alberta CS office, breaking glass and attempting to stab himself with pieces of the shattered glass. According to his mother, she was not permitted to go to Romain and comfort him or try to calm him down.

8 RCY was unable to interview Romain's father or any witnesses present during the second Belize stay. RCY investigators do not have any other evidence to support this allegation.

9 Case workers are employed by Alberta CS as the equivalent of MCFD social workers responsible for identifying safety and risk factors and developing case plans and services for children and families to address and reduce those risks.

Alberta CS called police, who responded to the incident, removed Romain under the *Mental Health Act*[10] and assisted with his placement in a Secure Services facility.[11] A safety assessment completed for Romain the same day rated his suicidal ideation as *"extreme."* Romain's mother entered into a voluntary Custody Agreement with Guardian[12] with Alberta CS and Romain came into Alberta CS's care for the first time.

Secure Services Certificate

The Alberta *Child, Youth and Family Enhancement Act* allows the issue of a secure services certificate: if a child (a) other than a youth who is the subject of a custody agreement is in the custody of a director, (b) is the subject of a supervision order, temporary guardianship order or permanent guardianship agreement or order or (c) is the subject of a family enhancement agreement and a director has reasonable and probable grounds to believe that (d) the child is in a condition presenting an immediate danger to the child or others (e) it is necessary to confine the child in order to stabilize and access the child and (f) less intrusive measures are not adequate to sufficiently reduce the danger. The director may issue a secure services certificate in the prescribed form, and on issuing it the director may convey the child and may detain the child while the child is being conveyed, to a secure services facility and may confine the child in a secure services facility.

According to Alberta CS records, Romain's stay in secure care involved constant *"out of control behaviors"* including aggression, not listening, and suicidal ideation. During one incident after Romain rubbed blood from his scabs on the walls and bit his tongue so hard that he started to spit out blood, he told staff that *"physical pain is better than mental pain."* On Aug. 5, 2011, Romain was released from secure care to a residential treatment home, where he remained for four months and continued to display concerning self-harm and aggressive behaviours toward staff and peers.[13]

In October 2011, Romain's mother signed a second Custody Agreement with Guardian with Alberta CS. After an incident in November 2011, in which he smashed a window with a hockey stick,11-year-old Romain was placed in secure care for the third time. Following his time in secure care, Romain was placed into a group care home in December 2011. He remained there for the next month and, in order to maintain Romain's placement in care, his mother signed a third Custody Agreement with Guardian with Alberta CS.

In January 2012, Romain was placed for two weeks at a new group home. Thirteen days later, he was placed into secure care for a fourth time after an incident involving threats to staff and property destruction. While Romain was in secure care, a psychologist

10 The *Mental Health Act* of Alberta Form 10 allows the police to apprehend a person and convey them to a facility for medical examination if a person is likely to harm themselves or others due to mental disorder.

11 Secure Services facility is defined within the Alberta *Child, Youth and Family Enhancement Act* as a facility designated by the minister, by regulation, as a secure services facility.

12 Custody Agreement with Guardian is defined within the Alberta *Child, Youth and Family Enhancement Act* under s. 9 or 57.2(2) that a director may enter into an agreement in the prescribed form of not more than six months each with the guardian of a child under which custody of the child is given to the director, if in the opinion of the director, the child is in need of intervention, and the safety, security or development of the child cannot be adequately protected if the child remains with the child's guardian.

13 RCY was unable to accurately track the number or type of placements Romain had in Alberta as Alberta CS case records were not provided for this investigation. Where placement information is not included or vague, it is due to a lack of verifiable information.

assessed his behaviours, including threatening suicide, as *"highly attention seeking and out of control."* The psychologist recommended that Romain be discharged to a community setting and not remain in secure care.

On Feb. 21, 2012, Romain was discharged to a residential treatment home, where he remained for more than a year.[14] Alberta CS records show that he did well in this placement and that, at the same time, his mother was engaging with support services including counselling and a parenting program.

Staff at the treatment centre worked with Alberta CS and Romain's mother to create a safety plan to address his behavioural outbursts as well as his past traumas and attachment challenges. Treatment centre staff reassured Romain that he would remain at the centre and that secure care would not be considered for him. His mother began visiting weekly and started working with Romain and the treatment centre therapist supporting his return home.

Romain's behaviours stabilized in this structured, therapeutic environment – evidenced by the lack of case notes indicating any behavioural issues or incidents, hospital admissions or returns to secure care. This year appears to be one of the most stable periods of Romain's life.

The success of the placement led Alberta CS to return Romain to his mother's home for an extended visit starting in February 2013. The purpose of the visit was to determine whether he could permanently return to her care. This situation lasted for three months before breaking down. At this time, Romain's mother consented to a three-month Temporary Guardianship Order as a means of keeping Romain in care. It is unclear from the records RCY was able to review why he was not returned to the residential treatment home where he had appeared to be doing well.

In May 2013, 12-year-old Romain was placed into a new group home and, two weeks later, he was confined to secure care for the fifth time. While in secure care, Romain reportedly stabbed a staff member with a pencil and threatened further harm to the staff and himself. He was charged for this incident and was subsequently hospitalized for suicidality before being returned to secure care and then back to his group home.

On June 3, 2013, Romain was admitted to secure care for a sixth time. While there, he disclosed to staff the extensive history of his drug use, including his first use of marijuana at age 10, as well as his use of alcohol, LSD and oxycontin. On June 5, Romain caused property damage and threatened to kill himself. Police were called, and Romain was escorted to a time-out room at the facility where he attempted to strangle himself with his clothing. He was taken to the hospital for an assessment and later returned to secure services by police. There, Romain reportedly displayed continuously violent behaviours to staff members.

14 This treatment home was a rural Alberta therapeutic, trauma-informed, campus-based residential youth program providing on-site education, recreation, mental health and therapeutic supports, and in-home supports to facilitate ongoing family contact.

By mid-July, Romain was placed in a residential treatment home co-located with the secure care facility in which he frequently had been confined. On Aug. 2, 13-year-old Romain was given intoxicants and sexually assaulted by another male youth from the placement while they were away from the home.

Placement staff reported this incident to both Alberta CS After Hours and the police. Romain received medical care and support for the police investigation. The offending youth was charged and, later in 2014, convicted for the assault. One month after being sexually assaulted, Romain was physically assaulted by another youth in retaliation for reporting the sexual assault and Romain was hospitalized with injuries.

In August 2013, a psychological assessment was completed for Romain which referenced the violence he had experienced as well as his previous diagnoses. It noted that Romain *"was allegedly using cough and cold medication to get high."* Psychological testing suggested Romain was at high risk for suicide, with signs of depression, anti-social behaviour, and uncontrolled anger. The assessment also noted a need for a referral to deal with Romain's drug and alcohol abuse.

With regard to placement, the assessment determined that Romain *"required a placement that is highly structured with consistent expectations and supervision . . . the placement [should] be a home-like environment with a long-term commitment to [Romain] so that he [knows] that his negative behaviours [will] not result in a change of placement."* The assessment concluded that Romain should continue to regularly see a psychiatrist. It is unclear how Alberta CS used these assessments to inform care planning.

Romain remained in his residential treatment home placement until October 2013 when Alberta CS, which still maintained temporary guardianship, made the decision to send him to live with his older sister in B.C. It is unclear to RCY investigators why or how this decision was made. Based on a review of records, investigators determined that Romain was moved at least eight times between parents and countries prior to the age of 10, and he was moved approximately 12 times during the two years he spent in the Alberta care system between the ages of 11 and 13. This included placements in group care, secure care, residential treatment and in the care of family members.

October 2013 to February 2014 – Romain's First Residence in B.C.

On Oct. 3, 2013, Alberta CS escorted 13-year-old Romain to B.C., where he was placed with his eldest maternal sister. The placement was organized directly between Alberta CS and Romain's sister, who was 26 at the time. No formal supports were arranged by Alberta for the sister prior to the move. Alberta CS informed RCY investigators that it consulted with MCFD child services about the plan for an extended family visit and requested courtesy supervision. However, MCFD records and RCY interviews with MCFD staff indicate that there was no prior notification or planning by Alberta CS with MCFD.

A week later, Romain and his sister met with the MCFD youth probation officer (YPO)[15] who was assigned by Alberta Community Corrections to supervise his reporting conditions. This request was faxed from the Alberta corrections directly to the YPO, which was common practice at the time. During this meeting, Romain acknowledged using substances since the age of 10. As a result of this meeting, the YPO referred Romain to the Reconnect Program.[16]

Immediately after the move to B.C., Romain began attending school, where he was observed by staff as being a target of bullying as well as exhibiting symptoms of possible post traumatic stress disorder (PTSD).[17] They were worried about the lack of supports for Romain and his sister and his history of trauma. In response to these concerns, school staff held an Integrated Case Management Meeting (ICM)[18] and referred Romain for an assessment by MCFD's Child and Youth Mental Health (CYMH).[19]

By early November, Romain's sister told his YPO she was having challenges managing his behaviour at home. Shortly after this, Romain's YPO made a referral to Youth Forensic and Psychiatric Services (YFPS)[20] for a post-disposition assessment[21] of Romain's mental health and treatment needs.

Near the end of November, two months after Romain's arrival in B.C., Alberta CS officially requested courtesy supervision from MCFD child services, including a home

15 Youth Probation Officers (YPOs) are employed by MCFD and are responsible for supervising young people in conflict with the law. YPOs provide information to the court to inform decision-making that balance the best interests of the young person and protection of society; and protect society by providing young offenders with the appropriate supervision and support in the community. YPOs work collaboratively with parents, caregivers and other professionals (e.g., social workers, teachers) to address the needs of the young person and reduce the risk of re-offending.

16 The Reconnect Program is offered through Pacific Community Resources Society, providing a service that assists street-involved youth and youth who are at risk of being on the streets by offering information, referrals to longer-term resources and supporting youth in making positive and healthy choices.

17 The criteria for diagnosing post-traumatic stress disorder (PTSD) in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes exposure to one or more event(s) that involved death or threatened death, actual or threatened serious injury or threatened sexual violation, either experienced directly or vicariously which may involve intense, disturbing thoughts and feelings related to the experience that last long after the traumatic event has ended.

18 Integrated Case Management is more than collaboration (which involves a group of service providers maintaining contact and sharing information while providing separate services). ICM refers to a team approach taken to coordinate various services for a specific child with the goal being to develop a plan for day-to-day management of the child and to prevent a situation from reaching a crisis point.

19 Child and Youth Mental Health (CYMH) offers a range of free and voluntary, community-based mental health services and supports for children from birth to 18 years of age and their families. These services include assessments, therapy and treatment, education and referrals to specialized programs and resources. CYMH is part of MCFD.

20 Youth Forensic Psychiatric Services (YFPS) is a specialized B.C. service that brings unique expertise to the comprehensive mental health assessment and treatment of young persons involved in the criminal justice system.

21 Post-disposition assessments are referrals made to YFPS after sentencing by probation officers and/or custody services to either assist in case management or help determine treatment goals.

Courtesy Supervision

Courtesy supervision is not a term used in the *CFCS Act*. As its name implies, it appears to be a practice born from a sense of responsibility and reciprocity regarding children in the care of another jurisdiction. If a child in care of one jurisdiction moves to a second jurisdiction, courtesy supervision ensures that child has a social worker in the receiving jurisdiction assigned to supervise the placement and report back to the originating jurisdiction.

visit and *"supervision of [the sister] and her home."*[22] MCFD child services responded to Alberta CS asking for further planning information. An MCFD social worker was assigned and met with Romain and his sister.

In early December 2013, Romain moved with his sister to a new residence. During this period, he continued to meet with his YPO. Meanwhile, CYMH closed Romain's file on Dec. 2, in advance of providing any services, after it was identified that he had a pending referral to YFPS. Senior YFPS staff confirmed to RCY investigators that it is common practice to not have both agencies involved providing services simultaneously. Through December, the Reconnect worker assigned to Romain continued meeting weekly with him and liaised with Safe Schools[23] outreach counseling for Romain.

Alberta CS arranged for Romain and his sister to spend Christmas 2013 with family in Alberta. Alberta CS met with Romain, his sister and his mother at that time. Romain stated during the meeting that he felt safe in his sister's care. His sister said that Romain's non-compliance at home was stressful, but she didn't communicate any other concerns.

In early January 2014, MCFD's YFPS reported its concerns to the YPO that Romain's behaviours were likely beyond the capacity of his sister to manage. On Jan. 10, 2014, Romain's MCFD child services courtesy supervision file was transferred to a new office and social worker because Romain and his sister moved to a new residence. The MCFD child services file at this time notes that Romain's sister began to have *"systems problems obtaining basic medical and dental services"* for Romain and requested MCFD to assist. But in recognizing the conflict between Romain and his sister, the social worker's team leader told her, *"Don't assume jurisdiction of [the] file. If [the placement] breaks down – repat him to Alberta."*

On Jan. 17, 2014, an interprovincial teleconference was held between MCFD and Alberta CS. A regional consultant was present for the teleconference, providing support to the MCFD child services team. It was determined during this teleconference that an Interprovincial Agreement[24] would not be sought until after the completion of Romain's YFPS assessment in order to gain additional information about his psychological and

22 Courtesy supervision is the term for ensuring that a social worker in the receiving jurisdiction is assigned to a child while the child is placed out of their regular provincial service area, province or territory, or country. Courtesy supervision workers ensure that children have someone to oversee their care.

23 Safe Schools delivers resources and programming that offer education, prevention, and intervention services for students, staff and families related to school and student safety, well-being and success.

24 An Interprovincial Agreement, also known as an Interprovincial Placement Agreement, is the template agreement used by provinces and territories for determining care of a child from another province or territory.

Regional practice consultants and analysts

The MCFD Service Delivery Areas and Delegated Aboriginal Agencies in B.C. use a mixture of practice consultants and practice analysts to provide consultation to front-line child service teams in complex case situations. Among their varied duties, these consultants and analysts also may be asked to assist in interprovincial planning and negotiations. For ease of reading, both are referred to in this report as regional practice consultants.

behavioural presentation, and the level of his care requirements. There was agreement that, if the placement with the sister broke down, B.C. would repatriate Romain to Alberta.[25]

Five days later, in response to an incident with a student at school for which he was suspended, Romain was put on a peace bond.[26] YFPS was aware that Romain's behaviours were escalating both at home and at school and his sister had advised YFPS and the YPO that she could not continue to care for Romain with the level of support she was receiving. YFPS documented speaking to her about *"safety planning, advocating for herself, and documenting her communication with the ministry."* Romain reported that he was now using drugs daily, including marijuana, ecstasy, methamphetamine, cocaine, mushrooms and LSD. YFPS records summarized that Romain was using drugs *"because it made him not think about things that were bothering him."*

On Feb. 5, Romain's sister contacted MCFD in crisis, telling the social worker and subsequently MCFD After Hours[27] about her brother's escalating behaviour, including self-harming and threatening and physically attacking her. In response, RCMP attended the home, found Romain *"smashing his head against the cement"* and transported him to hospital. Romain was assessed as not meeting the criteria for an involuntary admission under the *Mental Health Act*,[28] and he was discharged back to his sister's care. Romain's mother happened to be visiting and was present at the home during this incident.

Later that evening, Romain was again transported to hospital by police under the *Mental Health Act*, this time in response to him using a kitchen knife to threaten harm to himself, other family members and police. Romain was admitted and held at the hospital on this second admission. His sister again advised MCFD that she was no longer able to care for Romain without support.

On Feb. 6, without discussing Alberta's plans with MCFD child services or youth justice services, Romain's Alberta CS case worker attended the hospital with the intention of repatriating Romain to Alberta. Upon arrival in B.C., the Alberta CS case worker contacted the RCMP, requesting that police escort Romain back to Alberta in handcuffs.

25 Repatriate in this case means to return the child or youth to his home jurisdiction.

26 A peace bond (or recognizance) is an order from a criminal court that requires a person to keep the peace and be on good behaviour and to comply with other specified conditions for a period of time up to one year. The person who signs a peace bond must not be charged with any additional criminal offences during its duration.

27 MCFD After Hours includes trained social workers who provide emergency support to children, youth and families in instances outside normal office hours (8:30 a.m. to 4:30 p.m., Monday to Friday).

28 The *Mental Health Act* is a B.C. law that applies to individuals with a mental disorder in some particular situations. The Act describes how a person with a mental disorder can be apprehended, detained and/or given treatment in a hospital or in the community under specified conditions.

The RCMP denied this request and the hospital refused to discharge Romain at that time, telling the Alberta case worker that Romain would not be discharged for the purposes of travel as *"he could bring the plane down."* The Alberta CS case worker left the hospital and returned to Alberta without Romain.

Later the same day, the hospital contacted MCFD, advising that Romain was ready to be discharged. In need of an emergency placement and further assessment for Romain, MCFD child services consulted with MCFD's Maples Adolescent Treatment Centre[29] as a potential resource but was denied. Maples replied that Romain needed a *"stable placement, support for his trauma and mental wellness, and a concrete community plan"* in order to be placed. MCFD child services advised the hospital that there were no available resources for Romain and the impasse was resolved with an eventual agreement that the hospital would hold Romain overnight under the *Mental Health Act*.

On Feb. 7, MCFD child services advised Alberta CS about the hospital's discharge plan and informed Alberta that there were *"no resources to accommodate"* Romain in B.C. and that, as such, MCFD intended to immediately repatriate Romain to Alberta.

MCFD child services organized two contracted child care workers to accompany Romain by commercial passenger plane back to Alberta.[30] The two workers arrived at the hospital and met Romain as well as his mother and sister. Romain cried and apologized, saying goodbye to his family members. He told the care workers that he did not want to return to Alberta. Family members told RCY investigators that this move was against Romain's wishes and their own.

After boarding, but prior to takeoff, Romain became agitated and insisted on speaking with his Alberta CS case worker. Romain exited the plane with one of the child care workers to contact the Alberta case worker. Romain told the case worker over the phone that he was concerned about returning to the same Alberta care placement where he had been when he was sexually assaulted. Romain was assured by the Alberta case worker that he would not be sent there. Romain re-boarded the plane and was observed by the child care workers quietly crying and saying that he could not trust his case worker.

On arrival in Alberta, Romain and the B.C. child and youth care workers were met by a different Alberta CS case worker and a police officer, at which time Romain was apprehended, handcuffed, and brought to a secure care facility. Despite the promises from the Alberta case worker, this secure care facility was co-located with the placement where he had been sexually assaulted. The youth who assaulted him no longer lived there.

29 Maples Adolescent Treatment Centre offers specialized programs and services to young people with significant mental health or behavioural concerns. The Maples is a designated tertiary Mental Health facility under the *Mental Health Act*. It is not a placement resource or an acute care facility.

30 Child and youth care workers directly care for children in a variety of group settings, including early childhood day care, child development programs, day treatment programs, community youth and recreation programs, group homes, residential treatment centres, schools, hospitals and institutions.

On the same day he was taken back to Alberta, YFPS forwarded its completed assessment for Romain to MCFD child services. It stated, in part:

> *"[Romain] has incredibly low sense of self-worth . . . [he] is a sad, introverted youth who has difficulty relating one-to-one with others. [Romain] feels as though he has been cheated and mistreated by others; however, is highly dependent on others . . . He shared an idealized and protective view of his mother. He blamed himself entirely for being removed from her home as he felt he was too much to manage."*

YFPS concluded that, without efforts to manage Romain's risk – including a stable placement and a high level of support – his risk of future violent behaviour was *"very high,"* and that he was also at risk of seriously harming himself, whether intentionally or not. YFPS reported that Romain's mental health presentation was in keeping with *"conduct disorder,*[31] *adjustment disorder,*[32] *substance use disorder*[33] *and ADHD, the onset of which appeared to coincide with his early childhood experiences and be further exacerbated by his trauma, placement disruption, and abuse."*

YFPS also found that, *"Romain responded to his frustration and perceived abandonment … with rage and aggression in the home, school, and community . . . In terms of mental health interventions, this youth needs to be sufficiently stabilized before addressing other mental health concerns. It is most important for Romain to stabilize and abstain from drugs long enough to see a baseline of his mental health functioning. Romain does pose a significant risk to himself, peers, and those who are most responsible for re-directing his behaviour and whom may trigger attachment/trauma issues."*

YFPS summarized the challenges of interprovincial planning: "*The task of managing [Romain] in B.C. can be so overwhelming … when this youth's Ministry guardian and origin of probation is in another province. If the current placement breaks down, service providers can expect this youth to be highly distraught … aggressive … suicidal."* This report was forwarded to Alberta CS and there is little indication that it informed later planning when Romain returned to B.C. the next year.

Alberta – February 2014 to May 2015

Romain remained in secure care in Alberta for a month, after which he was transferred to a non-secure resource within the same facility. In April 2014, Alberta CS placed him with his other maternal sister in Alberta. During this time, Alberta CS held planning meetings to try to determine appropriate resources for Romain.

31 Conduct disorder refers to any of a group of serious emotional and behavioural problems in children and adolescents involving frequently behaving in extremely troubling, socially unacceptable, and often illegal ways, though they feel justified in their actions and show little to no empathy for their victims.

32 Adjustment disorder, sometimes referred to as situational depression, is an abnormal and excessive reaction to an identifiable life stressor. The reaction is more severe than would normally be expected and can result in significant impairment in social, occupational, or academic functioning.

33 Substance use disorder describes a problematic pattern of using alcohol or another substance that results in impairment in daily life or noticeable distress. Despite any consequences a person who has a problem with either alcohol or drugs suffers, they will generally continue to use their drug of choice.

On May 26, Romain's mother consented to Alberta CS's application for a Permanent Guardianship Order for Romain.[34]

This placement with his sister lasted three months until July, when 14-year-old Romain messaged her about his intention to jump off an area bridge. This disclosure resulted in Romain being re-admitted into secure care, his eighth admission. From that point until August 2014, Romain experienced multiple placements including custody, group homes, and an involuntary hospital admission. In describing Romain at this time, family members observed to RCY investigators that it was like he *"didn't know how to socialize"* anymore and that this appeared to lead to conflicts with peers, family and service providers.

Romain appealed his involuntary hospital admission and was released into another group home on Sept. 16, 2014. Later that month, he was transferred from the group home to a specialized placement, a rural youth assessment centre. He was subsequently sent back into youth custody for failing to comply with his conditions.

RCY investigators have limited documentation from Alberta for this time period. It appears that once he was released from custody in October 2014, Romain went to a group home, where he was promptly discharged to a location unknown to RCY. In November 2014, Romain was remanded back into youth custody for breaching his community reporting conditions. RCY investigators were unable to determine where Romain was placed or any other details about his well-being for the remainder of 2014 through to June 2015. Based on the documentation RCY did receive, from February 2014 to June 2015, Romain had a minimum of 15 placements in Alberta.

B.C. – August 2015 to June 2016, Romain's Second Residency in B.C.

In June 2015, Alberta CS contacted MCFD child services requesting a courtesy worker for a planned visit later that month by Romain to see his mother, who was visiting his older maternal sister. When MCFD requested more information, the new Alberta CS case worker stated that Alberta's intention was *"to rescind Romain's [Permanent Guardianship Order] PGO in the coming months . . . we need to ensure the coming visit goes well and mom is able to manage his behaviors."* The Alberta case worker added that Romain was stable, and his mother was *"very capable of managing him."* RCY investigators were unable to secure records from Alberta CS for this time period to determine what Romain's functioning or living situation was prior to the visit with his mother in B.C, or what assessments had been done regarding his mother's ability to meet Romain's needs. Romain did attend the planned June visit with his mother and sister and returned to Alberta without any reported issues.

In early August 2015, Alberta CS advised MCFD child services that it was sending Romain to live with his mother in B.C. Both were living in Alberta at the time and Alberta CS

34 With a Permanent Guardianship Order, Alberta CS becomes the permanent guardian of the child with the parent losing all guardianship rights and decision-making. Orders are only granted if there is a serious problem that can't be fixed within a certain amount of time.

planned to pay for them to fly to B.C. and live there together. The MCFD social worker, team leader and regional consultant responded by email with their concerns about the lack of planning or an assessment of Romain's mother as a care provider. Although Romain was permanently removed from his mother's care and was a permanent ward of Alberta, Alberta CS advised MCFD that the placement of Romain with his mother would be more like a *"semi-independent living situation."* Romain had recently turned 15.

On Aug. 10, after Romain and his mother had arrived in B.C. and found housing, the Alberta case worker emailed a formal request to MCFD for courtesy supervision. As part of the courtesy supervision, Alberta CS requested that MCFD conduct home checks, monthly face-to-face meetings and provide support to the mother. MCFD immediately opened a family service file and assigned a social worker. Several days later, MCFD requested *"much more"* information than the child assessments originally provided by Alberta CS, including additional family background, child protection concerns related to Romain's mother and information about Romain's care history. Additional but incomplete case records were provided by Alberta CS to MCFD following this request.

The MCFD social worker met with the family and, on Aug. 20, made a referral to the Family Preservation Program for the purpose of beginning *"intensive service delivery,"* including parenting education and support, locating a school for Romain, counselling for him, and employment assistance for his mother.[35] Romain's mother met with the family preservation counselor weekly for three months, but Romain refused to participate in the program. Romain's mother told RCY investigators that she enjoyed this service.

On Aug. 26, Romain's MCFD YPO was re-assigned to him, to again monitor his probation and community service work from Alberta. The YPO referred Romain to Reconnect services, which primarily consisted of his attendance at a weekly group for male youth. The YPO also agreed to help Romain find a school.

Two days later, Alberta CS sent MCFD child services a draft Interprovincial Agreement for review. The MCFD regional consultant responded with a proposed planning teleconference and summarized some of the identified issues with Alberta's draft agreement:

> *"It is an unusual situation for a youth in permanent care to be living with their parent, so some brief information should be included in the Interprovincial Agreement about how Romain came to be living with his mother in another province . . . We also need to be clear about the guardianship responsibilities and any child protection responsibilities."*

The MCFD Regional Director of Operations[36] was copied on this email and kept advised of the ongoing negotiations between the MCFD regional consultant and social worker with their Alberta counterparts.

35 The Family Preservation Program is an intensive, short-term (90 days), in-home family preservation service offered as an alternative to removing children from their families. Counselling, parenting and life skills are taught based on the individual strengths and needs of each family.

36 MCFD Director of Operations (DOO) is responsible for managing the day-to-day delivery of a continuum of integrated services to children and families including child and family development, Child and Youth Mental Health, community justice, early childhood development, child protection and services to children in care for a specific region or Service Delivery Area.

On Sept. 15, Romain attended an introductory school meeting, with his mother and sister, school personnel and his YPO. During the meeting, it was decided that Romain should participate in a modified school curriculum due to the amount of school he had missed. Romain was subsequently offered a modified school program with additional supports.

Following six weeks of scheduling challenges, the intended interprovincial teleconference between Alberta CS and MCFD occurred on Oct. 16. Both MCFD and Alberta CS expressed concerns about the stability of Romain's placement with his mother and the need for regular communication between the provinces. The resulting draft Interprovincial Agreement stated that some guardianship responsibilities would be transferred,[37] and that the two provinces would *"jointly review the care plan for Romain at least twice a year."* It also included the stipulation that, *"If this placement breaks down, Romain will immediately be returned"* to Alberta. Although the agreement was unsigned by the parties in the days following the meeting, MCFD child services opened a file to serve Romain.

On Nov. 13, Romain's school contacted MCFD child services to organize an updated plan for him and suggested a referral to a therapeutic counsellor whom the school referred to as a goals coach. The MCFD social worker responded, *"It is great that Romain is getting a lot of support from the school"* but added that *"history indicates that Romain is very resistant to counselling."* MCFD did not approve this referral, stating that it was Alberta's responsibility to approve, and the school needed guardian approval to proceed. Documentation from this time indicates that Romain's mother expressed she was beginning to have difficulty coping with Romain.

Later that month, the school administrator emailed the MCFD social worker and YPO, relaying the school's concerns that Romain *"truly needs guidance and counselling regarding his emotions and family dynamics/history."* The goals coach was again identified by the school as *"a unique resource that has built up trust and credibility with hard to reach youth and will be a great fit"* yet the MCFD social worker did not act on the referral because she believed approval for it to be Alberta CS's responsibility and she had not heard back from them on it.

At this time, Romain's mother expressed her frustration to the MCFD social worker about her care responsibilities for Romain, and her concerns about miscommunication between the social workers from Alberta CS and MCFD. During this period, Romain was not receiving mental health services from YFPS and he had never been re-referred for services through CYMH.[38]

A planning meeting was held regarding Romain on Dec. 11, 2015 at the MCFD office. Romain did not attend this meeting, but his mother and the other B.C. care team members (social worker, school administrator, Safe Schools outreach counsellor and

37 Guardianship responsibility transfer includes transfer of the day-to-day decision-making responsibilities related to a child's care including school, counselling, and emergency medical care, but not major decision-making or costs.

38 RCY investigators believe Romain was not receiving YFPS services at this time because he did not have a B.C. court order requiring counselling.

YPO) all attended. Romain was described by the school as capable of completing his assignments but unmotivated because he wanted to be in a mainstream school. The fact that Romain had even a minimal amount of engagement at the alternative school was attributed to his involvement with the school wrap-around support program which included an outreach counselor who regularly visited Romain's home in an effort to engage him and transport him to school.[39] A bi-monthly planning meeting was proposed for moving forward, but there are no case records to indicate whether the meetings consistently occurred with all parties present.

In December 2015, the Alberta CS case worker advised the MCFD social worker that Romain and his father had reconnected. The school and YPO continued to advise the MCFD social worker of Romain's identified counselling needs, while the MCFD social worker referenced the Interprovincial Agreement and Alberta CS's responsibility for consenting to counselling for Romain. Eventually, a request for counselling for Romain was forwarded to and approved by the Alberta CS case worker, although by this time Romain refused to meet with the counsellor. The primary focus of case planning between MCFD and Alberta CS continued to be supporting Romain's mother in coping with and managing his behaviour.

At the end of January 2016, Romain's mother informed MCFD and Alberta CS that his father was now living in B.C. and that he and Romain had been having visits. She described Romain as very agitated and added that she was fearful of him. This fear made her question if living with her was the right placement for Romain.

In February 2016, the Reconnect worker closed the file because Romain refused to continue attending the male youth group. The Reconnect worker recalled that Romain had the occasional outburst, but that he was always respectful of the staff, adding, *"I would not consider myself feeling unsafe around him."* Romain was still attending Safe Schools and continued to engage with the Safe Schools counsellor.

On March 10, Romain's mother contacted the B.C. care team by email, stating, *"I am really at a point of desperation. I love my son, he thinks I don't, but I do. I give so much to him from my heart and soul. I have no more in me at this point . . . I am so tired of crying non stop all day and night."* The MCFD social worker immediately emailed Romain's mother, praising her work in the family support programs and saying that MCFD would continue to support Romain's mother in coping.

The following day, the MCFD social worker and YPO discussed Romain's mother's frustrations. They expressed in an email to the Alberta CS case worker that Romain and his mother *"both need a break from one another."* However, RCY investigators could find no record of respite or other intervention services being offered by MCFD to create that break.

39 Wrap-around is a philosophy of care with a defined planning process used to build constructive relationships and support networks among students and youth with emotional or behavioural disabilities (EBD) and their families. It is community-based, culturally relevant, individualized, strength-based and family-centered.

On April 18, Romain's mother emailed the MCFD social worker and YPO to advise that, during the previous weekend, Romain had self-harmed by cutting himself and had destroyed his room. The RCMP and a mental health crisis counsellor responded, and Romain was transported to hospital and certified under the *Mental Health Act*.

Ten days later, following Romain's discharge from hospital, the school organized a planning meeting. During this meeting, school staff voiced Romain's perception that people did not follow through for him even though he had acknowledged needing and wanting help. School staff advised the MCFD social worker and YPO that they believed Romain required an urgent intervention. Despite the cautions of the school staff, Romain and his mother were sent home together with instructions for her to contact emergency services including police if he escalated.

On May 2, Romain's mother told his YPO that it was not working out for him in B.C. and that he intended to return to Alberta. She also said that Romain had spoken to his Alberta CS case worker, who was willing to support his return. Alberta CS confirmed that it was having planning conversations with Romain and that it intended to place him in a youth shelter if he did return to Alberta. It is unclear if this was to be a temporary placement measure for Alberta CS or its long-term placement plan for Romain. RCY investigators could find no evidence that MCFD child services was informed of this plan.

Through the end of May 2016, Romain's mother communicated to the MCFD social worker and the YPO about her ongoing high stress level and Romain's need for addiction services. During this time, the MCFD social worker emailed the Alberta CS case worker about the *"volatility and potential for violence"* in the home and sought clarity about planning for Romain. There was no clear response beyond an email requesting case notes from MCFD.

On June 20, 2016, Romain's family members arranged for him to visit his father, who had returned to Alberta, and to determine whether Romain might be able to live with him. Two days later, an interprovincial teleconference was held to discuss Romain's case and it was determined by both parties that Romain's placement with his mother had ended. MCFD child services advised Alberta CS that the placement breakdown, combined with MCFD's lack of an alternative placement for Romain, signalled the end of the existing Interprovincial Agreement. The MCFD regional consultant also advised Alberta CS that, if Romain was to return to B.C. following the visit with his father, it would require *"a new developed plan with both provinces in agreement."*

July 2016 to May 2017 – Romain's Third Residency in B.C.

The Alberta CS case worker met with 16-year-old Romain and his father in June 2016. His father had organized transportation for Romain from B.C. and secured employment for his son. That job ended almost immediately, however, after Romain had a confrontation on a work site. According to an Alberta CS email to MCFD that month, Romain's substance use escalated, he got into a dispute with his father and he was hospitalized for self-harm.

Following this incident, Alberta CS withdrew its support of Romain living with his father. As a result, the Alberta CS case worker arranged for Romain to return to B.C. to stay with the younger of his two maternal sisters who was now almost 26-years-old. This sister, with whom he had temporarily lived in Alberta in 2014, was now residing in B.C. and had young children. Once again, this move occurred without Alberta CS consulting MCFD or following proper process regarding interprovincial movement of children. According to the family, they were not offered any support or planning by Alberta CS prior to the move.

On July 6, the MCFD social worker and regional consultant emailed the Alberta CS consultant and case worker to request more information about planning for this living arrangement. The Alberta CS case worker replied the following day, confirming that Romain had been sent to B.C. to stay with his sister and that it was *"just a visit."* According to Alberta CS, the plan had been to develop a new Interprovincial Agreement with MCFD child services if the visit was successful.

On July 12, Romain was taken into police custody for a robbery he committed while under the influence of substances in B.C. the previous week. Romain pled guilty to the robbery and, as a result of his sentencing, he remained in the youth custody centre from July 14 until Dec. 7, 2016.

The Provincial/Territorial Protocol on Children and Families Moving Between Provinces and Territories

This document, referred to in this text as the Interprovincial Protocol, outlines the roles and responsibilities of statutory child welfare organizations (including government ministries, agencies, boards and societies and may include First Nations, Inuit and Métis child welfare organizations) when working together to provide child welfare services to children and families moving between provinces and territories. Interprovincial Agreements arise from the Protocol.

In a July 19 email to Alberta CS, the MCFD regional consultant referenced the Interprovincial Protocol and questioned Alberta CS about again sending Romain to live with another relative in B.C. without prior notification or planning for services. The email noted that *"this young man . . . now has criminal charges and will likely be released . . . without any plan in place."*

While he was in youth custody, staff documented their ongoing concerns about Romain, including approximately two-dozen incidents with other youth and overall challenges with managing his behaviour and safety. In one instance, on Aug. 10, 2016, Romain was assaulted in an organized attack by two youth. Romain refused to attend hospital but agreed to receive medical attention at the custody centre. Once medically cleared, on Aug. 16 Romain was transferred to a different custody centre for his own safety. At the second custody centre, he continued to require a high level of attention from the staff, including ongoing YFPS counselling services.

Through August and September 2016, the Alberta CS regional consultant sent drafts of a new Interprovincial Agreement to MCFD and continued to recommend the sister Romain had been staying with in July as the preferred placement option. The MCFD child services team, including the social worker, team leader, regional consultant and Director of Operations, restated concerns related to placing Romain with his sister.

At this time, MCFD child service emails continued to identify Romain as a *"courtesy case from Alberta"* but the planning focus shifted from placement options with family members to finding Romain an appropriate MCFD resource in B.C. Romain himself agreed to the plan of a placement at an MCFD resource if it meant staying in B.C. and near his family members. Initially, Romain was referred for placement within the existing network of contracted resources used by MCFD; however, no suitable placement options were available. Case notes from his time in custody indicate Romain expressed that he was *"worried about where he [was] going to live after release."*

On Sept. 14, MCFD resources staff informed Alberta CS that a *"specialized contract placement"* would cost Alberta between $14,000 and $18,000 monthly. According to Alberta CS, one of its managers completed a contract pre-approval form and forwarded it to MCFD five days later as evidence of its commitment to this plan. RCY investigators were unable to locate this form in MCFD records and it was not mentioned in interviews with MCFD staff.

On Oct. 18, the MCFD resources team leader informed his Director of Operations that Alberta CS had agreed to a monthly financial commitment for developing a specialized resource through *"an approval in principle."* According to MCFD emails, this approval was for $15,000 to $20,000 a month. As part of the discussion, Alberta CS requested *"a budgetary breakdown from the proposed contractor"* prior to approval. Despite this email, there was no further movement toward the development of a specialized resource for Romain by MCFD or any further communication with Alberta CS about the specialized resource funding cost or approval process.

On Nov. 22, four months after Romain had returned to B.C., a new Interprovincial Agreement was signed. The agreement identified the specific guardianship responsibilities to be transferred to MCFD from Alberta CS and specified that Alberta CS and MCFD would jointly review Romain's care plan every six months. The agreement called for MCFD to meet with Romain monthly and *"provide him with opportunity and support to address his trauma and feelings of abandonment and neglect."* It also stipulated that MCFD would report any significant events, occurrences or hospitalizations to Alberta CS.

While the Interprovincial Agreement was being signed, numerous discussions were taking place to clarify resourcing for Romain once he was released from custody in December 2016. On Nov. 22, an MCFD Director of Operations emailed the MCFD resource team leader, writing, *"Given all the time we have had to plan I'm really hoping that Romain will not be going into an emergency placement."* The resource team leader responded that MCFD was still waiting for budget approval from Alberta CS. It is unclear to RCY investigators what further information MCFD was seeking, as it already had email confirmation of the amount Alberta CS was willing to pay for Romain's resource.

MCFD youth justice notes from this time documented MCFD child service's struggle to locate a placement for Romain and resulting concerns regarding discharge planning for him from custody. YFPS noted the need to advise Romain's future resource of an upcoming scheduled community psychiatric appointment. However, as no resource had been established, it does not appear that this notification occurred.

On Dec. 7, 16-year-old Romain was released from custody to an emergency staffed residential resource (emergency bed home).[40] Romain did not learn of his placement until the day of his release. Youth custody staff noted that, in the days leading up to his release, Romain's uncertainty about his pending placement had made him anxious and negatively impacted his behaviour. During this time, both the MCFD YPO and youth custody staff were in contact with the MCFD social worker and resources team to determine the placement plan for Romain in advance of his release. There appeared to be general confusion amongst MCFD staff about whether Alberta was funding a specialized resource, as well as the status of MCFD's progress in creating the resource.

Romain left his resource almost immediately upon arrival, resulting in his arrest as he had court ordered conditions to be at his resource by curfew time. Romain was returned to youth custody on Dec. 14 and remained there until February 2017.

On Jan. 6, 2017, YFPS identified the need to engage Romain prior to his re-release from custody, noting concerns around his *"last unsuccessful transition"* to community the previous month. YFPS staff further noted that Romain was a *"risky young man who can fall through the cracks"* and that *"there is currently no discharge plan . . . as he is from Alberta he would likely end up in an emergency bed."*

On Jan. 9, Romain began weekly meetings with an Intensive Support and Supervision Program (ISSP) worker.[41] This worker initially met Romain in the custody centre and continued supporting him upon his release in February 2017.

Throughout January, emails between the YPO, Romain's legal counsel, the MCFD resources and guardianship social workers and the Alberta CS case workers show continued confusion around the placement and resourcing plan for Romain following his pending release from custody. The MCFD resource worker advised the rest of the B.C. team that *"there is an expectation that a resource be developed for Romain specifically for him that will [be] paid by Alberta,"* but added that the MCFD contract resources team was still waiting on responses from potential contractors.

On Feb. 17, Romain was released from custody and placed in a two-bedroom emergency bed home. Upon reviewing Romain's intake information, staff immediately contacted MCFD with safety and planning concerns. This included a very specific concern – Romain had been a victim of a previous sexual assault and the other male youth already placed in this home had a documented history of sexual intrusion with male co-residents. RCY investigators could find no documented efforts by MCFD to respond to this concern.

In the early-morning hours of March 2, 2017, Romain and the other youth residing with him returned to the emergency bed home together and appeared to the staff member on duty to be under the influence of substances. In two separate overnight incidents, the

40 Emergency bed homes are short-term placement beds for housing youth involved with the child welfare system.

41 ISSP workers are responsible for providing additional outreach-based support and monitoring to youth with identified needs who are court ordered to receive such services.

lone staff member on duty located the other youth in Romain's room and directed him to leave.

The staff member remained concerned with Romain's extreme level of intoxication and contacted the HealthLink BC helpline to discuss symptoms.[42] While on the telephone, the staff member heard sounds *"like someone jumping on the bed."* The staff member entered Romain's room and observed Romain apparently sleeping, face down on the bed, with the other youth on top of him.

Following the instructions from HealthLink BC, the staff member decided to keep Romain on the living room couch overnight to monitor his safety and breathing. The next morning, after a relief staff member arrived and was debriefed, the incident was subsequently reported to the agency manager and to MCFD. A critical incident report detailing the assault was forwarded by staff to the MCFD social worker and resource worker. Despite having received the critical incident report from the emergency bed home, Romain's social worker did not complete a critical injury report to MCFD Provincial Office or the Representative's Office.

Romain woke up several hours later and was observed by staff to be struggling with slurred speech and still unsteady on his feet. Emergency bed home staff called an ambulance, which responded with the RCMP at approximately 9:30 a.m. Romain acknowledged taking Xanax pills and consuming marijuana and alcohol. He voluntarily attended the hospital with the paramedics.

At the hospital, Romain became highly agitated. Medical staff surmised that this was possibly due to a previous *"traumatic hospital experience,"* referring to his 2014 removal from B.C. RCY investigators found no evidence that police or hospital staff were made aware at the time of the hospital admission that Romain may have been sexually assaulted. Romain was discharged from the hospital the following day.

The same day that Romain was taken to hospital, the emergency bed home manager and the MCFD social worker sent emails to emergency bed home staff identifying the need to immediately report to police and MCFD After Hours whenever a critical incident is suspected. MCFD then contacted the RCMP regarding the alleged sexual assault and the other youth was moved to a different home. An MCFD After Hours social worker attended Romain's emergency bed home, explaining to him that *"another youth may have sexually assaulted him … while he was passed out on drugs."* RCY investigators could find no documentation regarding a victim services referral or any other supports or counselling offered to Romain in relation to this incident.

The next day, on March 3, RCMP arrived at the emergency bed home to transport Romain to the RCMP detachment so he could make a victim statement and submit a DNA sample in relation to the suspected sexual assault. Romain informed the RCMP that he had no memory of the alleged sexual assault and did not want the police to investigate.

42 HealthLink BC (8-1-1) is a 24/7 free-of-charge provincial health information and advice phone line available in B.C. The 8-1-1 phone line is part of the Ministry of Health.

In the days following the alleged assault and hospitalization, Romain caused approximately $1,000 in property damage to the emergency bed home, which was an ongoing issue with him at the home. The damage was repaired by a contractor but payment for this work was a topic of a dozen emails over the next two months, both between MCFD and the emergency bed home and, subsequently, between MCFD child services and Alberta CS. At issue was which province was responsible for paying for the damage. Eventually Alberta paid.

On March 24, the MCFD resource worker for the emergency bed home emailed the other members of Romain's MCFD care team informing them of the home's increasing concerns about Romain's use of *"whatever substances he [could] get his hands on,"* as well as *"the increase in aggression and damage to the resource,"* and the need to connect Romain with detox services. Despite ongoing involvement by the care team, RCY investigators could find no documented efforts to engage Romain in counselling or in any substance misuse programs.

On March 27, emergency bed home staff again communicated their escalating concerns about Romain to the MCFD YPO and child services social worker, stating by email, *"Before something happens staff are feeling that there needs to be some support and intervention of some kind – is there anything in [Romain's court] condition to support this, or any kind of detox/treatment or anything that might be an option for him?"*

On this same date, Romain's YPO emailed Alberta CS and copied the MCFD social worker, requesting an update on housing for Romain. She noted that the issue of where he would be housed had been ongoing from August 2016 until almost April 2017. Alberta CS expressed its understanding that a *"specialized placement"* had been previously approved. The YPO next questioned the MCFD child services team, including the social worker and resources social worker, about which resource team was responsible for developing this specialized placement. This question was never answered and, instead, there was agreement from all parties on the need for an interprovincial planning meeting. It was proposed for early April 2017.

On March 31, the final school-based meeting regarding Romain occurred, including his ISSP worker, social worker and YPO. Planning focussed on re-engaging Romain with school and with his other established supports – the ISSP worker and the school counsellor.

In early April, emergency bed home staff again informed the MCFD social worker and resource worker of their *"serious concerns about this youth and his drug use."* These concerns were echoed by family members, who felt he was *"spiralling"* but did not know how to help him. On April 7, Romain was moved to another two-bed emergency resource managed by the same placement operator. The resource staff he had connected with moved with him.

Romain returned to his emergency bed home after curfew in the early morning hours of April 8 and appeared impaired by substances. Concerned for his well-being, the emergency bed home staff called paramedics. Paramedics attended with the RCMP and transported Romain to the hospital. He was released on April 9 and transported by

RCMP back to the emergency bed home. However, since Romain was upset with staff at the home, the RCMP decided instead to transport Romain to his mother's home for a cooling-off period. It is unclear to RCY investigators whether MCFD was included in this decision-making process.

At his mother's home, Romain was intoxicated and cutting himself on his arms, back and legs. His mother called the police and his emergency bed home. Romain was highly upset and self-harming, so the police apprehended him under the *Mental Health Act* and took him to the hospital. Emergency bed home staff reported the incident to MCFD. It is unclear to RCY investigators how Romain returned to the home and what, if any, community supports were considered after this incident. In his hospital assessment prior to his release, he told the doctor, *"I don't like the living, I don't like all the pain, but I don't want to die."* The hospital reports indicate Romain had elevated chronic risks for self-harm due to his substance use, poor social supports, and lack of services. The hospital provided Romain with a list of resources should he choose to access help.

RCY investigators could find no documented response by MCFD child services, youth justice services, or Alberta CS to this incident, nor could they verify whether Alberta CS was even informed about it.

At this point, Romain had been placed at the emergency resource for nearly two months without any progress made toward developing a specialized resource. The ongoing planning impasse was summarized in an April 11 email by an MCFD resource social worker, who advised the YPO, *"I have not heard anything, so we are unable to move forward until we have confirmation from Alberta that they will pay for a resource."*

On April 15, Romain was arrested on a warrant, held in custody, then released on April 19 with a condition of five days of house-arrest. Emergency bed home staff advised MCFD of their safety concerns related to monitoring Romain on 24-hour house arrest while he was withdrawing from substances. RCY investigators could find no documented response by MCFD child services or resources to those concerns.

On April 27, emergency bed home staff advised MCFD of Romain's suicidality and ongoing drug abuse, including Romain telling staff, *"It would be easier to be dead because then [I] would not have to think about things."* When emergency bed home staff questioned Romain about MCFD interventions with him, he responded that he had been directed to attend drug and alcohol counselling by his YPO but had not done so.

An interprovincial teleconference occurred on May 4 – the first interprovincial planning meeting regarding Romain in five months. A summary of that conference shows acknowledgement that Romain was not doing well in his placement and required a single-youth, staffed resource that could provide a *"low-barrier"* approach and include an outreach function to Romain in the community. MCFD identified the amount of funding required from Alberta in order to develop this type of specialized resource as between $17,000 and $23,000 a month. How this funding was to be received by MCFD was unclear.

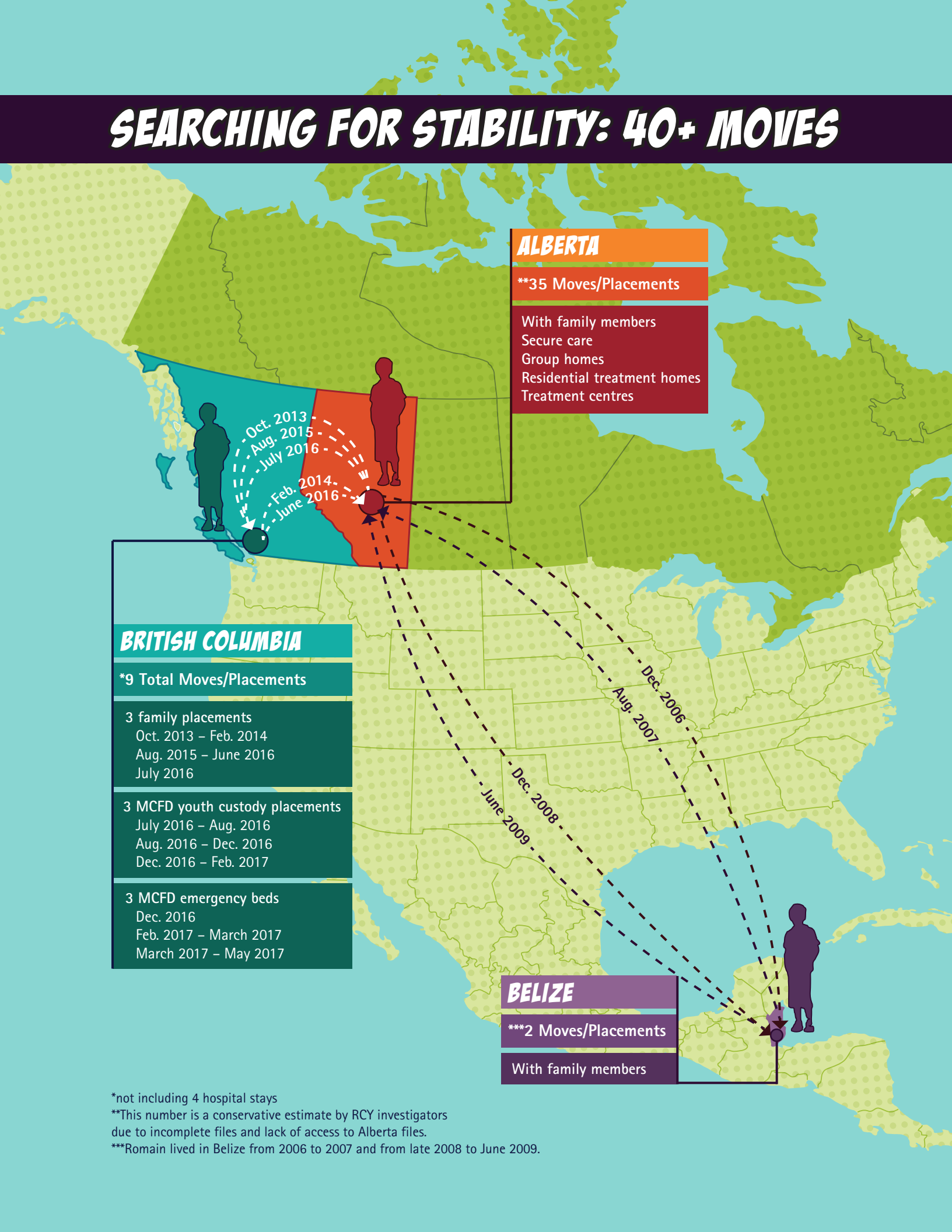
On May 9, Romain left his resource. While away, he experienced an accidental overdose of fentanyl. When his overdose was discovered, those he was with called his family and then 9-1-1. He was transported to hospital, but he never regained consciousness. On May 11, 2017, with the consent of his family and his Alberta CS worker, medical staff discontinued life support. Family members – as well as many of the professionals involved with Romain – helped organize and attended separate memorial services held in B.C. and Alberta following his death.

MCFD completed a file review of Romain's case and determined that:

- MCFD did not meet its responsibilities outlined in the Interprovincial Protocol.
- While Romain was in custody a *"specialised placement could have been pursued; this did not occur despite funding."*
- Romain's MCFD social worker and the regional consultant advocated for Romain to not be put in an emergency resource, *"yet that was the only option provided by the B.C. resource team."*
- Romain experienced multiple serious incidents that were not reported to Alberta CS.
- Romain did not meet monthly with his MCFD social worker.
- There is no record of Romain's MCFD social worker offering services, safety planning, or support concerning the ongoing critical incidents Romain was experiencing.

MCFD actions in response to this internal review included the creation of a Placement Review Committee in January 2018, the assignment of a permanent supervisor for the youth child services team assigned to this case, and a leadership forum focused on resources for high-risk youth, which occurred in April 2018.

SEARCHING FOR STABILITY: 40+ MOVES



*not including 4 hospital stays
**This number is a conservative estimate by RCY investigators due to incomplete files and lack of access to Alberta files.
***Romain lived in Belize from 2006 to 2007 and from late 2008 to June 2009.

Analysis

Overall Finding: *There is a link between the reviewable services provided to Romain in British Columbia and his death by overdose in May 2017. Contributing factors to Romain receiving services that were inadequate to meet his needs included limitations in the current Interprovincial Protocol process, a lack of provincial coordination and oversight of these cases in B.C., a lack of training and policy to guide MCFD employees in navigating interprovincial cases, and the B.C. system's inability to resource and wrap responsive supports around children and youth who have experienced trauma.*

Romain's story illustrates challenges that many children face moving between provinces and territories when child-serving agencies are involved in their lives. This investigation pointed to a child falling through the cracks and his best interests getting lost in confusion, miscommunication and discord between provincial child welfare authorities. MCFD does not track these cases and was unable to provide RCY with an exact number of children from B.C. who are on Interprovincial Agreements in other provinces, or how many children from other provinces are on Interprovincial Agreements in B.C., although MCFD loosely estimated that total number at around 200.

The following findings discuss four areas in which systemic barriers arising from MCFD's approach to the interprovincial process resulted in Romain not receiving the care he deserved and required while he lived in B.C.:

- Challenges and limitations with the current Interprovincial Protocol
- A lack of provincial coordination, tracking, and oversight of these cases
- A lack of training and policy to help MCFD employees navigate these complex cases
- B.C.'s continued inability to adequately resource and provide responsive, trauma-informed, identity affirming services to children with complex needs and life experiences.

Representative's Comments on the Findings

It is beyond RCY's scope to establish findings about Alberta CS, but RCY would like to frame this analysis with a recognition that MCFD did not receive adequate notification and information from Alberta each time Romain was placed in B.C. On each occasion, MCFD continued to negotiate and plan after Romain had already arrived in this province despite the impacts the lack of notice and information had on its ability to adequately address Romain's needs. The findings of this report are not intended to discredit the work that individual front-line staff and their supervisors within MCFD did to try to support Romain with the limited resources and knowledge they had.

The Representative would also like to highlight areas of quality services received by Romain and his family, including through the education system and the youth justice system. Romain's YPO remained engaged with Romain throughout his three placements in B.C. The YPO described Romain as one of her highest priority cases regardless of his interprovincial status, meeting with him regularly at the office and in the community and showing through her reports that she understood and was trying to respond to Romain's history and needs. Romain's February 2014 YFPS assessment was also exemplary in considering all facets of Romain's experiences including family history, Alberta care history, MCFD involvement, education, leisure, current functioning, psychological test results, mental health and behavioural functioning, risk assessment, with care and intervention recommendations.

The Interprovincial Protocol and Agreements

Finding: *A lack of clarity in the current Interprovincial Protocol (2016) and the resulting Interprovincial Agreements led to confusion in the planning and delivery of services for Romain in B.C.*

Bright Spot

MCFD formed a Youth Outreach and Empowerment Team (YOET) in May 2017.[43] The YOET team is a multidisciplinary team comprised of social workers, CYMH clinicians, and youth advisors (former youth in care) formed to provide services to Indigenous and non-Indigenous youth in care or on a youth agreement between the ages of 13 and 18 years. The team has developed partnerships with the RCMP, as well as health and other community services providers; and is able to deliver one to one support including outreach to vulnerable youth. The team began working with youth in May 2017, and sadly Romain was identified as a potential referral to this team prior to his overdose death.

There are many reasons why children in one province might be moved to another province, including family relocation for work, affordability, cultural reconnection, climate or to be closer to extended family members. Children involved with child welfare services may also be relocated as part of a long-term foster placement, as part of an organized visit, or to a placement with extended family members living in another province.

Interprovincial placement moves by child-serving agencies such as MCFD require careful planning, including the allocation of financial resources necessary to support a child in another province. These considerations are born from the acknowledgement that relocating an already at-risk child to a new province where there is no established formal support network – or possibly not even informal supports – increases the vulnerability of that child.

While it's not uncommon for provincial child welfare authorities to work together to provide care to children moving between provinces, service delivery for these children is not thoroughly addressed in any of the various provincial or territorial statutes or regulations.

The first Interprovincial Protocol was developed by the Provincial/Territorial Directors of Child Welfare in the 1990s. The first Protocol that MCFD has a record of came into effect in March 2001. That Protocol contained a commitment whereby each province agreed to work cooperatively to facilitate continuity and minimize disruptions in the delivery of services as well as to consider changes to legislation and policy that would enhance the provision of services under the Protocol. The Protocol contained three main sections, including child protection, guardianship and adoptions. All the provinces and territories except Quebec were signatories to the Protocol.

The Interprovincial Protocol was to be formally reviewed every five years. The first formal revision occurred in December 2006 and the second in June 2011. The Protocol was last amended by the Provincial/Territorial Directors of Child Welfare in April 2016 and this version remains in place today with some minor changes. The Protocol is next scheduled for formal review in 2021, although it may be informally discussed and amended prior to that date.

43 Ministry of Children and Family Development. *Service Delivery Division Newsletter.* (Nov. 2017.)

In April 2016, the current Interprovincial Protocol came into effect covering the service areas of child protection, children and youth in care, children and youth in out-of-care placements, and adoption services. Within these service areas, the 2016 Protocol addresses notification and coordinating services, information-sharing and case management, financial responsibilities and dispute resolution.

One key change between the 2011 and the 2016 Protocol was a new placement funding formula requiring the originating province to pay all care costs, which replaced a more complicated model of cost-sharing between the provinces. B.C.'s Deputy Director of Child Welfare told RCY investigators that the rationale for this change was to ensure more accountability by the originating jurisdiction – specifically, that paying all the financial maintenance costs for a child would help to ensure focus on planning and guardianship responsibilities.

The 2016 Interprovincial Protocol's basic operating principles are:

a. The safety, best interests and well-being of children and youth is the paramount consideration in all decisions

b. The Protocol shall be administered so that the rights of children and youth as defined in the *United Nations Convention on the Rights of the Child* (1990) are respected

c. The originating province/territory always maintains the legal responsibility for children and youth in its care, custody or guardianship and this legal responsibility ends in accordance with the originating province/territory's legislation; however, both provinces/territories have responsibilities for delivering required services to children, youth and families

d. In unique situations, exceptions to the Protocol can be made where necessary to promote the best interests of a child or youth

e. In unforeseen circumstances where the Protocol does not provide sufficient direction, the provinces/territories will work collaboratively to promote the child or youth's best interests consistent with both provinces/territories' legislation

f. Services are not delayed due to budgetary, administrative or jurisdictional issues or disputes and, where these do arise, a timely and effective resolution is promoted.

Jordan's Principle

Jordan's Principle is a child-first principle named in memory of Jordan River Anderson, a First Nations child from Norway House Cree Nation in Manitoba who died from health complications during a funding dispute between the province of Manitoba and the federal government. In December 2007, Federal Motion-296 was passed unanimously by the House of Commons in support of Jordan's Principle, which calls on the government of first contact to pay for the services and seek reimbursement later so that children are not denied essential educational, medical and social services due to government bureaucracy.[44]

The final principle – that services not be delayed due to budgetary, administrative or jurisdictional issues or disputes – is very similar to Jordan's Principle.

During this investigation several notable concerns about the current Protocol and the resulting Interprovincial

44 "Jordan's Principle: A brief history." *First Nations Child and Family Caring Society of Canada.* (August 2014.) https://fncaringsociety.com/sites/default/files/Jordan%27s%20Principle%20Information%20Sheet.pdf

Agreements were identified that should be addressed when the Protocol is reviewed in 2021. These include:

- Protocol: clear expectations set on the level and types of detailed case information required for effective case planning in Interprovincial Agreements
- Protocol: clarity around guardianship responsibilities transferring between provinces and territories
- Protocol: clarity that a child arriving without notice may trigger dispute resolution.
- Interprovincial Agreements: need for clarity in key tasks and responsibilities in a jointly developed case plan
- Interprovincial Agreements: guidance for how payments between provinces are to be made, perhaps in the form of a financial framework appendix
- Interprovincial Agreements: recognition of the importance of cultural identity and planning in the current Interprovincial Agreements.

Practice Consideration

The Representative believes that, when dealing with interprovincial cases, the provinces and territories should assess what is in the best interests of the child, including whether transferring full or partial guardianship responsibilities would be beneficial to the child, especially in circumstances where the child is likely to remain in the receiving province.

Although interprovincial cases are relatively infrequent for individual social workers, there are well-known cases in which similar confusion surrounding interprovincial processes resulted in a lack of adequate services to a child. One prominent case involving interprovincial child welfare authorities occurred in 2013, when 15-year-old Alex Radita was found deceased by Calgary paramedics. He died from complications related to his untreated diabetes and starvation – he weighed less than 37 pounds. His parents were convicted for his murder.

A contributing factor to Alex's deteriorating health was the fact the family had relocated from B.C. to Alberta in an effort to avoid child welfare involvement. There was insufficient child welfare follow-up by B.C. or notification to Alberta following Alex's relocation. B.C.'s then Representative for Children and Youth identified that the 2011 Interprovincial Protocol in place at the time had not proven effective.

In another tragic interprovincial case, a young Indigenous girl from B.C. was placed with a maternal grandfather in Saskatchewan despite his lengthy criminal history. The girl was confined to a windowless basement room for 18 months before being removed from his care at the age of three showing signs of starvation and physical abuse. The grandparent was convicted of failing to provide the child with the necessities of life and sentenced to three years custody. This case was the subject of RCY's 2013 report *Out of Sight: How One Aboriginal Child's Best Interests Were Lost Between Two Provinces*, which found that poor practice around interprovincial cases by both B.C. and Saskatchewan contributed to the child's critical injuries.[45]

45 *Out of Sight: How One Aboriginal Child's Best Interests Were Lost Between Two Provinces,* RCY (September 2013.)

Recommendations arising from this report were:

- 1(a): That the B.C. Provincial Director of Child Welfare review MCFD's current policies and standards for out-of-province placements for all children under the guardianship of the province to ensure there are clear guidelines for assessing and recommending such placements.
- 1(b): That upon completion of the ministry's review of its policies and standards, the B.C. Provincial Director of Child Welfare issue a practice directive detailing the guidelines for out-of-province placements, including any training required to adhere to the directive.
- 1(c): That B.C.'s Provincial Director of Child Welfare ensure that MCFD reports annually on all transfers in and out of B.C. of children under the guardianship of the province.
- 2: That the Provincial Director of Child Welfare strongly recommend to the Provincial and Territorial Directors of Child Welfare that a review be undertaken of the current Interprovincial Protocol to ensure that there is a commitment by all provincial/territorial child welfare authorities that placement decisions fully support the needs of children and families for a seamless transition of services.

The second recommendation was fulfilled by MCFD, the first recommendation was never implemented.

Overall, limitations to the current Interprovincial Protocol and the resulting Interprovincial Agreements led to missed opportunities to recognize, address and meet Romain's needs as a child being served by two provinces. For the benefit of other children and youth in similar circumstances, these limitations should be addressed during the next phase of Protocol development in 2021. It is essential to learn from the experiences of Romain and his family as they tried to navigate and receive services from what at times appeared to be an unduly complex and confused system.

Oversight, Tracking and Coordinating of Interprovincial Cases

Finding: *MCFD does not coordinate, track, support or oversee interprovincial cases in a meaningful way. As a result, communication breakdowns and a failure to adhere to the Protocol's dispute resolution process can occur. For Romain, this failure resulted in his needs getting lost in the conflict between two provinces.*

Interprovincial Coordinators, Regional Consultants and Training

MCFD's Manager of Adoption Services-Intercountry/Interprovincial currently fulfills the role of Interprovincial Coordinator for the entire province but does so as one of her several job functions. The Interprovincial Coordinator reports to the Deputy Director of Child Welfare and, amongst other duties, is meant to track and monitor Interprovincial Agreements. This includes maintaining an accurate account of all incoming and outgoing children, ensuring that all interprovincial children in B.C. are receiving services, analyzing trends, completing quality assurance and identifying best practices. Due to a

lack of resourcing and priority given to this function, the Interprovincial Coordinator is currently unable to fulfil these duties.

The Interprovincial Coordinator explained to RCY investigators that as well as capacity issues, her job is hindered by the fact that she does not receive Interprovincial Agreements on a consistent basis from the regions or DAAs. These concerns were echoed by the Deputy Director, who told RCY investigators that the Interprovincial Coordinator is able to provide *some* monitoring of agreements during single points in time. However, the position is not dedicated full-time to interprovincial matters and therefore is not adequately resourced to provide consistent agreement tracking or analysis. The Deputy Director told RCY investigators that additional resources dedicated to interprovincial work would be necessary for all Interprovincial Agreements to be tracked.

During her interview with RCY investigators, the Interprovincial Coordinator identified the following concerns or barriers to staff having a good understanding of interprovincial issues and the Interprovincial Protocol:

- Lack of clarity that the originating province determines the services and standards to be included in an Interprovincial Agreement
- Lack of information-sharing between provinces around Interprovincial Agreements despite that the receiving province has the right to receive all relevant case information essential for safety and planning for a child in care within 30 days of the placement
- Relevant case information is not always provided, or not provided in a timely way, often due to a lack of understanding of the Protocol in relation to other provincial child welfare legislation
- An *"out-of-sight, out-of-mind"* mentality of not continuing to focus on a case once the child is placed out of province
- A lack of full disclosure of information of a child's presenting issues if those issues relate to additional service costs
- Children's service needs too often being only generally described in Interprovincial Agreements, instead of specifically naming the exact service or type of service required to meet the child's needs. This is exacerbated by the fact that services are often provided and funded differently between provinces
- Confusion around the ongoing guardianship requirements of the originating province. Whenever a child relocates to another province, guardianship remains with the originating province. There is no "opt-out" provision for a receiving province and the receiving province must meet the service requirements of the originating province when caring for children
- Front-line workers being overwhelmed with heavy caseloads. The Interprovincial Coordinator stated, *"They have a lot of competing demands. And … it's one more kid on their caseload who they may not have had any role in the planning and may not agree with the planning and may not even understand how that became the plan."*

In addition to the role of the Interprovincial Coordinator, as has already been described in this report, several MCFD staff throughout B.C. are meant to provide support to front-line workers managing interprovincial cases. They are referred to in this report as regional practice consultants. They report to MCFD Directors of Practice.[46] In addition to working on interprovincial issues, their other job responsibilities may include involvement in complex cases, or in cases involving a dispute that cannot be resolved by local staff. The Interprovincial Coordinator told RCY investigators that the MCFD Directors of Practice acknowledge that the regional practice consultants require additional support and training on the Protocol.[47]

The two regional practice consultants interviewed for this investigation told RCY that regional practice consultants are engaged inconsistently across the province regarding interprovincial matters and that they have varying levels of training and experience when it comes to handling interprovincial issues. One regional practice consultant said that the process for Interprovincial Agreements is not clear, stating, *"It's just nobody is dedicated to do it. And I think if you moved through the [regions], everybody does it a little bit differently. Like in [my region], [the consultants] are very hands-off … The teams only reach out to us if they don't know what to do and they need some guidance."*

There has been no training offered by MCFD to its staff on the Interprovincial Protocol since it was last revised in 2016. When that training occurred, it was primarily offered to consultants and managers, not front-line social workers. One regional practice consultant commented on this to RCY investigators, stating, *"Since 2016, we've had a bunch of new consultants and I don't know who would say they're familiar with [the Protocol], because they didn't get that overview that we got in 2016 … I don't think anybody has a clear picture of who's responsible for what and who they can turn to."*

The 2016 Protocol is available on MCFD's Intranet for staff to review, but it is not included in any ministry training or onboarding processes for new staff, nor is it translated into easily understood policy or practice guidelines for social workers and their supervisors to follow. In Romain's case, both the involved social worker and the team leader told RCY investigators that neither had been involved with a previous interprovincial case, and that neither had received training on the protocol. They had a regional practice consultant involved to assist in guiding their practice, but that consultant also did not fully understand the process or how the process is meant to link up with the Interprovincial Coordinator. Given the lack of training, guiding documents, and the relative infrequency of these cases, it is not surprising to the Representative that staff may not be well prepared to manage interprovincial cases.

46 A Director of Practice is assigned to each of the ministry's 13 Service Delivery Areas. Reporting to the Executive Director of Provincial Practice, the Director of Practice is responsible for maintaining a collaborative practice environment for the provision of child, youth and family services, and the ongoing development of practice at a provincial level. The Director of Practice is also responsible for establishing and maintaining relationships with both internal and external stakeholders.

47 In the DAAs, support for interprovincial cases is provided by practice analysts rather than MCFD practice consultants.

How MCFD Becomes Aware of Interprovincial Cases

At the time Romain received services, interprovincial service requests were received several different ways, including through MCFD After Hours, directly through the regional offices, through Centralized Screening and through the Interprovincial Coordinator.

Coordination of interprovincial and international service requests changed after MCFD formed the Centralized Services Hub (Hub) in 2017. One of the reasons the Hub was formed was to provide centralized screening and notifications for all incoming and outgoing interprovincial and international service requests.

The Interprovincial Coordinator advised RCY investigators that while some provinces/territories have established a centralized screening system such as the Hub, which includes an interprovincial email inbox for monitoring and actioning interprovincial service requests, other provinces have no centralized screening function. The Interprovincial Coordinator noted that, in instances in which B.C. contacts a province/territory without a centralized system, it is often a matter of communications trial and error until the correct individual or office is located.

There is no mechanism currently in place that requires or enables oversight from MCFD's Provincial Office into the creation, administration, or ongoing supervision of Interprovincial Agreements. MCFD's Deputy Director acknowledged the need for awareness, tracking, monitoring and training regarding the Protocol, telling RCY investigators:

> *"There's a whole bunch of cases that I don't know about, that [the Coordinator] doesn't know about, the consultants don't know about that are going sideways, as we speak, probably interprovincial matters that would likely come out if we sat down with people and said, 'By the way, did you know that when you place a child in care in another province you remain responsible? Did you know that you need to have an IP protocol? Did you know that when kids come here these are the forms you have to use?' Invariably you have people go, 'Oh … I've got a couple of those cases. I didn't know this.'"*

The Deputy Director recalled in one case several years ago *"two wards [of B.C.] were placed and one of them was in Alberta … and his sister was placed in Saskatchewan. [They had] been there for a year and we didn't know anything about it. So that's even worse is when we don't know till several years later, or months later."* It is difficult to fathom that B.C. has a system where the Director of Child Welfare, the legal guardian of these children, could place them out of the province and lose sight of where they are. It is clear to the Representative that MCFD needs a much more robust system for overseeing interprovincial cases.

Dispute Resolution in Interprovincial Cases

The 2011 Protocol identified two levels of dispute resolution:

- **Disputes Between Local Authorities** – If a dispute between provinces/territories cannot be resolved, the matter shall be referred to the provincial contact (in B.C.'s case, the Interprovincial Coordinator) for the province to facilitate a mutually satisfying resolution.
- I**nvolvement of the Provincial Directors** – If the provincial contact cannot help resolve the dispute, the matter shall be referred to the Provincial Director responsible for child welfare in each province/territory.

The 2016 Protocol identifies three different levels of dispute resolution:

- **Dispute Resolution at the Local Level** – The expectation is that most issues arising between provinces/territories will be resolved between the case workers and their supervisors and managers *"in a timely fashion."* Practice consultants in B.C. are responsible for helping to resolve disputes at the local level.
- **Involvement of Interprovincial Coordinators** – The Interprovincial Protocol stipulates that, in the event a dispute or other issue cannot be resolved in a timely fashion at the local level, the matter should be referred to the Interprovincial Coordinator for each province or territory to negotiate a mutually satisfying resolution within 14 calendar days.
- **Involvement of Provincial and Territorial Directors of Child Welfare** – In the event that the dispute cannot be resolved by the Interprovincial Coordinators, the issue should be referred to the Director of Child Welfare in each province/territory. A mutually satisfactory resolution is expected to be determined and communicated within 14 calendar days of the Directors of Child Welfare receiving the matter. However, the Directors may take longer to resolve the dispute if an extension of time is mutually agreed upon.

Romain's case was not referred for dispute resolution in any of the three instances in which he was sent by Alberta CS to B.C. without notification or planning, nor during any of the conflicts that arose between the two provinces while he was in B.C. The Representative notes that both the 2011 and the 2016 versions of the Protocol are silent on how a receiving province/territory ought to respond if an originating province/territory is not providing the notification required by the Protocol. It seems reasonable to infer from the Protocols that this ought to have led to the initiation of the dispute resolution process.

Romain's second arrival in B.C. in August 2015 was without the required 60-day notification to MCFD and without the required case records. Ultimately, an Interprovincial Agreement was drafted in October 2015. This is an example of when the Interprovincial Coordinator could have been effectively involved to facilitate the completion of the Interprovincial Agreement. Based on interviews, the Representative suspects that the lack of clarity Romain's assigned social worker and team leader had about the Interprovincial Coordinator's role may have contributed to her not being aware about or informed of the situation.

The 2016 Interprovincial Agreement was also delayed and ought to have been raised to dispute resolution to address the delay. Romain arrived in B.C. in July 2016 and MCFD was aware of his arrival, but an agreement was not signed until November 2016, four months later. The 2016 Agreement makes it clear that Alberta was to pay for his resourcing. When resourcing for Romain became an issue in late 2016 to mid-2017, MCFD staff again could have initiated the dispute resolution process to address the placement funding impasse and resulting delay of placement development. If so, the Interprovincial Coordinator and Deputy Director of Child Welfare could have become involved to assist in ensuring an adequate resourcing plan for Romain.

In the interviews for this investigation, RCY was given multiple reasons for why this dispute resolution process did not occur, including: a lack of familiarity with or training about the Protocol, a lack of familiarity of line staff including the consultants with the role of the Interprovincial Coordinator, and that the involved front-line staff did not identify that the issue of securing payment for creating a specialized resource was actually a conflict requiring resolution. RCY investigators also found that there is no centralized information identifying dedicated interprovincial practice experts for front-line workers or for regional practice consultants.

Through all the disputes, the Interprovincial Coordinator was never advised of nor involved in the interprovincial planning issues related to Romain's case. The Coordinator told RCY investigators that conflicts brought to her attention are typically resolved as described by the Protocol. The Representative requested information from MCFD about the number and types of disputes that the Interprovincial Coordinator handles. The ministry was unable to provide this information because it doesn't track or have a record of disputes handled. The Representative was therefore unable to assess whether the overall dispute resolution process works effectively. However, it is clear to the Representative that the application of the dispute resolution process was not effective in Romain's case, because it was not known of or used by front-line staff.

When a dispute does come to the Interprovincial Coordinator and she is unable to resolve an issue or conflict, the final level of dispute resolution is with the Deputy Director of Child Welfare. B.C.'s Deputy Director told RCY investigators that he intervenes only *"in exceptionally complex interprovincial matters where there's a dispute that can't be resolved at lower levels."*

Romain's case was never brought to the Deputy Director's attention. He told RCY investigators that if he had been involved in the impasse around developing a specialized resource for Romain, he would have contacted his Alberta counterpart to find a resolution.

The Deputy Director told RCY investigators that any unresolved interprovincial disputes can typically be settled at the Deputy Director level. However, he said this final level of dispute resolution does not always guarantee a successful outcome for the child.

One clear challenge to the current system of Interprovincial Agreements is that the dispute resolution system becomes meaningless if Provincial Office is not aware of interprovincial cases and if the local offices are not raising disputes to the provincial level. It is impossible to know how Romain would have been served had Provincial

Office and the Interprovincial Coordinator been made aware of his case and of the difficulties front-line care providers were having in cooperating and collaborating with Alberta to provide services. The Representative believes MCFD must make the dispute resolution process better known to front-line staff through training and policies in order to facilitate its use.

Signing Agreements

Joint signatures by both parties entering into an Interprovincial Agreement are important because they signal that negotiations are complete, providing some certainty to the parties around responsibilities for service delivery. Currently in B.C., these agreements are signed at a local level, not by the Provincial Office.

The Director has a responsibility to ensure that all agreements – regardless of whether they originate in B.C. – are signed jointly with the other province/territory involved. If agreement cannot be obtained, this is the clearest indication that dispute resolution is required. Whether or not an agreement is signed, MCFD still has a legal responsibility to protect children living in B.C. from abuse, neglect, or threat of harm under s.13 of the *CFCS Act*, and once it was aware of Romain, MCFD had a responsibility to provide him with services to meet his needs.

Romain's first Interprovincial Agreement was created in October 2015; however, a signed copy was never included in the records forwarded to RCY, leaving RCY investigators to conclude that a jointly signed copy does not exist.

In the course of this investigation, The Representative requested Interprovincial Agreements for out-of-province children placed in British Columbia as well as for B.C. children placed out of province. The request was for any agreements active at the time of March 1, 2019, the month in which the data request was submitted. Initially, MCFD Provincial Office was unable to provide either a list of agreements or copies of the agreements, so it had to contact each of the 24 Delegated Aboriginal Agencies and the 13 Service Delivery Areas in the province to receive the requested copies. The purpose of the request was to conduct a thorough review and assessment of Interprovincial Agreements in the province. In this report, it will be referred to as the RCY Interprovincial Agreement Review.[48]

The request resulted in the Representative receiving 157 relevant Interprovincial Agreements spanning from 2007 to March 2019. MCFD was not confident that it had provided agreements for every interprovincial child because the ministry does not track these cases. The RCY Interprovincial Agreement review found that only 63 per cent of agreements were signed by both jurisdictions. A matter of significant concern to the Representative is that 37 per cent of the reviewed Interprovincial Agreements were signed by one jurisdiction only or were not signed by either jurisdiction.

48 See Appendix 3. S. 10 Data Review.

Practice Consideration

To give better assurances of tracking, oversight and monitoring, consideration could be given to MCFD requiring that only Provincial Office can sign off on Interprovincial Agreements.

The lack of consistency in signing agreements and the failure to understand the importance of having them signed is another gap in MCFD's Provincial Office oversight of these interprovincial cases. The Representative believes that the dispute resolution process should be triggered, and Provincial Office should be involved through the role of the Interprovincial Coordinator, in interprovincial cases when there are delays in finalizing and signing agreements.

Tracking Interprovincial Cases

As previously stated, MCFD does not have a centralized system to track or monitor interprovincial cases. In her interview, B.C.'s Interprovincial Coordinator acknowledged the importance of monitoring incoming and outgoing Interprovincial Agreements as a necessary practice for several reasons. These include maintaining an accurate account of all incoming and outgoing children, ensuring that all interprovincial children are receiving services, the opportunity for trend analysis and for quality assurance and identifying best practices.

There are several communication and structural challenges impacting the provincial monitoring and tracking capacity beyond the already described insufficient resourcing to the Interprovincial Coordinator's position. One major issue is that it does not appear to RCY investigators that local MCFD offices are consistently aware that they should forward signed agreements to the Interprovincial Coordinator, nor does there seem to be a clear policy directive making it a requirement.

> *"I sometimes get the signed Interprovincial Agreements and sometimes I don't … it's hit-and-miss whether it comes to me or stalls at a consultant or just stays in the child's file and I don't see it."*
>
> —Interprovincial Coordinator

Despite the inconsistency in receiving them, receipt of completed Interprovincial Agreements is currently the only way for MCFD to reliably track and monitor interprovincial children. Beyond inconsistent forwarding of initial Interprovincial Agreements, renewal agreements are also an issue. The Interprovincial Agreement form within the 2016 Protocol requires that the Interprovincial Agreements *"must be reviewed every 12 months or earlier at the request of either jurisdiction."* In her interview with RCY investigators, B.C.'s Interprovincial Coordinator confirmed that renewal agreements are almost never forwarded to Provincial Office. The Representative is concerned that Interprovincial Agreements may not be renewed on an annual basis.

These concerns were validated by the Interprovincial Agreement review completed by the RCY as part of this investigation. Only four of the analyzed agreements were renewal agreements. Given the long-term placement planning indicated on many Interprovincial Agreements, it is likely that there are more renewal agreements required. It is unknown whether expiring agreements are not being renewed or if these renewal agreements are being completed but not forwarded to Provincial Office. Additionally, Interprovincial

Agreements are not being regularly uploaded to a child's computerized Integrated Case Management (ICM) file, another issue preventing monitoring and oversight. Only 22 per cent of reviewed agreements originating in B.C. were located on ICM.

> *"I think we are actually one of the better provinces. But I think as a country … our interprovincial planning is not good. And part of the reason it's not good is because we are a country with 13 different pieces of legislation, thousands of pieces of policy, different mandates, different ages of majority. We have a lot working against us. We don't even have a common database … we don't have a common child welfare database that we can quickly look at."*
>
> —MCFD Deputy Director of Child Welfare

In addition to the need for provincial tracking within B.C., MCFD's Deputy Director raised the need for improved interprovincial tracking across the country. He pointed out that this issue was previously raised at the Provincial/Territorial Directors of Child Welfare level in the wake of the 2013 RCY report *Out of Sight* and that it had not been adequately addressed.

In addition to a lack of accessible training on completing Interprovincial Agreements, Romain's case highlights the need for a practice guideline or standard for interpreting the information contained within the Provincial/Territorial Protocol. An interprovincial guideline could provide more direction to staff on key issues including: courtesy supervision, information-sharing, guardianship responsibilities, incident reporting, dispute resolution, case planning, management, cultural planning, permanency planning, transition planning, placement planning and financial planning.

MCFD's Duty to Serve Romain Under the Protocol and the *CFCS Act*

Finding: *After Romain arrived in B.C., MCFD had a duty to ensure he was safe and receiving the services he needed, but ministry staff were not properly prepared to ensure that this happened. There is a lack of clarity for MCFD employees on the current Protocol and associated Interprovincial Agreements that led to confusion and uncertainty in the planning and delivery of services for Romain in B.C. No policy, practice guidelines or training exist for MCFD front-line staff and their supervisors working on these interprovincial cases.*

Summary of Interprovincial Agreements for Romain

In early October 2013, with Romain in care in Alberta, Alberta CS arranged to move him from an Alberta resource to live with his sister in B.C. Alberta CS did not consult with MCFD in advance and did not formally ask MCFD to provide courtesy supervision for Romain until the end of November 2013, following which a B.C. social worker was assigned to support Romain.

In November 2013, Alberta CS asked MCFD to support Romain's sister, although it appears that MCFD took a broader view of its role as also supporting Romain. There were discussions of formalizing the courtesy supervision into an Interprovincial Agreement which was halted pending a psychiatric assessment for Romain that was completed in February 2014. That same month, Romain was hospitalized and returned to Alberta, against his wishes, after the placement with his sister broke down.

In accordance with the Protocol, Alberta ought to have notified MCFD in writing about Romain's move to B.C. at least 60 days prior to allow for sufficient planning and coordination between provinces. This did not happen, leaving Romain with his sister and without an appropriate assessment of her home. MCFD was placed at a disadvantage and forced to respond reactively rather than proactively in its attempts to support the family.

When Romain moved to B.C. for the second time, in August 2015, he was in the permanent care of Alberta CS. Once again, this move was not preceded by the 60-day written notification required by the Protocol. Alberta CS's objective in moving Romain to B.C. a second time was to trial a new placement with Romain's mother in the hopes that its care order could be lifted, and Romain could return to his mother's custody. Despite the challenges it faced in not having time to coordinate services for the family, MCFD again provided courtesy supervision. At the end of August 2015, Alberta CS commenced a formal Interprovincial Agreement discussion with MCFD child services.

An agreement was drafted and discussed on Oct. 16, 2015. The agreement called for MCFD to provide courtesy supervision, including the provision of services to *"strengthen the relationship of the child with his mother."* The agreement also delegated some day-to-day parental responsibilities to B.C. including decisions about school, counselling and medical treatment and authority to *"sub-delegate"* some of those responsibilities to a specific caregiver. Not delegated were major decisions such as where Romain would live, adoption, or consent to major medical treatment.

In addition to some guardianship responsibilities, under the 2015 Interprovincial Agreement, MCFD agreed to provide the following supports and services:

Services B.C. agreed to provide	Occurred (yes/partial/unknown/no)
Providing monthly contact with Romain's mother and facilitating her enrollment in parenting teen workshops	Yes
Providing face-to-face contact with Romain, every 90 days, as per MCFD standards	Unknown – know some face-to-face occurred but insufficient documentation to assess
Jointly reviewing the care plan for Romain with Alberta CS at least twice a year as per MCFD policy	No
Immediately reporting any significant events such as serious occurrences or hospitalization of Romain to Alberta CS	No
Forwarding monthly emails about Romain's progress and interactions to Alberta CS	No
Maintaining case records and being aware of the assigned case worker	Partial – case records not obtained but assigned worker known

The Representative had challenges confirming whether B.C. fulfilled its responsibility of face-to-face contact with Romain under both the 2015 and 2016 Interprovincial

Agreements due to a lack of case documentation on Romain's file and because some individuals interviewed by RCY had limited memory of specific events and details regarding their time working with Romain.

In June 2016, Romain moved back to Alberta. He was only in Alberta for a few weeks before Alberta CS decided, for the third time without consulting with MCFD child services, to move him back to live in B.C., this time with the sister he had lived with when he was 13. When MCFD learned of this move, Alberta CS communicated that it was *"just a visit,"* although the plan was to seek an Interprovincial Agreement if things worked out. MCFD's concerns, which originally focused on the suitability of Romain's sister to look after him, were magnified after Romain committed a robbery only days after returning to B.C. and was sentenced to custody.

In August and September 2016, Alberta CS pursued a new agreement with MCFD child services. In November 2016, an Interprovincial Agreement was signed, identifying the youth custody centre as Romain's placement. It is necessary for the Representative to highlight that a custody centre is not a permanent placement option – it is typically short term and should never be included on an Interprovincial Agreement without reference to the plan at discharge from custody.

The Interprovincial Agreement at this time stated, *"Alberta to transfer guardianship responsibilities as outlined in the schedule of delegated and non-delegated matters so B.C. can provide supervision and monitoring for [the child] as negotiated in this agreement."* Under the 2016 Interprovincial Agreement, MCFD child services also agreed to provide the following supports and services:

Services B.C. agreed to provide	Occurred (yes/partial/unknown/no)
Meeting with Romain once per month "to build a connection" as per Alberta CS standards for contact with permanent wards	Unknown – insufficient records
Jointly reviewing the Care Plan with Alberta at least every six months	No
Supporting Romain to learn self-care and basic life skills	No
Providing a youth worker to support Romain in developing these skills and transitioning to adulthood	Partial – provided primarily through school supports and youth justice supports
Reporting any significant events such as serious occurrence, hospitalizations, etc. to the guardianship worker in Alberta as soon as is reasonably possible.	Partial – Alberta received information about some but not all of Romain's serious occurrences and hospitalizations
Providing Romain with the opportunity and support to address his trauma through individual and/or family therapy	No

Both the 2015 and 2016 Interprovincial Agreements described their purpose as being for MCFD to provide *"supervision,"* but they also refer to a transfer of guardianship responsibility to MCFD. The Representative is concerned that supervision and the formal exercise of parental authority (guardianship) were blended in Romain's Interprovincial Agreements. As a result, its unclear to the Representative whether MCFD and Alberta CS had a common understanding of what MCFD was expected to do.

In fact, despite signing the 2016 Interprovincial Agreement which indicated that *"Alberta will transfer the guardianship responsibilities as outlined in the attached Schedule of Delegated and Non-Delegated matters,"* MCFD advised the RCY that it is not legally possible for one province to transfer or delegate guardianship responsibility for a child in care to another province.

The Representative disagrees. It is clear from s.121 of the Alberta statute that the Director has the power to formally delegate any of his or her duties or power to *"any other person or government."*[49] It is also clear from s.93(2) of the *CFCS Act* that the B.C. Director can receive delegated authority from other provinces. Section 93(2) provides that the *"director is authorized to receive any authority that a) is delegated to the director by a government or child welfare authority, and b) relates to a child in the custody or under the guardianship of that government or child welfare authority."*

> *"I . . . see situations where children in care arrive here, either planned by another province or by accident, and a file is opened somewhere else and somehow the social worker thinks that, because they're from another province, that they're not entirely responsible. And I've said many times, the child's in B.C., they're your responsibility, just like any other child . . . But somehow there's this sense that, if another jurisdiction has a file open and they're working with a family, somehow, we don't have the same responsibility. So, it may not have been a good plan for the child to have ended up here, or the family, but the reality is they're here and you have to now pick up the ball and run with it."*
>
> —MCFD Deputy Director of Child Welfare

It is possible that Alberta CS was of the view that, since it delegated partial guardianship responsibility to MCFD, the B.C. Director would serve as the parent and take an active approach in addressing and deciding all the delegated matters including discipline, school, counselling, medical procedures and sub-delegation to his caregiver. It is possible based on interviews conducted by RCY that MCFD staff saw their role as being limited to support and monitoring services. An example of the resulting confusion can be found in November 2015, when Romain's school began advocating for Romain to receive a goals coach. Romain's MCFD child services social worker repeatedly put the onus to approve this coach onto Alberta CS, although MCFD had the authority to make decisions on counselling for Romain. By the time the goals coach was approved a month later, Romain no longer wanted to engage with this service, a missed opportunity to connect him with counselling.

49 *Child, Youth and Family Enhancement Act,* R.S.A. 2000, c.C-12, s.121(4)(d)

The Requirement for MCFD to See Romain

Both the 2015 and the 2016 Interprovincial Agreements required MCFD to see Romain at set periods of time, initially every 90 days in 2015 to reflect MCFD standards and then every 30 days in 2016 to reflect Alberta standards. There are no MCFD social worker case notes to support that these visits consistently occurred between Romain and his assigned MCFD social worker. The MCFD social worker acknowledged treating Romain's case as a family service file, focused on supporting Romain in the family home as opposed to acting as his guardian and coordinating appropriate services for him.

Through 2015 and the first half of 2016, while Romain was placed with his mother, his social worker stated that she initially saw and observed him in the home or at planning meetings every 90 days or more as agreed upon in the Interprovincial Agreement. However, the social worker reported that, as Romain's participation at the meetings decreased, so did her interactions with him. RCY investigators could not verify the frequency of Romain's interactions with his social worker because they were not recorded in the ministry's case management system and her handwritten case notes were lost.

Romain's social worker acknowledges not seeing Romain through the second half of 2016 until Feb. 17, 2017 while he was placed in youth custody,

> *"I wasn't close to Romain before he went into jail and I became less close to him after he came out of jail … he was a stranger to me. I was his social worker, yes. I picked him up from the Correction Center and whatnot, but there was a distance because he had been gone so long."*

Emergency bed home staff told RCY investigators that they repeatedly reached out to Romain's social worker asking that she meet with Romain. They also said that the social worker never met with Romain at the resource and only visited the facility to pick up his belongings after Romain died. The social worker told RCY investigators that she saw him *"informally"* when he was visiting his YPO. The Representative believes that a child with Romain's needs should have been seen by his social worker much more frequently than he appears to have been. The Representative is concerned that Romain being in care in Alberta may have contributed to his social worker not prioritizing seeing him.

Although Romain was being seen regularly by his YPO and ISSP, these services are not a substitute for strong guardianship from MCFD child services. YPO supervise youth who are subject to a community-based supervision order and provide the youth with assistance to comply with the conditions of the order, prepare reports as directed by the court, and attend court where appropriate. MCFD guardianship or child service social workers like Romain's are responsible for day-to-day decisions for the child and responding to their emerging care needs with a plan.[50]

50 The B.C. government maintains an inventory of jobs and careers retrieved at: https://www2.gov.bc.ca/assets/gov/careers/for-job-seekers/current-bc-government-job-postings/featured-careers/social_worker_roles.pdf

The absence of contact with Romain meant that the social worker was unable to learn from Romain about what he needed, how to try to help him or whether he was in crisis. She was not engaged in supporting his needs or ensuring that appropriate services were provided to respond to his needs and circumstances.

Financial Planning

In the 2011 Interprovincial Protocol, while providing services to interprovincial children and families, the receiving province/territory was responsible for:

- Salaries and normal operating costs in service delivery
- Basic foster care rates and special foster care rates of no more than 10 additional dollars a day
- Dental and optical services, prescribed drug costs
- Other costs as negotiated on a case-by-case basis.

The originating province/territory was responsible for paying for special foster care rates, financial assistance to young adults, psychological services not paid for by public funding, and specialized residential care costs.

The 2016 Interprovincial Protocol maintained many of the same cost responsibilities for each province, although it shifted responsibility for payment of dental, optical and drug costs to the originating province if those costs are not covered by public funding.

> *"In any good or bad [interprovincial] relationship, it all boils down to communication and money."*
>
> —B.C. Interprovincial Coordinator

One key change between the 2011 and 2016 Interprovincial Protocols was the in-care payment formula. Under the 2011 Protocol, the receiving province/territory was responsible for the resource costs for the child, unless the placement exceeded the basic rate, and then a formula of the originating province paying the care amount over the basic rate was applied. This changed with the 2016 Protocol, which made the originating province/territory responsible for all in-care service costs. The Protocol is silent, however, on how the receiving province is supposed to recover the costs of the services it provides. RCY investigators learned from interviews that Romain's placement costs were never invoiced to Alberta and that the involved front-line workers were not aware of any invoicing processes in place for interprovincial payments.

The apparent lack of process to enable interprovincial payments may lead to fewer services being provided in interprovincial cases. In Romain's case, it contributed to the confusion around his resource development. The Representative believes the current situation must be corrected to ensure children who are being served outside of their home province receive prompt, responsive services. The 2016 Protocol states that service must *"not be delayed due to budgetary, administrative or jurisdictional issues,"* yet in Romain's case, significant delays did occur.

The lack of clarity and processes around financial costs also resulted in delays for Romain receiving dental attention in B.C. This occurred on Feb. 23, 2017, when Romain had an infected tooth and required emergency dental care. MCFD did not promptly ensure that

Romain received emergency dental surgery due to confusion about his medical coverage and about whether Alberta would pay for the surgery. As a result, this surgery was delayed by approximately one week and did not occur until March 2, 2017. Under the 2016 Interprovincial Agreement, B.C. was responsible for providing medical, dental, and prescription drugs and had delegated authority to consent to and pay for this surgery. Given the stipulation in the Protocol that treatment to children not be delayed for bureaucratic reasons, the Representative finds this delay unacceptable.

In addition, the lack of clarity and process around payment for resourcing resulted in confusion and ultimately not arranging or developing an appropriate resource for Romain when he was released from custody in December 2016. While he was in custody, MCFD and Alberta identified the need for a specialized placement for Romain because none of the existing service providers were either available or able to manage his complex needs and behaviours. A commitment of $15,000 to $20,000 monthly for Romain's care was offered by Alberta CS however, they also indicated that it required a breakdown of the costs before it would formally commit to the funding. MCFD, meanwhile, determined that it could not begin creating a specialized resource without a firm financial commitment from Alberta CS. It is unclear to RCY what this was supposed to look like.

When Romain was released from custody on Feb. 17, 2017, rather than going into a specialized resource, he was placed into two separate emergency receiving beds until his fatal overdose in May of that year. Despite having seven months while Romain was in custody to arrange for an appropriate placement, MCFD and Alberta CS did not do so.

Although the 2016 Interprovincial Protocol identifies Alberta, the originating province as responsible for paying Romain's in-care costs, including residential placement, MCFD paid for the costs of Romain's care in the emergency resource throughout the placement. Neither the emergency placement nor the financial arrangement for it prompted further planning or the Protocol's dispute resolution process. There were no meetings between MCFD and Alberta CS from the time the Interprovincial Agreement was signed at the end of November 2016 until April 2017. Representatives from the two child welfare bodies finally met in May 2017 as a result of MCFD invoicing Alberta CS for $1,200 in property damage that Romain caused at the emergency placement. Until this point, MCFD had been caring for Romain at no cost to Alberta CS, therefore providing no financial motivation for Alberta CS to continue negotiating on service expectations or resource costs.

It seems the confusion around paying for Romain's resource arose from the lack of a clear process for billing and recovering costs between provinces, or from having that process defined within the Interprovincial Agreement. One interviewed resource social worker advised that the costs of Romain's placement would need to be invoiced to Alberta but that they were not aware of any process to do so, an observation that was echoed by the resource team leader involved in this case. It would be worthwhile for MCFD Provincial Office to clarify this process for their regional offices involved in service delivery for interprovincial cases.

The Duty to Report to Another Province/Territory, to Provincial Office and to RCY

Reporting to Another Province

The 2011 Interprovincial Protocol is silent on how provinces/territories should respond to significant or critical life events for children affected by Interprovincial Agreements. The 2016 Protocol addressed this gap, stipulating that the receiving province/territory will report any significant events to the originating province/territory as soon as reasonably possible. The duty to report is key for ensuring that the originating province/territory, which is legally still responsible for the child or youth and is responsible in most cases for case planning, is aware of emerging needs and able to respond to issues in a timely matter.

Due to inconsistencies in tracking Interprovincial Agreements and an apparent lack of understanding of when and how to complete injury reports for these cases, it is unclear to the Representative how many critical injuries and deaths of children under Interprovincial Agreements may be going unreported.

A serious occurrence/incident is defined in the 2016 Protocol as including, but not limited to:

> *The death or serious injury of a child or youth; alleged abuse or mistreatment of a child or youth by family members, foster parent, staff, volunteers or others associated with providing the services; serious complaints made by or about a child or youth, or any other serious occurrence involving a child or youth that is considered to be of a serious nature in a receiving province/territory.*

In addition to the reporting requirements in the 2016 Protocol, there are specific reporting requirements regarding all children in B.C. MCFD's Practice Standard 2.1 states:

> *If a critical injury occurs of a child or youth who has received or whose family has received an MCFD/DAA-provided reviewable service within the preceding 12 months, a reportable circumstance report is completed and provided to the Provincial Director of Child Welfare, the appropriate provincial director(s) and the RCY within 24 hours of MCFD and/or DAA having been informed of the critical injury.*

Reviewable services include any service provided by MCFD and/or a DAA under the *CFCS Act* or *Youth Justice Act* and include all mental health and addictions services for children. This reporting requirement is in place regardless of whether or not a child is subject to an active Interprovincial Agreement, as is clarified by MCFD's *Reportable Circumstances Policy Practice Guidelines (June 2015)*, which state:

> *Information regarding concerning events may be received regarding children from other provinces who are receiving reviewable services in B.C. – if these children or their family members are receiving reviewable services in B.C., then the RC policy applies, even if the services are provided at the request of another province.*

A critical injury is an injury to a child or youth that has resulted in, or which may in the future result in, a serious impairment of the child or youth's health in which the child is unable to carry out their usual day-to-day activities on an ongoing basis or requires considerable ongoing support to carry out usual day-to-day activities. The impairment may be physical and/or emotional in nature.

MCFD did not consistently comply with the requirement in the Interprovincial Agreement to report significant events to Alberta CS. This lack of reporting resulted in Alberta CS not having the information it needed to address Romain's safety and well-being. Of note, Alberta CS was not informed when Romain was hospitalized for self-harm in April 2016, for two alleged assaults he committed in custody in August 2016, for the alleged sexual assault he experienced in March 2017 and for the hospitalization for extreme intoxication that same month, or for a self-harm hospitalization in April 2017. The Representative cannot determine how Alberta CS may have responded if these reports had been made, but Romain was clearly in crisis and this was not being communicated to his guardian.

Reporting to MCFD Provincial Office and to RCY

MCFD is required to report critical injuries and deaths of children who receive reviewable services to the RCY and to MCFD Provincial Office. Injury and death reports are reviewed by the RCY to determine whether they meet its mandate, whether to review the injury or death in more depth, conduct an investigation, use the injury or death in an analysis of themes and trends or refer the case to an RCY advocate or to the Provincial Director as a 'case of concern'.[51] This process is governed by the *RCY Act* (2006).

Practice Reminder

Under s.11 of the *RCY Act*, public bodies responsible for providing reviewable services to children and youth are required by law to report critical injuries and deaths of those children and youth to the Office of the Representative of Children and Youth. Critical injury reports are required for all children served by MCFD including children in care from other jurisdictions.

Romain experienced several serious occurrences and critical injuries while he was living in B.C. and in receipt of reviewable services under both the *CFCS Act* and the *Youth Justice Act*. Yet, as is demonstrated in the table below, the only report the RCY received for Romain was following his fatal overdose in May 2017.

As illustrated in the table below, there were numerous events that should have been reported to Alberta CS and both MCFD's Provincial Director and RCY in accordance with MCFD Practice Standards. In explaining the absence of a report for the alleged sexual assault, Romain's social worker told RCY investigators, *"I don't recall [the incident] being very detailed. So probably . . . it just passed me by."* Despite receiving critical incident reporting for all of Romain's injuries from the emergency bed home, the social worker could not recall why this information was not forwarded to Provincial Office. When asked about the lack of reporting his incident of self-harm at his mother's residence, she

51 *Representative for Children and Youth Act*, S.B.C. 2006, c. 29. A case of concern is not defined in the *RCY Act*. It is a process jointly developed by RCY and MCFD to bring to MCFD Provincial Office's attention cases they may not be aware of that are reported to RCY and for which RCY has heightened concern. The process is dependent on workers completing reports.

responded: *"No, I never thought of it, of doing one, and there was no direction to do one . . . Stabbed himself in the arm. That was all I knew."*

Date	Incident	Serious Occurrence Report Required and Made to Alberta	Critical Injury Reporting Required to MCFD Prov HQ and RCY	Report Completed and Provided to MCFD HQ and RCY
January 2014	Threatening with a knife at school	Yes	Not Required	N/A
February 2014	Hospitalized for self-harm	Yes	Required	No
April 2016	Hospitalized for self-harm	No	Required	No
July 2016	Armed robberies	Yes	Not Required	N/A
August 2016	Assaulted in custody	Yes	Required	No
August 2016	Alleged assault committed in custody	No	Not Required	N/A
August 2016	Alleged assault committed in custody	No	Not Required	N/A
March 2017	Alleged sexually assaulted at emergency bed home	No	Required	No
March 2017	Hospitalized for extreme intoxication	No	Required	No
April 2017	Hospitalized for self-harm	No	Required	No
April 2017	Alleged theft	No	Not Required	N/A
May 2017	Overdose fatality	Yes	Required	Yes

The Representative recognizes that front-line social workers face an enormous workload and that completing a report for a critical injury may seem to be low priority when faced with their other daily responsibilities. However, not reporting critical injuries meant that MCFD Provincial Office, RCY and Alberta CS were not made aware of Romain's case and the significant challenges he was facing. Had reports been made, the challenges Romain and his family faced in receiving appropriate and timely services and supports in B.C. may have been resolved.

Trauma-Informed, Identity Affirming Resources and Service Provision

Finding: *A lack of robust services and residential resource options in B.C. meant that Romain, who had experienced considerable trauma and was searching for belonging and connection, was left without appropriate services, without connection to his cultural heritage, and was living in a resource that wasn't meeting his needs in the months prior to his death.*

An in-depth assessment of case planning for Romain is beyond the scope of this report as that was legally Alberta CS's responsibility. The planning that was MCFD child service's responsibility, under the Interprovincial Agreements, the *CFCS Act*, and the Protocol, was determining how to respond to and appropriately serve Romain based on his complex needs and presentation once it was clear he was residing in B.C.

Under the 2015 and 2016 Interprovincial Agreements for Romain, MCFD child services committed to making decisions regarding his social activities, mental health and counselling services, and medical care. It also agreed to implement Alberta CS's case planning requests, which included supporting Romain's skill development, strengthening his familial connections, and *"providing him with opportunity and support to address his trauma and feelings of abandonment and neglect"* with individual and/or family therapy. MCFD did not fulfil these responsibilities. After it was determined that Romain required a specialized resource to accommodate his needs, MCFD did not work effectively with Alberta CS to create the individualized, low-barrier support necessary to safely maintain him in care.

In October 2013, Romain was placed with his sister in B.C. for six weeks before an Alberta CS regional consultant emailed MCFD After Hours requesting courtesy supervision for him. During that time, Romain and his sister were only being supported through his school and his YPO. It took 12 days for the request to be assigned to the appropriate MCFD child welfare office, and it took another month for the file to be reassigned to a social worker after Romain and his sister moved in January 2014. Although there was a short period of time between this file being assigned and Romain returning to Alberta in February 2014, MCFD services were not put in place. This lack of services may have contributed to the breakdown in Romain's placement with his sister, as they had no supports to help them cope with living together given Romain's extensive needs.

In 2015, Alberta CS planned to send Romain to B.C. to visit his mother. Alberta CS followed the Interprovincial Protocol by requesting courtesy supervision for the visit, 30 days in advance of his June visit. RCY investigators could not verify that MCFD provided the requested supervision or assessments for this visit.

> *"It's like trying to negotiate the sale of a house after you've already moved in. It's very difficult … because you've basically got the reality of the child or family is already here and plans are already in motion so … the receiving province doesn't have the opportunity to put services in place, to prepare for it, to negotiate around roles and responsibilities . . . It's too late for that . . . With Alberta and B.C., where you have a kid moving back and forth like this, and an [Interprovincial Agreement] is being done after the fact – not a good scenario at all."*
>
> —MCFD Deputy Director

Romain lived with his mother from August 2015 to June 2016. The 2015 Interprovincial Agreement indicates that MCFD was to complete a home study for this placement, but RCY investigators could not locate any documentation or witnesses who could verify that it took place or explain what it entailed. There is no record suggesting a home study determined that Romain's placement with his mother was appropriate or what supervision and supports would be required for the placement to be successful.

During this time, B.C. ought to have been providing Romain and his mother with responsive, trauma-informed services to work toward stabilizing the placement. This was partially achieved through the family preservation worker, but the Representative believes that was clearly insufficient to address Romain's complex needs at that time.

At the start of July 2016, Romain was again sent without notification by Alberta CS to live in B.C. – this time with the younger of his maternal sisters. Upon MCFD learning of the placement informally from Romain's mother on July 4, 2016, Alberta CS explained that its intention was that this was just a visit and not a placement. MCFD raised significant concerns about this decision with Alberta CS, but MCFD had limited time to act on those concerns. Within five days of being placed with his sister, Romain had been arrested and remanded into youth custody. With the exception of one week, he would remain in custody until February 2017.

The Representative acknowledges the work that was done by MCFD staff in trying to support Romain in the absence of Alberta CS providing the required notification of its intention to place Romain in B.C. However, there is no *"opt-out"* option for caring for children once they have arrived in this province, regardless of whether the originating province/territory has followed the Protocol. Once a child is in B.C., they have the right to be safe, protected, and to receive the same level and quality of services that any other child in the province receives. MCFD had a duty to ensure Romain was safe, supported, and receiving appropriate services once it was made aware of his presence in B.C. This duty was not fulfilled.

Throughout his time in care, Romain constantly reiterated his strong desire to be with his family in B.C. Although Alberta CS did not follow the Protocol in providing notice before sending Romain to B.C., it did respect his wishes and his voice by ensuring he was near or with family. However, because Alberta CS did not provide the required notice or case records and B.C. did not complete the required assessments of his placements with family, there was insufficient consideration given to the supports or services that would have been required for those placements to be successful.

Romain and his family would have needed much more support than they received from MCFD to cope with the challenges of living together after years of him being in care and with the significant trauma he had experienced, as well as his known mental health and substance use challenges. In hindsight, the breakdown of Romain's family placements seems inevitable with the lack of support he and his family received, and likely contributed to his own stated feelings of worthlessness, self-blame, emptiness, and not belonging.

"He needed someone who was committed no matter what to just be there for him, and somebody who had the capacity to do that . . . Honestly, I really feel like if there would have been consultation with extended family members – I can't speak with certainty, but I know every time we'd go to [Romain's mother's] house, there was a house full of loving people and at least, you know, a couple of them would have been competent in taking him in . . . I have family on my maternal side who are, like, active foster parents and, you know, so there were ways to keep him like connected . . . So being more intentional about the placement options would have been, like, essential."

—Romain's family member

MCFD and Alberta CS did not live up to the principles of the Protocol, that *"the safety, best interest and well-being of children and youth is the paramount consideration in all decisions"* and, in their jurisdictional and administrative disputes, they lost sight of their responsibilities to plan for and support Romain and his family. This lack of support to Romain started with insufficient case and care planning in the interprovincial

discussions and agreements, which trickled down to affect multiple areas of service provision, including the offering of trauma-informed services, cultural planning, appropriate resourcing, permanency planning, and support and counselling.

Trauma-Informed Practice

There is a growing recognition that chronic and complex trauma is at the core of many behavioural and psychological disorders experienced by children and adolescents. Trauma is one possible outcome of exposure to adversity. Trauma occurs when a person perceives an event or set of circumstances as extremely frightening, harmful, or threatening – either emotionally, physically, or both,[52] and it can have lasting and holistic effects on the individual's functioning.[53]

The Trauma-Informed Practice Guide (2016),[54] available to all social workers in MCFD, defines traumas as experiences which *"overwhelm an individual's capacity to cope."* Reactions to these traumas vary between individuals but are understood to include a continuum of experiences including *"anxiety, terror, shock, shame, emotional numbness, disconnection, intrusive thoughts, helplessness and powerlessness."*

Children who have experienced trauma tend to have more challenges than those who have not. These may include challenges with behaviour regulation, learning, and relational regulation.[55] Co-occurring mental health issues and disorders such as conduct disorder and oppositional defiant disorder, post-traumatic stress disorder and depression have commonly been associated with traumatic experiences.[56]

Romain's Experience

Romain experienced many adverse childhood experiences during his early childhood and while in care and living in Alberta and B.C., including but not limited to:

- His alleged experience of physical abuse and neglect while living with his father in Belize.
- According to Alberta CS records, Romain's repeated moves between his mother and father in his early childhood led him to tell a social worker he felt like *"He was passed around for 20 million years."*

52 Victoria Latham Hummer, Norin Dollard and John Robst, "Innovations in Implementation of Trauma-Informed Care Practices in Youth Residential Treatment: A Curriculum for Organizational Change," University of South Florida. *Child Welfare* 89. no. 2 (2010): 81.

53 Revital Goodman. "Contemporary Trauma Theory and Trauma-Informed Care in Substance Use Disorders: A Conceptual Model for Integrating Coping and Resilience," *Advances in Social Work* (Spring 2017): 187.

54 Nancy Poole, Christina Talbot and Tasnim Nathoo, "Healing Families, Helping Systems: A Trauma-Informed Practice Guide for Working with Children, Youth and Families," Centre of Excellence for Women's Health and Ministry of Health, Government of British Columbia. (November 2016).

55 Liz Wall, Daryl Higgins and Cathryn Hunter. "Trauma-informed care in child/family welfare services," *Australian Institute of Family Studies.* Australian Government. CFCA Paper No. 37. (February 2016).

56 Liz Wall, Daryl Higgins and Cathryn Hunter. "Trauma-informed care in child/family welfare services", *Australian Institute of Family Studies.* Australian Government. CFCA Paper No. 37. (February 2016).

Adverse Childhood Experiences

The Adverse Childhood Experiences (ACE) Study[57] conducted in San Diego in the 1990s is one of the largest population health research initiatives ever analyzing linkages between childhood maltreatment and household dysfunction with subsequent lifespan health and well-being outcomes. The study reviewed the life histories of more than 9,508 respondents regarding their first 18 years of life. Ten questions were categorized relating to abuse (emotional, physical and sexual), neglect, and household challenges (domestic violence, substance abuse, mental illness, parental separation or divorce and incarcerated household members). The study found that individuals who reported experiencing four or more categories of adverse childhood experiences were at substantially greater risk of subsequent substance misuse, mental and physical health issues, including chronic diseases such as diabetes. The study concluded that there is a strong relationship between the amount or severity of exposure to abuse and/or household dysfunction with multiple risk factors for several of the leading causes of premature death in adults. However, the negative impact of adverse childhood experiences can be mitigated by supporting families, connecting children and youth to positive caring adults and activities, offering appropriate care and treatment, fostering resiliency, and increasing coping capacities.

- In care in Alberta from the age of 11 on, Romain experienced multiple placement breakdowns and disruptions and times in involuntary secure care.
- While in care in Alberta, Romain experienced serious physical and sexual assaults.
- In February 2014, Romain was moved to Alberta against his wishes after his placement with a sister broke down. He made it clear to MCFD that he did not want to go and that he wanted to remain with family. He was assured by his Alberta case worker that he would not be returned to the same group home where he had previously been sexually assaulted. After a time in secure care, he was nevertheless placed in a group home that was collocated on the same campus where he had been assaulted.
- While in B.C., Romain served seven months custody, where he experienced physical assaults. He was eventually released to a two-bed emergency receiving home. Despite having a history of being the victim of a sexual assault, Romain was placed with another youth who was known to be sexually intrusive. Romain is believed to have been sexually assaulted by this youth.
- Romain had more than 40 different moves, including family, care homes, secure care, and custody centres in his short life.
- Romain expressed experiencing racism by service providers. Racialized trauma recognizes the subtle forms in which individuals and communities may be racialized or singled out for different treatment. This may include a lack of access to culturally safe services.

Romain's early childhood and family experiences likely contributed to his behavioural difficulties and substance misuse. This situation was likely exacerbated by constant placement disruptions and the sexual and physical assaults by his peers. In a meeting

57 Vincent Felitti et al. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study," *American Journal of Preventative Medicine* 56, Issue 6, June 2019: 774–786.

summary from 2017, the MCFD regional consultant acknowledged the link between Romain's history of traumatic events to his overall response style, stating, *"Romain often has difficulty managing his emotions in a safe way as he has spent much of his life having to fight to get his needs met."*

When Romain arrived in B.C. at the age 13, MCFD records indicate that he had *"a very serious behavioural and emotional problem."* His social worker was aware of the caregiver disruption and multiple placements he had experienced in Alberta, the abuse he had experienced, and that he showed complex behaviours as a result. When Romain started school in B.C. in 2013, he was described by school staff as exhibiting symptoms of PTSD. The school referred Romain to CYMH services.

During this time, assessments by mental health professionals acknowledged his prior diagnoses had not been effectively addressed or recognized in planning and service delivery. These written assessments made it clear that Romain required structured supervision with intense one-to-one support and encouragement, and that he was unlikely to do well in a school or residential setting without such supports. Recognizing his risks, the assessments noted that his team needed to target his known risk factors arising from trauma by implementing clear strategies and ensuring *"the presence of supportive, consistent adults within a stable, substance-free, long-term placement."*

RCY investigators interviewed a school outreach counsellor who worked with Romain, who described what he perceived as Romain's response to the trauma he had experienced. The counsellor described Romain as a *"gentle soul, very child-like,"* adding, *"He was also broken, ashamed and … 'crippled' in terms of the impact his childhood and events and traumas had had on him … It almost felt like it was impossible for him to move out of where he was at without some really strong support."*

> *"I wish, for youth, there were more programs, maybe geared towards trauma before they got into custody… not like an addictions program but a trauma program, that could really support youth. There are some kids in custody who maybe have committed some very violent things. But there are definitely some youth there that have … really hard lives and that have, like, snowballed into them being in custody. And I think that maybe before they get there, there could be more supports around trauma early on in their lives."*
>
> —Youth custody employee

A critical time for well-planned, comprehensive trauma-informed mental health interventions for Romain in B.C. would have been during his year-long stay with his mother from 2015 to 2016. At this time, the hope had been to stabilize Romain and support his family to live together. Although Romain's school and YPO were working to ensure he had some services and connection, there is no evidence of an over-arching plan, co-developed between MCFD and Alberta CS, to address Romain's behavioural and mental health concerns in a trauma-informed way. Providing these services was MCFD's responsibility. Specifically, the 2016 Interprovincial Agreement for Romain indicates that MCFD would:

- "strengthen his familial connections with his mother and sisters in B.C. Alberta requests individual and/or family therapy" and
- provide Romain with "opportunity and support to address his trauma and feelings of abandonment and neglect. Alberta requests individual and/or family therapy."

Bright Spot: School Support Program

One positive example of trauma-informed approaches in Romain's case was observed in the school's wrap-around program. Program staff provided a multidisciplinary approach including education, community engagement, addictions and counselling tailored to Romain's needs. This program repeatedly engaged Romain at home and in the community and was proactive in organizing planning meetings with MCFD staff and advocating for Romain based upon his wishes and identified needs. This included attending Romain's home in efforts to engage him and maintain his connection with the school and with services. It also included regularly organizing planning meetings with Romain and his mother and providing Romain's mother with education and support. The program supported the family through one of Romain's hospital admissions and provided an addictions counsellor for him. Recognizing a service gap for Romain in late 2015, this program further advocated with MCFD for a referral to an outreach counselor labelled as a *"goals coach"* in order to make the referral more acceptable to Romain.

"The system creates a lot of barriers unnecessarily for kids who already have been dealt the sour hand. Unnecessary ones ... time frames in getting things done; lack of recognition of needs in terms of mental health and general wellness. I think the thing I love about the [school program] is that we don't see our kids necessarily as files and cases. They're kids. We see them as people. And when you branch out into the large system, it's a file and it's an appointment. It's a tick in the box, it feels like . . . They're kids, and they don't deserve to be treated like a piece of paper or a file."

—School Program Supervisor

MCFD did not fulfil these responsibilities. They did not provide individual or family therapy or other opportunities for Romain to address his trauma and feelings of abandonment.

While living in B.C., Romain's self-injurious, suicidal, aggressive, attention-seeking and other mental heath and behavioural issues, including substance use, continued. The Representative cannot determine if these behaviours escalated while Romain was in B.C. due to the lack of documentation available from Romain's time in Alberta. However, once released from custody in February 2017, Romain's use of street drugs increased to the point that he was observed daily by emergency bed home staff as being significantly impaired. His traumas remained unaddressed.

In a 2014 RCY report entitled *Who cares? B.C. Children with Complex Medical, Psychological and Developmental Needs and their Families Deserve Better*, the Representative found that B.C. had been slow to adopt a system-wide approach that is integrated and trauma-informed.[58]

Given the significant and ongoing trauma that Romain experienced, he needed intensive wrap-around intervention and support and a long-term, stable placement.

58 *Who Cares? B.C. Children with Complex Medical, Psychological and Developmental Needs and their Families Deserve Better*, RCY (December 2014).

Trauma-informed care means providing services that are trauma-aware, safe, strengths-based and integrated. At the very minimum, trauma-informed services aim to mitigate these risks so as to not further harm individuals through re-traumatizing experiences, such as denying the child's concerns and wishes or disrupting connections through multiple unplanned placements.[59] The Representative is of the view that B.C. did not provide Romain with the trauma-informed care and services that he required while he was living in B.C.

Mental Health and Addictions Support and Counselling

Given Romain's history, it is unfortunate that the 2015 and 2016 Interprovincial Agreements did not identify a need for wrap-around supports and specific referrals to a community or private outpatient addictions centre, respite services or other programming that Romain clearly needed based on his presentation. Although the 2016 Interprovincial Agreement did request Romain receive trauma and mental health counselling, stating the B.C. was to "Provide Romain with the opportunity and support to address his trauma and feelings of abandonment and neglect [with] individual and/or family therapy," this did not occur.

> *"We felt powerless often because you had to … follow these certain routines, or you had to, jump through these hoops to get simple things done, like [Romain] seeing a clinician. When a young person agrees to see a clinician, that's a big deal, especially a traumatized . . . fragile young person."*
>
> —School support person regarding B.C. services

In 2015 MCFD referred Romain and his mother to the Family Preservation Program for a period of three months, a program that included bi-weekly interventions. This program is short-term and generally used for families with child protection concerns. It is not typically used to support a permanent ward in a return to living with a parent, nor does it offer trauma-informed mental health or substance use counselling as was recommended for Romain. This service provided Romain's mother with support for her ongoing conflicts with Romain.

Although well-intentioned and beneficial for Romain's mother, this service was insufficient in meeting Romain's needs given his history of trauma. In the course of the investigation, it appeared to RCY investigators that the social workers engaged with Romain were working from the assumption that he was resistant to services, resulting in fewer efforts by those workers to engage with him on his substance use, trauma, and mental wellness. This was shown through interviews RCY conducted with his YPO and social worker, both of whom mentioned Romain did not want services and that it *"didn't make sense to keep adding services that, at that point, Romain probably wasn't going to access anyway."* They noted, there was *"so much going on"* that they did not know where to start or what might help Romain.

Despite the challenges MCFD child services was having with Alberta's case planning, Romain was living in B.C. and he was a child whose behaviours were escalating and likely exacerbated by his trauma-filled life. Assessments indicated that Romain

59 Eva Klain and Amanda R. White, "Implementing Trauma-Informed Practices in Child Welfare," ABA Center on Children and the Law (November 2013): 3–5.

needed mental health and substance use services however he did not receive care and treatment that focused on his complex needs.

As a reason for not engaging community YFPS during Romain's 2015/2016 placement with his mother, his YPO offered to RCY investigators, *"We were going to leave counselling with [the school counsellor] at that point rather than get, forensics and a bunch of outsiders, involved. Romain appeared to be comfortable with [the school counsellor]."* MCFD informed RCY that decisions about the level of counselling required for a high-risk adolescent should be made by mental health professionals with clinical expertise such as those with youth forensics.

The lack of mental health and addictions services became more of an urgent issue when Romain was released from custody in February 2017 with no formal supports except for his ISSP worker and his YPO. There were no community orders requiring Romain to attend YFPS upon his release from custody. Through this time, Romain was frequently missing from his resource, not attending school, was allegedly sexually assaulted, had been hospitalized for substance use and self-harm, and MCFD was receiving repeat communications from his emergency bed home raising concerns that Romain was spiraling and at extreme risk. RCY investigators found no evidence of any safety planning or services in response to these clear warning signs and, within three months of being back in the community, Romain had died with no apparent supports other than his youth justice workers, his emergency bed home and his informal contact with his maternal family.

Practice Observation: Working with Survivors of Sexual Assault

Young people who are survivors of sexual assault may experience a myriad of feelings such as increased self-blame, negative self-concept, and anxiety.[60] Some may feel that their actions contributed to the incident and may be confused as to whether the incident was consensual. Male child sexual assault survivors may face additional challenges, brought on by the social attitudes and stereotypes about men and masculinity.[61] Some male children may feel shame or self-doubt in relation to not measuring up to society's perceptions of men and believing that they should have been strong enough to fight off their perpetrator. Some may have concerns or questions about their masculinity or their sexual orientation and may experience challenges in expressing their feelings.[62]

These feelings and concerns may contribute to a male child's reluctance to report an incident and may lead to the use of harmful coping strategies, such as the use of alcohol, drugs, and cutting. While most of the research on child sexual assault has focused on female survivors,

60 James E. Crawford-Jakubiak, Elizabeth M. Alderman, John M. Leventhal, Committee on Child Abuse and Neglect & Committee on Adolescence. "Care of the Adolescent After an Acute Sexual Assault," *American Academy of Pediatrics* 139, no. 3 (March 2017).

61 Charlotte Gagnier & Delphine Collin-Vezina. "The disclosure experiences of male child sexual abuse survivors," *Journal of Child Sexual Abuse* 25, no. 2 (2016).

62 Michelle Davies. "Male sexual assault victims: a selective review of the literature and implications for support services," *Aggression and Violent Behaviour* 7 (2002).

Practice Observation *(continued)*

there has been an emergence of literature that addresses the experiences of male child sexual assault survivors.[63] A review of the literature suggests that a child-centred approach, that is gender-sensitive and trauma-informed, may better support male survivors of sexual assault.

Access to advocates, multi-disciplinary teams,[64] and child advocate centres[65] were consistently identified as supportive practices. An advocate or a team educated on and trained to serve the unique experiences of male child sexual assault survivors are recommended. The advocate or team may provide the child with reassurance that they are not to blame and validate their experience as sexual assault. They may also inform the child of the significance of accessing support, provide the child access to supports and services, and improve the child's compliance with follow-up care.

The timely access to mental health services was also identified as important to ensure that male child sexual assault survivors acquire the support and skills they need to cope with their trauma.[66] Introducing children to positive coping strategies such as individual counseling, group therapy, peer-led support groups, and even alternative treatment modalities such as art, sports, journaling, and yoga were identified to improve outcomes and avoid the use of harmful coping strategies.[67]

Of most importance, was a gender-sensitive approach and the elimination of service gaps arising from services being directed toward female survivors. As most services and practices are female-centred, there is a great need for services and practices that recognize the unique experiences of male survivors. Moreover, the use of proactive strategies, as well as reactive strategies, was a common theme in the literature to enforce safety and minimize harms.[68]

In 2016, the Representative reported on the prevalence of sexualized violence in the lives of youth in care. The Representative recommended that MCFD implement a broad strategy with adequate policy, standards, resources and training to address sexualized violence against children and youth in care. MCFD has yet to satisfy this recommendation.

When asked about the lack of services for Romain in 2017, his social worker responded, *"I guess I should have offered counselling … Romain [was] in a holding pattern . . . It's an oversight. I hadn't really seen him for many, many months."* The Representative believes that the lack of mental health and substance use support arose from an overall lack of continuous, collaborative case planning, services and supervision. The Representative is

63 While emergent, there is still a lack of literature, awareness and education on male child sexual assault.
64 A team consisting of experts and professionals (law enforcement, child protection services, prosecution, mental health services, victim advocacy services, etc.).
65 Child advocate centres provide a safe and child-friendly environment to provide supports and services, reducing system induced trauma. A multi-disciplinary team works to prevent re-victimization and support the child's long-term well-being.
66 Marudan Sivagurunathan, Treena Orchard & Marilyn Evans. "Barriers to utilization of mental health services amongst male child sexual abuse survivors: service providers' perspective," *Journal of Child Sexual Abuse* 28, no. 7 (June 2019).
67 National Sexual Violence Resource Center, "Serving Teen Survivors: A Manual for Advocates" (2018).
68 Wilfred Laurier University Faculty of Social Work, "Policies and Practices of Child Welfare Agencies in Response to Complaints of Child Sexual Abuse 1960–2006" (September 2007).

concerned that Romain's status as a child in care in Alberta may have also influenced how his case was prioritized and responded to. MCFD clearly tried to serve Romain, but his social worker acknowledged that these were *"perhaps not the same services"* he would have received as a B.C. child in care.

Cultural Planning

Culture is commonly defined as the beliefs, values, practices, worldview, lifestyle and knowledge belonging to a particular group. Ultimately, it is the way a person interacts with – and makes sense of – their place in the world and in society.[69] Ethnicity refers to the ethnic origins of a person's ancestors, their "roots," not to be confused with their citizenship or place of birth. Ethnic identification reflects an individual's perception of their ancestry.[70]

Canadians of Caribbean descent

There are more than 37,700 Canadians of Barbadian descent residing in Canada.[71] Canadians of Caribbean origin make up one of the largest non-European ethnic-origin groupings in the country. In the 2016 Canadian Census, nearly 750,000 Canadians reported being of Caribbean descent or origin, with the largest group identifying as Jamaican.[72] The Canadian population of Caribbean origin is largely concentrated in Ontario and Quebec.

Romain's mother is a Canadian of Barbadian descent from the Maritimes. She also identifies as having distant Indigenous heritage. She told RCY investigators that Romain always identified as being of Jamaican descent, which she believes originated from his exposure to popular culture as opposed to his actual ethnic heritage. He was of European descent on his father's side. Romain had a large, caring extended family on both his paternal and maternal sides.

Under the Interprovincial Protocol, the originating province/territory is responsible for developing a *"thorough, detailed and long-term"* case plan. The Protocol indicates that the case plan should identify the goals of the placement, the services to be provided and the roles and responsibilities of the case workers and service providers.[73] However, the Protocol is silent on the responsibility for cultural planning. The Representative believes this is a gap in the current Protocol that should be addressed.

It is not surprising, then, that cultural planning for Romain was never part of the Interprovincial Agreements or discussions. RCY investigators found no evidence of formal or informal efforts by MCFD to discuss culture or to engage Romain with his culture. Most case workers involved with Romain did not appear to make any inquiries about his family's ethnic or cultural background or his own cultural identification. Case records reviewed for this investigation included physical descriptions of Romain and his

69 *Creating Cultural Safety*. Wabano Centre for Aboriginal Health. (January 2014): 3

70 "Ethnic Origin Reference Guide, Census of Population, 2016," Statistics Canada. https://www12.statcan.gc.ca/census-recensement/2016/ref/guides/008/98-500-x2016008-eng.cfm

71 "The Barbadian Community in Toronto," Barbados in Toronto. www.barbadosintoronto.com/the-bajan-community.html

72 "The Caribbean Community in Canada," Statistics Canada. https://www150.statcan.gc.ca/n1/pub/89-621-x/89-621-x2007007-eng.htm

73 Provincial/Territorial Protocol On Children, Youth and Families Moving Between Provinces and Territories. (April 2016.) Section 8.3.

mother rather than an informed ethnic or cultural identification, referring to him with terms such as *"mulatto"* or a *"light skinned black person."*

Bright Spot: Ontario's Anti-Oppression Approach to Child Welfare

Ontario's child welfare system includes the use of an anti-oppression approach that is aimed at removing the oppression faced by marginalized groups. An anti-oppression approach recognizes that those from marginalized social locations may not have the same access to power and resources as more dominant groups. This approach recognizes that power imbalances are socially construed and often result from the social norms, values, and perspectives imposed by the dominant culture. Keeping this in mind, the anti-oppression approach acts to consciously challenge the status quo to address inequalities.

An anti-oppression approach first analyzes power imbalances that exist based on a person's race, ethnicity, gender, class, employment status, geographic location, religion, sexual orientation and identity, age, and other social factors. The approach continuously identifies the processes by which power imbalances occur and begins addressing those imbalances at an individual, organizational, and systemic level. To address the inequalities, there is a continuous reflection of our own social location and how we consciously or unconsciously maintain power disparities in our individual, organizational and systemic actions. In doing so, the goal is for organizations to find more ways in accommodating for the disparities to diminish inequalities.

Ontario has included the anti-oppression approach into their Child Protection Standards, which sets out the framework in which child protection services are to be delivered.[74]

Throughout Romain's time in B.C., Alberta would have been responsible for overseeing his cultural planning, which was not mentioned in its brief case plan on the 2015 and 2016 Interprovincial Agreements. Despite its absence, B.C. ought to have considered whether culturally specific or targeted services may have been appropriate for Romain if they were available. Given the challenge of finding services matching Romain's needs that he would engage in, connection to a larger community and culture might have helped to develop a level of support, belonging and acceptance that Romain did not otherwise experience in either province. It is unclear to the Representative why this was not considered.

According to case records, Romain expressed to multiple MCFD and Alberta CS employees that he felt he was the victim of racism on the part of service providers. This feeling may have been a result of racialization, defined as *"the social process by which certain groups of people are singled out for unique treatment on the basis of real or imagined physical characteristics."*[75]

74 "An Anti-Oppression Framework for Child Welfare in Ontario," Ontario Association of Children's Aid Societies, (August 2010). http://www.oacas.org/wp-content/uploads/2017/01/Framework.pdf. "Ontario Child Protection Standards (2016)," Ministry of Children and Youth Services, http://www.children.gov.on.ca/htdocs/English/documents/childrensaid/Child-Protection-Standards-2016.pdf

75 "The Process of Racialization," York University, www.yorku.ca/lfoster/2006-07/sosi4440b/lectures/RACIALIZATION_THEPROCESSOFRACIALIZATION.html racialized definition

The impacts of racialization, although not always observable, can be measured in the over-representation of Indigenous and certain groups of minority children within the child welfare and youth justice systems.[76] In this way, racialization may occur both explicitly and implicitly based upon the beliefs and experiences of even the most well-meaning systems and their practitioners. RCY investigators found no evidence of staff even exploring the idea of talking to Romain about the impacts of racialization.

The necessity of connecting Indigenous children with their culture, language, extended family and community is critical to well-being. For children in care, or at risk of coming into care, cultural connection is a protective factor for which there are many documented positive outcomes including: decreasing the number of Indigenous children coming into care, improving care outcomes and providing the opportunity for life-long connection and identity.[77] The Representative believes a similar approach of using *"culture as medicine"* should be extended to non-Indigenous cultures. A major step in this direction would be the collection of information about ethnicity and culture for the purpose of planning and establishing broader community connections for children and their families.

Interrupted childhoods: Over-representation of Indigenous and Black children in Ontario child welfare[78]

The Ontario Human Rights Commission (OHRC) launched a public interest inquiry to identify whether racial disproportionalities were a potential indicator of systemic racial discrimination in the child welfare system. Although the data presented was not conclusive of discrimination, the report observed that it represented a starting point for the government to look critically at racial disparities which could indicate racial inequality. Agencies have a responsibility to ensure they are not unconsciously engaging in systemic discrimination and ensure they are meeting their obligation to provide services in a way that respects cultural differences.

What they found was that there were significant gaps in the collection of race-based data, including training on data collection, as well as differences in how racial backgrounds or Indigenous identities were determined. Few agencies had policies, procedures or training on the collection and recording of data.

Without adequate collection of race-based data, the determination of whether systemic racial discrimination is a factor that contributes to racial disparity can be challenging. Gaps in data collection also limit an agency's ability to: *"fully understand who they are serving; proactively address human rights concerns; measure progress of equity-based initiatives; gain trust with communities and stakeholders who may be concerned about racial disparities and disproportionalities in child welfare; and reduce exposure to possible legal action and human rights complaints."*

76 *Interrupted Childhoods: Over-representation of Indigenous and Black children in Ontario Child Welfare,* Ontario Human Rights Commission (February 2018).
77 *Creating Cultural Safety*, Wabano Centre for Aboriginal Health. January 2014, 3.
78 *Interrupted Childhoods: Over-representation of Indigenous and Black children in Ontario Child Welfare,* Ontario Human Rights Commission (February 2018).

When RCY investigators asked service providers if they felt Romain was treated differently due to his race, they all emphatically denied witnessing such treatment. This may be true but there is also a risk that MCFD and other service providers are operating unaware of cultural blindness, which refers to an *"inability to understand how particular matters might be viewed by people of a different culture because of the rigidity to the views, attitudes, and values of one's own culture, or because the perspective of one's own culture is sufficiently limiting to make it difficult to see alternatives."*[79]

Cultural blindness may extend to case workers not asking basic questions about ethnicity and culture of the children and families they serve. Beyond better understanding the backgrounds, needs or issues impacting their clients, the purpose and benefits of collecting this data is its utility in determining potential community connections and appropriate service-delivery options.

RCY Interprovincial Agreement Data Analysis: Cultural Planning

The Interprovincial template does not include a section for capturing the ethnicity of non-Indigenous children, nor does it include a section for cultural planning or cultural safety considerations. In the 157 Interprovincial Agreements reviewed by RCY in the course of this investigation, cultural planning was only identified in 10 per cent of those agreements.

Currently, MCFD's computer case management system has the ability to record ethnicity of the children MCFD serves, but this field is not being used reliably by social workers and is not mandatory for them to fill out. In the absence of information about the cultural identity, heritage, or ethnicity of the children MCFD is serving, the Representative questions whether MCFD is able to adequately connect children to possible cultural supports or to understand impacts of racialization. As a first step, MCFD ought to ensure its social workers are asking the children they serve how they self-identify ethnically and culturally, and that their social workers are using the already provided computer field to record this data.

Contracted Resources

One final area where service provision did not adequately support Romain was in planning his placement and resourcing while he was in B.C. In 2014, when Romain's sister could no longer safely provide care for him, Alberta CS informed MCFD that it had nowhere to send Romain except to a hotel or to live with his father in Belize. MCFD responded to Alberta indicating that it also had nowhere for Romain to go except *"a hotel [with] a youth worker."* Assessments from the time documented Romain's need for a skilled, stable placement with mental health support and a *"concrete community plan."* One mental health professional with whom Romain's B.C. social worker consulted commented that Romain was *"a highly traumatized boy"* and added that service providers kept *"putting him in other places with no stability."*

79 Definition of cultural blindness. American Psychological Association. Retrieved from: https://dictionary.apa.org/cultural-blindness

From interviews and files reviewed for this investigation, it is clear that Romain did not want to be returned to Alberta. He stated that he wanted to be near his mother and maternal sisters. It appears that the decision to return Romain to Alberta in 2014 was made by the Executive Director of Service (EDS) for the region in which Romain was living. It does not appear that Romain's wishes to stay close to family in BC nor the emotional impact that this could have on Romain was considered by either province. Upon his arrival in Alberta he was handcuffed and placed in secure care and ultimately placed in the same group of residences in which he had been assured he would not be placed, something that would have further traumatized him.

From RCY's perspective, this decision was not in Romain's best interest, was contrary to his wishes, and it likely greatly exacerbated the trauma he had already experienced and his lack of trust in the system's ability to meet his needs. A trauma informed, child-centred decision would have taken into account the child's and family's interests and needs in the development of a negotiated comprehensive plan and Interprovincial Agreement between the parties and would likely have aimed to stabilize and support the child closer to family and apart from the known harm he had experienced in Alberta. Costs and financial implications should have been subsequently determined.

During Romain's time with his mother in 2015 and 2016 – when it was evident that the placement with her was breaking down – it is unclear if offering additional supports or placing him in a residential resource were options considered by MCFD and Alberta CS. Once Romain arrived back in B.C. in July 2016, this matter became an urgent issue. Soon after his arrival, Romain was in custody and Alberta CS was informing MCFD that its plan was for him to live alone or with a sister. MCFD rightly pushed back on this placement. In an email sent by the area's regional practice consultant in July 2016 to both province's teams, she stated: *"I am concerned that this young man was sent here without planning for a placement or other services he needs."* She also sent Alberta CS the Protocol, requesting that it be followed. By August 2016, an email between the teams of both provinces sent by the regional practice consultant stated, *"For now, we are all in agreement to seek a residential home in B.C."*

Once this plan to find a residential placement for Romain was agreed to, B.C. ought to have promptly begun coordinating residential services for Romain's release from custody. Instead, creating an appropriate resource for Romain became yet another jurisdictional dispute between provinces regarding finances and planning that was never resolved or brought to a dispute resolution process.

In reviewing the file notes and in interviews, it was clear to RCY investigators that service providers in B.C. were working hard to resolve the issue and continuously pushing Alberta CS to respond with a concrete, mutually acceptable resource plan for Romain. However, at a certain point, one of the several senior MCFD employees involved in these negotiations ought to have recognized that this matter had gone on far too long and taken ownership of developing a resource while initiating a dispute resolution process. Romain was secure and in custody for half a year, which ought to have been ample time for MCFD to develop or locate a suitable placement for him.

For reasons never made clear to RCY investigators, Romain's specific placement needs were not mentioned in his 2016 Interprovincial, which was signed in November 2016. This was a large omission, as it meant there was no documented, formal statement by Alberta CS that it would support the cost of a specialized resource or that it had really considered what Romain's placement needs would be. The Representative believes that the Interprovincial Agreement should never have been signed by MCFD without a clear plan to resource and properly support Romain.

Romain's MCFD YPO persistently contacted the resource team in the area and Romain's Alberta CS social worker, trying to understand his placement plan but did not receive a concrete response. His MCFD social worker also tried to contact resources with no success. The resource team wrote back that given the concerns around Romain, he needed a more intensive, specialized resource. This was reflected in a resource referral form filled out in September 2016 stating that *"Romain should really be placed in a highly skilled resource."* After multiple inquiries by Romain's MCFD social worker, she received confirmation from Romain's Alberta CS social worker in October 2016 that the resource was approved.

After the resource was approved, the issue was forwarded to the MCFD resource contracting team for Romain's area. After this point, the decision-making appeared to stall. RCY investigators learned that MCFD never even began developing a resource for Romain. The MCFD resources manager told investigators:

> *"They required a budget breakdown from our end as to how much a residential service would cost . . . it seemed a bit odd that we would have a $15,000 to $20,000 budget cap without the budget breakdown necessarily, because we didn't have an identified resource. So, in terms of efforts to, to do an RFQ [request for quotation] or create or design something, that process didn't [happen]. In my recollection, no, we, we did not proceed with a contracted resource development."*

The resources team leader explained that MCFD never took steps to develop a resource for Romain because the financial maintenance amounts pledged by Alberta were never negotiated or confirmed. This again illustrates a lack of understanding of interprovincial cases at the local level and the need for a provincial coordinator overseeing and supporting these cases. As this negotiation was happening under the 2016 Protocol, B.C. did not need further commitment from Alberta. The Protocol is clear that the originating province is responsible for paying for the cost of a resource at the receiving province's rate.

By the time Romain was released from custody in February 2017, MCFD had not developed a placement for him and he was released to an emergency resource, a two-bed emergency bed home where he remained until his fatal overdose. One of the principles of the Protocol is that services are not to be delayed due to budgetary, administrative, or jurisdictional issues or disputes and, where these things do arise, a timely and effective resolution should be achieved. The Director of Operations had raised concerns about Romain's placement with her staff but didn't escalate the matter to her superiors or to dispute resolution.

The Representative acknowledges that the availability of an appropriate resource, or the creation of specialized resource for Romain, would not have guaranteed a different outcome. However, a resource tailored to Romain's needs could have provided a strong start towards addressing his substance use, mental health and trauma needs. At a minimum, despite whatever resource limitations MCFD faced, Romain should never have been placed in an emergency bed home where the staff raised concerns about the risks of sexual intrusion from another youth. After the staff raised the concerns, there are no documented responses by MCFD resources or child services to address them.

Emergency bed home staff told RCY investigators that they had consistently raised concerns regarding Romain's long-term placement there, clearly communicating that he was *"living in a resource that wasn't meeting his needs."*

Over the years, serious concerns have been raised regarding shortcomings in the system of contracted residential services for children and youth in care including issues around lack of oversight and monitoring by MCFD in its use of contracted residential services.

In 2012, the *Residential Review Project: Final Report* was released as a joint report by MCFD and the Federation of Community Social Services of BC.[80] This report identified issues and made recommendations on the use and management of contracted residential resources. Of note, the report recommended that MCFD develop a planned system of contracted residential services that would meet the care and treatment needs of children and youth in care.

In following years, the Representative continued to raise concerns about contracted residential services. For example, in RCY's *Who Cares?* report released in 2014, the Representative recommended improvements to the system and the creation of *"an oversight and accountability body to advise on and guide the creation of a continuum of residential services."*[81]

In 2017, the RCY released two investigative reports, both of which discussed the many shortcomings of contracted residential services. In *Alex's Story*, the RCY found there was a lack of oversight of contracted residential resources which directly contributed to the harms suffered by Alex and to his ensuing death. The report included the recommendation that MCFD *"allocate additional resources within the ministry to significantly enhance the provision of quality assurance oversight and financial accountability for all contracted resources."*[82]

In *Joshua's Story*, the RCY reiterated the lack of a well-developed system of contracted residential services, particularly for those with serious mental health issues. Moreover, this report stated that there was a lack of available and appropriate contracted residential services for young people, contributing to the overall decline in the well-being of young people.[83]

80 *Residential Review Project: Final Report*, Federation of Community Social Services of B.C. and Ministry of Children and Family Development (June 2012).
81 *Who Cares? B.C. children with complex medical, psychological and developmental needs and their families deserve better*, RCY (December 2014).
82 *Broken Promises: Alex's Story,* RCY (February 2017).
83 *Missing Pieces: Joshua's Story,* RCY (October 2017).

In 2018, the Representative released a statement calling attention to the ongoing issues in contracted residential services and called for MCFD to make significant changes. In response to this statement, the Minister of Children and Family Development acknowledged the ongoing issues and stated the ministry's plan to overhaul the system of contracted residential services.[84]

In June 2019, the Office of the Auditor General released a report, *Oversight of Contracted Residential Services for Children and Youth in Care*, concluding that MCFD was not providing effective oversight of contracted residential services.[85] Of note, the Auditor General found that the current system was more reactive than proactive, with services being used on an ad hoc basis resulting in unnecessarily high costs and a higher risk that young people are not receiving the care and treatment they need. Contributing to this problem was the lack of oversight and a province-wide strategy, a lack of effective monitoring and planning of services, a lack of effective contract management, and a lack of consistency in policies, standards and service descriptions on the use of contracted residential services. Importantly, the Auditor General found that the current system failed in providing adequate support and care that was culturally appropriate for Indigenous children and youth utilizing contracted residential services.

The Auditor General's report made four recommendations: (1) MCFD create, implement and communicate a strategy for contracted residential services; (2) MCFD clarify roles and responsibilities related to policy development, information-sharing, communication and monitoring for the delivery of contracted residential services; (3) MCFD establish a quality assurance framework; and (4) MCFD improve management and oversight of contracts. The Auditor General called for the ministry to work in partnership with Delegated Aboriginal Agencies and Indigenous communities to fulfil these recommendations.

The Auditor General's report echoed what has already been said many times before. The issues in the system of contracted residential services are systemic, with repeated concerns being raised by multiple organizations. If not addressed, these issues will continue to affect some of the most vulnerable children and youth in care, who require appropriate and available services to meet their needs.

The Representative finds that MCFD continues to be challenged when it comes to providing adequate residential resourcing complete with the type of trauma-informed and/or low-barrier service delivery required for children such as Romain with complex needs including unresolved trauma, mental health or substance use, or other behavioural issues.

The lack of planning and coordination between the provinces left Romain in a resource that was clearly and frequently communicating to MCFD that it was unable to meet his considerable needs at a time when he was using an increasing volume of substances

84 "Statement on residential agencies," RCY (June 12, 2018).

85 *Oversight of Contracted Residential Services for Children and Youth in Care,* Office of the Auditor General of British Columbia (June 2019).

and was very vulnerable. The outcome for Romain could have been different had he received appropriate, adequate support, including a skilled residential placement with accompanying trauma-informed, wrap-around counselling services and support for his familial and cultural connections, from the time he first came to B.C. in 2014 through to the final months of his life.

Recommendations

Recommendation 1

That the Ministry of Children and Family Development bring forward to the next review of the Protocol by the Directors of Child Welfare recommendations to address shortcomings. These include the addition of cultural planning to the Protocol; clarification that when a child arrives from another province or territory without notice, the dispute resolution process may be triggered; clarification about delegation of guardianship responsibilities; and an amendment to Interprovincial Agreement forms to allow for detail regarding financial expenditures and payment mechanisms.

Recommendation 2

That the Ministry of Children and Family Development fully dedicate an Interprovincial Coordinator who will work together with an adequately resourced network of regional analysts to support, track and monitor interprovincial cases.

MCFD to put this network in place by December 2020.

Recommendation 3

That the Ministry of Children and Family Development create provincial practice guidelines or policies for interprovincial cases and develop an online training course that is required for staff who work on interprovincial cases.

MCFD to complete this work by December 2020.

Recommendation 4

That the Ministry of Children and Family Development direct staff to speak with children in care about their ethnicity and desired cultural supports/connections and record the child's self-identified ethnicity in the ministry's case management system.

MCFD to complete this step by June 2020.

Recommendation 5

That the Ministry of Children and Family Development ensure a trauma-informed method is implemented in resourcing decisions for children in its care who have experienced multiple adversities in their lives.

MCFD to have this trauma-informed method to resourcing in place by June 2021.

Recommendation 6

As part of the Ministry of Children and Family Development's overhaul of residential services, MCFD to assess the need for residential care and treatment resources across the province to accommodate children with complex needs and to create sufficient resources to meet the assessed need in a timely way.

MCFD to complete this work by September 2021.

Appendix 1: Methodology

The *RCY Act* requires that MCFD and other public bodies report to the Representative on critical injuries and deaths of children who received a reviewable service from MCFD in the year prior to the critical injury or death.[86]

The Representative conducts an initial review of these reports to determine whether an injury or death of a child meets the criteria for a comprehensive review under the *RCY Act*. The comprehensive review assists in the determination of whether a full investigation is warranted.

The Representative conducted an initial review of Romain's fatality in May 2017. Following the initial review, a comprehensive review commenced. In September 2017, the BC Coroner's Service completed its review of Romain's death with a recommendation that RCY examine the case.

RCY's comprehensive review, completed in January 2018, found that Romain's overdose death met the requirements for an investigation because a reviewable service and/or the policies and practices of a public body may have contributed to his injuries and overdose. Although MCFD was still conducting its own internal case review (which was completed in September 2018), MCFD granted the Representative permission to begin an investigation in March 2018.[87] The RCY investigation commenced the following month.

The RCY investigation focused on the entirety of Romain's life and specifically the time in which MCFD, as well as Health and Education services, were involved with Romain (October 2013 to February 2014; June 2015 to June 2016; and July 2016 to May 2017). Romain spent most of his childhood in Alberta and Belize. The Representative does not have the legislative authority to make findings or recommendations about child welfare practice in Alberta. Alberta Children's Services (CS) was contacted and invited to participate in this investigation. Alberta CS did not provide case records or make social workers and other involved professionals available for interview. Instead, it agreed to review Romain's chronology completed by RCY and to provide fact verification and accuracy regarding events that occurred in Alberta and regarding Alberta CS's interprovincial planning with MCFD.

RCY investigations aim to understand the experience of the child who is the subject of an investigation. For Romain's case, this required a review and analysis of documents from a variety of sources, including MCFD, hospitals, schools, police departments, government offices and non-profit organizations (see Appendix 5).

RCY also conducted interviews with 42 individuals, including family members and involved B.C. professionals, who provided sworn evidence to RCY investigators (see Appendix 4). Significant case documentation was not reviewed by investigators due to an unfortunate incident where the notes of the key social worker responsible for Romain while he was in B.C. from 2015 through to his death in 2017, were lost by MCFD.

86 Reviewable services are outlined in the *RCY Act* and include services or programs under the *Child, Family and Community Service Act* and the *Youth Justice Act*; mental health services for children; and addiction services for children.

87 Under the *RCY Act*, the Representative was required to wait for MCFD to complete its internal review (to a maximum of 12 months from the date of the critical injury). However, s. 13 of the *RCY Act* allows MCFD to provide written consent to waive this review time.

The Representative makes every attempt to include a child's family in the investigative process to obtain valuable information that may not be available in records and to provide an accurate reflection of the family's story. This is not always possible, however, as in some cases circumstances prevent meaningful participation by family members. In Romain's case, three family members, including Romain's mother, voluntarily participated in interviews and maintained contact with RCY investigators throughout the investigation. Although he initially agreed to the process, Romain's father did not attend a scheduled interview with RCY investigators, nor did he respond to follow-up interview requests.

In order to better understand how interprovincial cases are typically dealt with, the Representative's investigators also reviewed 157 Interprovincial Agreements provided through a data request made to MCFD (see Appendix 3).

The Representative's Multidisciplinary Team (see Appendix 2) met on two occasions to provide feedback to RCY investigators. For the purpose of administrative fairness, organizations and individuals providing evidence for this investigation, including Romain's family, were offered an opportunity to review the draft report and provide feedback.

Appendix 2: Multidisciplinary Team Members

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

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

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

- BC Coroners Service
- Ministry of Children and Family Development
- Youth Justice
- Child health, mental health and trauma
- Child abuse and revictimization
- Education
- Caribbean ethnicity and cultural perspective.

Wilma Clarke is the Assistant Director Social Policy and Projects Division, Arts Culture and Community Services with the City of Vancouver. Previous to this, she was the Executive Director, Teacher Certification Branch with the B.C. Ministry of Education. She brings extensive experience in the social services and education fields and is also of Caribbean descent. She offers extensive insight regarding many of the cultural experiences of Caribbean-Canadian and Afro-Canadians and specifically their experiences in relation to the dominant culture.

Dr. Lisa Van Bruggen is a registered psychologist with the Vancouver Island Health Authority, Queen Alexandra Centre for Children's Health – Child, Youth & Family Mental Health Services. She brings extensive experience regarding child and youth mental health, and the impact of trauma on children's developmental process.

Michael Egilson is the Chair of the Child Death Review Unit for the BC Coroners Service. Michael has worked in the public sector for the past 30 years in various capacities related to the health and well-being of children and youth. He has convened multiple child death review panels culminating in public recommendations to improve public safety and prevent similar deaths in the future. He has lent his expertise to previous investigations conducted by the Representative.

Alan Markwart is the Acting Deputy Representative for Children and Youth, bringing to the position more than 40 years working in justice and children's services. He retired from the Ministry of Children and Family Development in 2013 as an Assistant Deputy Minister with extensive experience and responsibility for youth justice and forensic psychiatric services, children's mental health services and youth services in the province. He is recognized as a provincial and national expert and leader in youth justice who has helped to shape the evolution of youth justice legislation, programs and services for the past 30 years. He has also authored and co-authored numerous book chapters and articles in scholarly journals, which led to his appointment as an adjunct professor in the School of Criminology at Simon Fraser University.

Appendix 3: Interprovincial Agreement Data Review

Interprovincial Agreement Data Request

Section 10 of the *RCY Act* provides the Representative with authority to obtain information in the custody or control of a public body that is necessary for the Representative to exercise her mandate.[88] The Representative initially asked MCFD to provide the number of children from out of province receiving services in B.C. and the number of B.C. children receiving services out of province under Interprovincial Agreements. The ministry was unable to provide this data because it is not tracked centrally. Rather, Interprovincial Agreements are included in individual client files. The Representative then requested that MCFD provide copies of all active Interprovincial Agreements as of March 1, 2019. The ministry requested Interprovincial Agreements from the 24 DAAs and the 13 SDAs to provide to the Representative.

The Representative received a total of 160 agreements. However, MCFD was not confident that it had provided every active agreement. A total of 157 of the agreements received were original agreements (ie. not renewal agreements). The Representative analyzed these 157 agreements. Of the total reviewed, 86 agreements concerned children who were in B.C. from another province or territory and 71 agreements concerned children from B.C. receiving services in another province or territory.

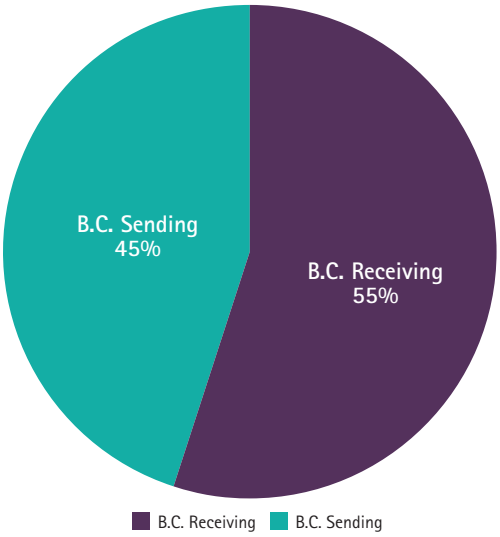
Generally, the Representative found inconsistency in how the agreements were completed. The Representative saw examples of robust case planning, agreements that included information about a child's background and life, agreements that clearly explained the reasons for the out-of-province placement, and agreements that included details about the planning for the child and the financial responsibility for the child's care. However, the Representative also saw a concerning number of agreements with minimal planning, limited information about the child and the reason for the placement, and very few details about services and financial responsibilities. Many of the agreements were not even signed.

88 Section 10 of the *Representative for Children and Youth Act*, S.B.C. 2006, c. provides the authority to the Representative any information that is in the custody or control of a public body other than an Officer of the Legislature, or a Director, and is necessary to enable the Representative to exercise her powers or perform her functions or duties under this Act. The public body or Director must disclose to the Representative the information to which the Representative is entitled.

Data Analysis – Provincial/Territorial Placement Breakdown

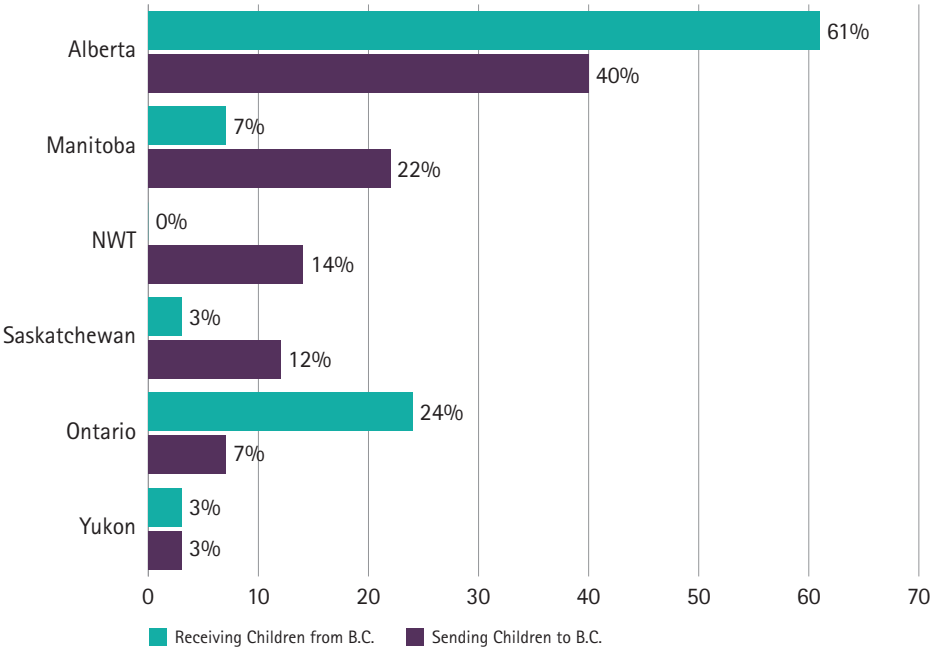
The table below (Figure 1) shows the 55 per cent (N=86) of agreements received by B.C. compared to the 45 per cent (N=71) of agreements sent by B.C. to other provinces and territories.

Figure 1: The percentage of agreements received and sent by B.C. in the sample



The table below (Figure 2) shows the provinces and territories most actively involved in sending or receiving children on Interprovincial Agreements with B.C. The most active province is Alberta, representing more than half of the agreements, followed by Manitoba, Northwest Territories, Saskatchewan, Ontario and the Yukon. Most but not all of the provinces and territories completed an agreement with B.C.

Figure 2: Percentage of Provinces/Territories sending and receiving agreements with B.C.



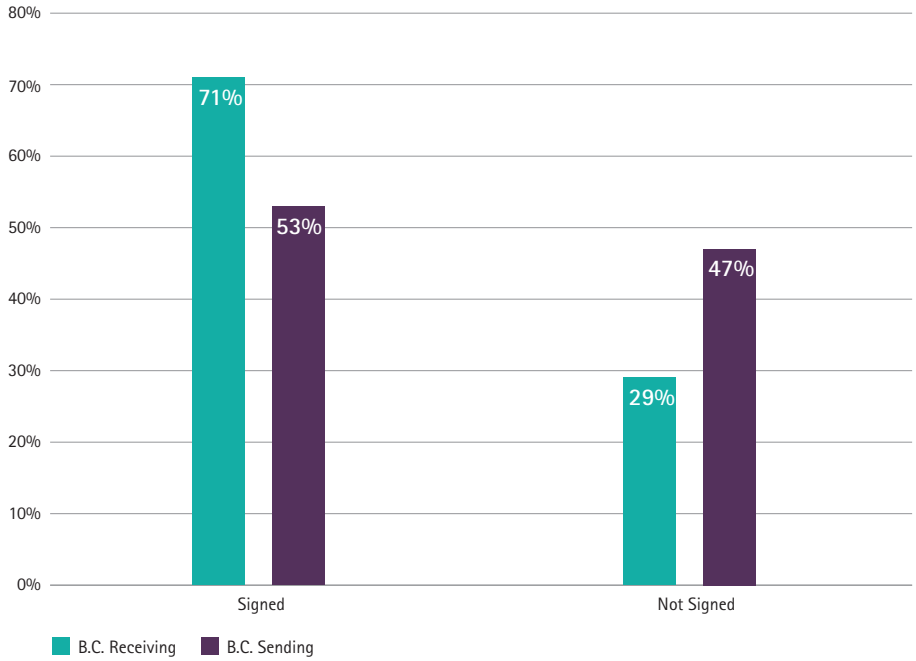
Note: The majority of the other nine provinces and three territories were involved in planning agreements with B.C. but only the most involved provinces and territories are represented in this table.

Data Analysis: Signatures

Of the total 157 reviewed agreements, 63 per cent (N=99) were jointly signed, while 37 per cent (N=58) of the agreements were signed by one or neither jurisdiction.

The table below (Figure 3) shows the percentages of signed agreements received and sent by B.C.

Figure 3: Percentage of signed agreements received and sent by B.C.



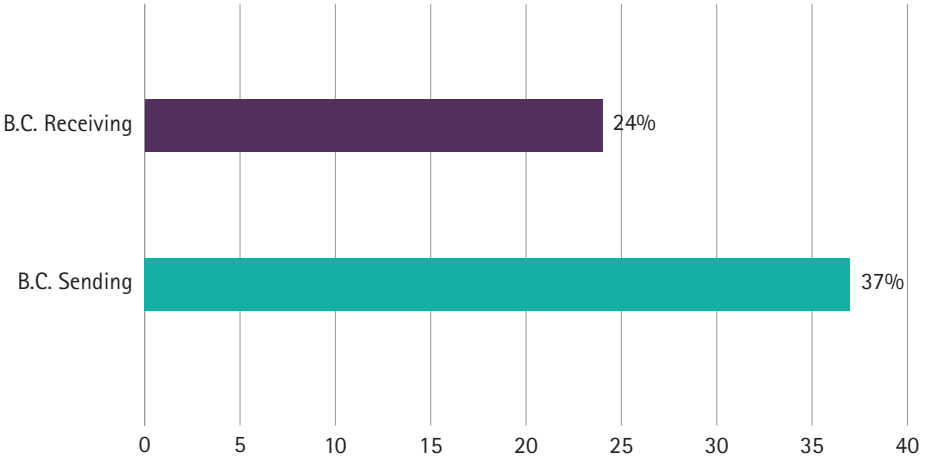
Data Analysis: Case Planning and Management

Agreements were reviewed for case planning descriptions including the purpose, timeline and resources to be dedicated; the reason for the interprovincial transfer; and the key care and planning activities and responsibilities.

Although case planning and management currently exists as a field within the Interprovincial Agreement template, only 30 per cent of the reviewed agreements included detailed descriptions of case planning and management activities and responsibilities including the identification of the reason and purpose of the agreement.

The table below (Figure 4) compares the percentage.

Figure 4: Percentage of completed case planning and management within the agreements sent and received by B.C.



Note: The current Interprovincial Agreement template includes case planning and management activities together instead of separating the case plan from the management tasks and activities to be completed. The majority of reviewed agreements were observed to default to the inclusion of activities only, without identifying the specific case plan or purpose of the agreement. There is nowhere in the agreement template for the inclusion of a brief case summary about the child, which would serve to further inform the purpose and planning for the agreement.

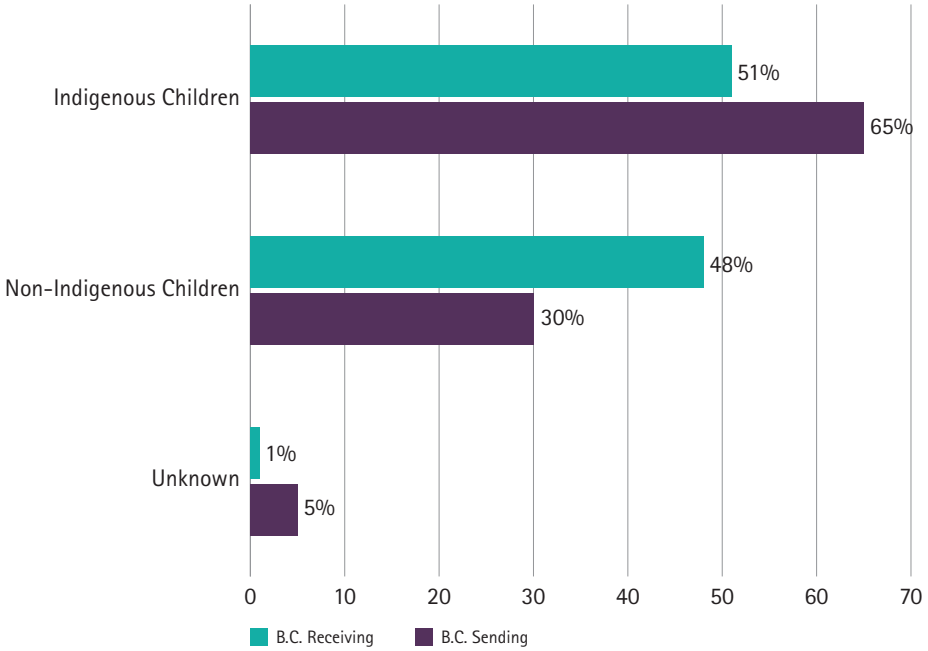
Best Practice: A 2018 agreement completed by an SDA for the purpose of a child being adopted by a grandparent living in another province provided a fulsome summary of case planning and management responsibilities for both provinces with an excellent itemization of all the child's records and assessments.

Data Analysis: Cultural Planning

The Interprovincial Agreement template includes a section for identifying the Indigeneity of a child including the child's community or band name. Fifty-nine per cent of the total reviewed agreements indicated an Indigenous child, with an additional three per cent of the agreements involving children whose Indigeneity was unconfirmed.

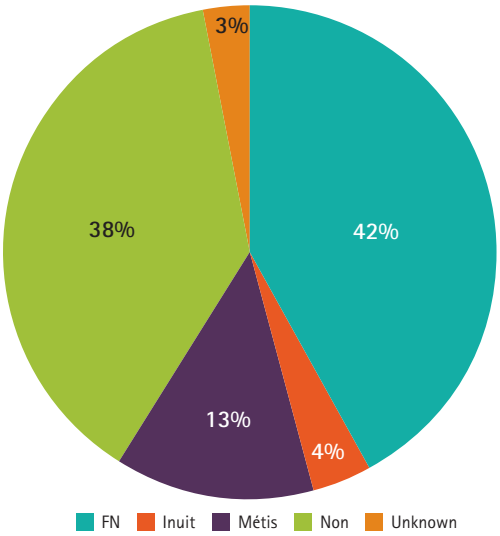
The tables below reflect a summary of Indigeneity of all the children on the reviewed Interprovincial Agreements within the sample.

Figure 5: Percentages of the Indigeneity of children identified in the sample of agreements



Note: There was no reliable data on children of non-Indigenous ethnic identities received or sent by agreement.

Figure 6: Percentages of Indigeneity of the children receiving agreements



Note: This table summarizes the 157 total reviewed agreements and reflects how Indigeneity was summarized within the agreements.

There is no current section within the Interprovincial Agreement template for cultural planning, and cultural planning activities were included in only 10 per cent of the reviewed agreements.

Currently, the Interprovincial Agreement template does not include a section for capturing the ethnicity of non-Indigenous children.

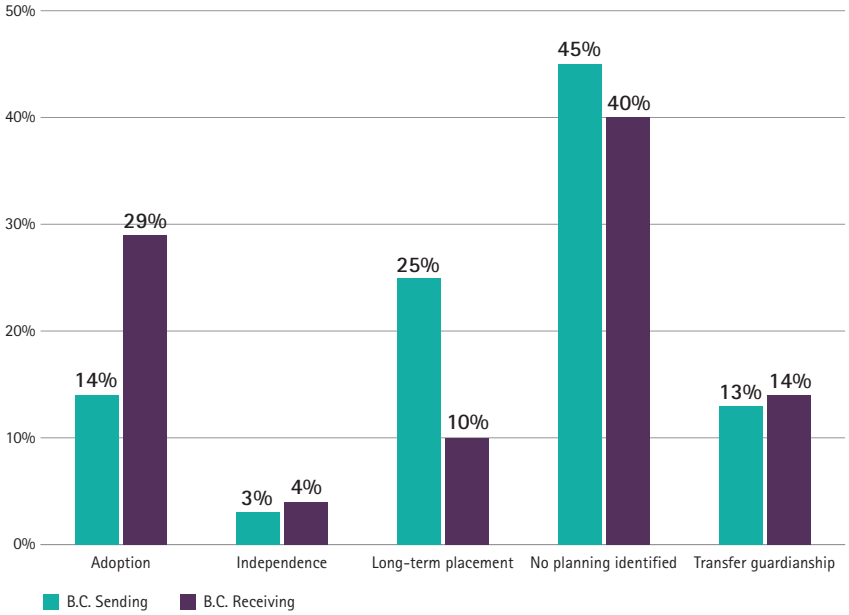
Best Practice: A 2017 agreement completed by a DAA for the purpose of placing a child into a long-term living situation with a family member living in another province demonstrated best practices across all reviewed responsibilities. This included a clear case plan with a fulsome list of responsibilities, financial planning and cultural planning on behalf of the child. This type of best practice is noted given the lack of a cultural planning section or prompts contained within the Interprovincial Agreement template.

Data Analysis: Permanency/Transition Planning

The inclusion of permanency and transition planning exceeded all other reviewed planning activities within the agreements. For the purpose of this review, placement with family of origin is considered as family reunification, while placement with extended family is coded as either a long-term placement, adoption and/or transfer of guardianship.

Of the total agreements, 59 per cent involved descriptions of permanency or transition case planning including adoptions, long-term placements, transfers of guardianship, family reunifications and youth independence. Of the total agreements, 41 per cent did not involve permanency or transition planning identified within the case planning or as a management activity.

Figure 7: Percentages of permanency/transition planning identified in agreements received and agreements sent by B.C.



Note: Agreements were reviewed for case planning or management activities which indicated permanency or transition planning including adoption, independence, long-term placement or transfer guardianship. Agreements that did not identify planning beyond the placement were determined as no planning identified.

Interprovincial Agreement Data Analysis: Financial Data

There is a section within the Interprovincial Agreement template for documenting financial arrangements and 70 per cent of the total reviewed agreements included some financial planning.

Of concern, nearly one-third, 30 per cent, of the remaining reviewed agreements lacked any type of financial arrangements despite the importance of funding to any out-of-province placement and the existence of a dedicated financial section within the template.

Best Practice: Two 2019 agreements completed by an SDA for the purpose of placing children into separate placements in another province included the itemized costs for additional placement supports such as respite, infant care, babysitting, recreation and funding for exceptional travel including to medical appointments or foster parent training.

Appendix 4: Interviews Conducted During the Representative's Investigation

- Family members (3)
- Community social service providers (2)
- Community agency child care workers (2)
- Hospital staff (1)
- Emergency staffed residential resource (e-bed) managers (2)
- MCFD child protection and guardianship staff and managers (14)
- MCFD youth justice staff and managers (9)
- MCFD Youth Forensic Psychiatric Services staff (4)
- School staff members (4)

Total: 41 individuals interviewed

Appendix 5: Documents Reviewed for the Representative's Investigation

Medical Records
Hospital medical records

BC Coroners Service Records
Kimble report
Coroner's report

Ministry of Education Records
School records

Community Agencies
Records from two community service agencies

Law Court Records
Youth justice Provincial Court records, including court proceedings and release documentation

Police Records
Records from five police departments/detachments

Contracted Service Provider
Emergency staffed residential resource records

Alberta Ministry of Children's Services
Partial records obtained from MCFD

MCFD Records
Family Service file
Child Service file
Electronic case management records
Youth justice – community
Youth justice – youth custody
Youth Forensic Psychiatric Services
Quality Assurance File Review, 2018
Interprovincial Placement Agreements (requested s. 10 Data – see Appendix 3)

MCFD Standards and Policy

British Columbia Ministry of Children and Family Development. (2003). Child and Family Service Standards

British Columbia Ministry of Children and Family Development. (2019). Children and Youth in Care Policies – Chapter 5

British Columbia Ministry of Children and Family Development. (2012). Child Safety and Family Support Policies

British Columbia Ministry of Children and Family Development. (2015) (2018). Reportable Circumstances Policy Practice Guidelines

British Columbia Ministry of Children and Family Development. (2017). Practice Guidelines: Responding to and Supporting Youth at Risk and/or Parent(s) known to be using Illegal Opioids

British Columbia: Ministry of Children and Family Development. (2016). Model of Care for Children and Youth Experiencing Complex Care Needs

British Columbia: Ministry of Children and Family Development. (2016). Healing Families, Helping Systems: A Trauma-Informed Practice Guide for Working with Children, Youth and Families

British Columbia Ministry of Children and Family Development. (2012). Community Youth Justice Programs Operations Manual

British Columbia Ministry of Children and Family Development. (2014). Care Plan Practice Guide

British Columbia Ministry of Children and Family Development. (2017). Practice Guideline For Centralized Services Hub Screening of Caregivers in Contracted Agencies

British Columbia Ministry of Children and Family Development. (2003). Child and Family Service Standards

British Columbia Ministry of Children and Family Development. (2013). Practice Directive: CARECARD – BC Services Card and BC Pharma Care

Interprovincial Guideline

Provincial/Territorial Protocol On Children, Youth and Families Moving Between Provinces and Territories (2016)

Provincial/Territorial Protocol On Children and Families Moving Between Provinces and Territories (2011)

Legislation

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

Province of Alberta – Child, Youth and Family Enhancement Act (2000). Edmonton, AB. Alberta Queen's Printer.

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

Mental Health Act (1996). Victoria, B.C. Queen's Printer.

Representative for Children and Youth Act (2006). Victoria, B.C. Queen's Printer.

Contacts

Representative for Children and Youth

Phone
In Victoria: 250-356-6710
Elsewhere in B.C.: 1-800-476-3933

E-mail
rcy@rcybc.ca

Fax
Victoria: 250-356-0837
Prince George: 250-561-4624
Burnaby: 604-775-3205

Website
www.rcybc.ca

Offices
400 – 1019 Wharf Street
Victoria, B.C. V8W 2Y9

1475 10th Avenue
Prince George, B.C. V2L 2L2

#150 4664 Lougheed Hwy.
Burnaby, B.C. V5C 5T5

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

@rcybc and @rcybcyouth

Rep4Youth

@rcybcyouth

REPRESENTATIVE FOR
CHILDREN AND YOUTH