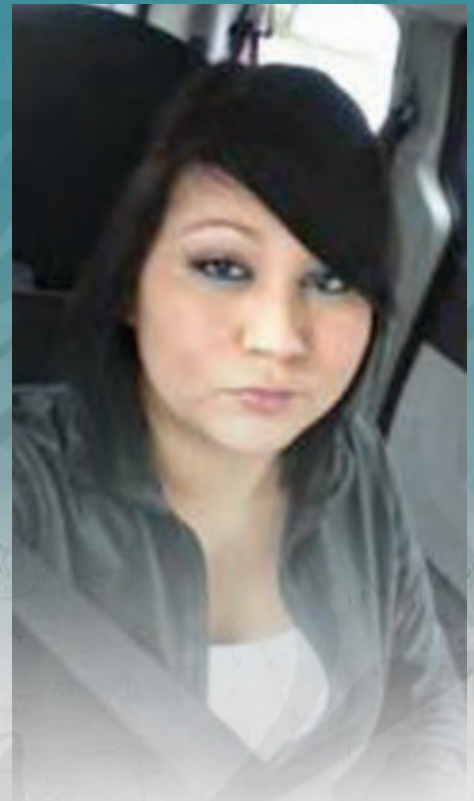


# Paige's Story

ABUSE, INDIFFERENCE  
AND A YOUNG LIFE DISCARDED



REPRESENTATIVE FOR  
CHILDREN AND YOUTH

May 2015



May 14, 2015

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

Dear Ms. Speaker,

I hereby submit the report *Paige's Story: Abuse, Indifference and a Young Life Discarded* 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,

A handwritten signature in black ink, reading "melturpelafond". The signature is written in a cursive, lowercase style.

Mary Ellen Turpel-Lafond  
Representative for Children and Youth

pc: Craig James  
Clerk of the Legislative Assembly

Jane Thornthwaite  
Chair, Select Standing Committee on Children and Youth



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# Preface

There is no greater tragedy than the death of a child or youth, especially when it could have been prevented. It is an occurrence that produces an immense and unrelenting sense of loss and grief for the immediate and extended family and also a tremendous loss of potential for society as a whole.

This report tells the story of one such tragedy. It examines the life and death of Paige, an Aboriginal girl from British Columbia who never received the nurturing or protection she deserved. As a result, she died of an overdose shortly after her 19th birthday in Vancouver's Downtown Eastside.

The Representative has taken the unusual step of using Paige's actual name in this report, because it is important to acknowledge that this is the story of a real girl, a real person – a person who deserved much better from the society in which she briefly lived. Her life was one of incomprehensible suffering, and how she felt as she searched for love, acceptance, learning and safety, is not entirely known. But we must put ourselves in her place to learn how to stand beside and support children who are vulnerable, to provide a different life for them – one which most British Columbia children enjoy, but those such as Paige can only imagine.

Paige's story is a difficult one to tell, perhaps the most difficult report this Office has ever undertaken. The Representative is extremely grateful to Paige's family for their participation in this investigation and their willingness to share information and insights. This family has suffered loss across the generations and we can only offer this report in the spirit of ending the trauma such families experience again and again. The Representative recognizes that it has taken tremendous courage for the family to share this story and hopes that the resulting report will help prevent such tragedies in the future.

The Representative also recognizes there are dedicated staff working with children such as Paige and that telling her story can cast a pallor of blame on individual staff and can traumatize these individuals. That is not the intent of this report. We thank those who work in social care and child welfare, but it is time to own the dysfunction and disarray that resulted in a failure to save Paige. The purpose of this report is to focus on changing the pathway that Paige's life took in order to prevent other girls from a similar fate.

## Related RCY Reports and Activities

(All reports available at [www.rcybc.ca](http://www.rcybc.ca))

Several reports by the Representative have explored the well-being of Aboriginal children and framed the key challenges:

- *Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl* (2014)
- *Out of Sight: How One Aboriginal Child's Best Interests Were Lost Between Two Provinces* (2013)
- *Much More Than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care* (2013)
- *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children* (2013)
- *When Talk Trumped Service: A Decade of Lost Opportunity for Aboriginal Children and Youth in B.C.* (2013)
- *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm* (2012)
- *So Many Plans, So Little Stability: A Child's Need for Security* (2011)
- *Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Children* (2011)
- *Growing Up In B.C. Joint Report with the Office of the Provincial Health Officer* (2010)
- *No Shortcuts to Safety: Doing Better for Children Living with Extended Family* (2010)
- *Housing, Help and Hope: A Better Path for Struggling Families* (2009)
- *Kids, Crime and Care: Youth Justice Experiences and Outcomes: Joint Report with the Office of the Provincial Health Officer* (2009)
- *Amanda, Savannah, Rowen and Serena: From Loss to Learning* (2008)
- *Health and Well-Being of Children in Care in B.C.: Educational Experiences and Outcomes* (2007)
- *Health and Well-Being of Children in Care in British Columbia: Report 1 on Health Services, Utilization and Mortality: Joint Report with the Office of the Provincial Health Officer* (2006)

In addition to these reports, the Representative:

- made a submission to the Truth and Reconciliation Commission titled *Aboriginal Children: Human Rights as a Lens to Break the Intergenerational Legacy of Residential Schools* (2012);
- presented a paper at the International Summer Course on the Rights of the Child in Moncton, N.B., *Making Human Rights Relevant to Children* (2012); and
- as a member of the Canadian Council of Child and Youth Advocates, released a *Special Report, Aboriginal Children – Canada Must Do Better: Today and Tomorrow* (2011)



# Executive Summary

Every professional who works with British Columbia’s most vulnerable children – from those in child welfare, to those in education, health care and justice – has a clear responsibility to do everything in their power to ensure the proper care and safety of those children.

When that responsibility is not fulfilled over the 988 weeks that constitute childhood, the results can be disastrous. Such was the tragic case for Paige, an Aboriginal girl who, sadly, was treated with what the Representative for Children and Youth can only describe as professional indifference. Paige – an outgoing, funny, bright girl who loved animals – died in April 2013 of a drug overdose in a communal washroom adjacent to Oppenheimer Park in Vancouver’s Downtown Eastside. She was just 19-years-old.

Children who have been maltreated are more likely to develop emotional, behavioural and psychological problems. The psychological effects, or “trauma,” of persistent maltreatment include isolation, fear and loss of the ability to trust others. Long-term consequences for those who experience severe and prolonged maltreatment often include alcoholism, drug abuse, smoking, suicide and certain chronic diseases. Paige was no exception. Friends and family watched as this engaging young woman with a typical adolescent interest in fashion and make-up became overwhelmed by the enormity of her life challenges.

B.C. has a great interest in preventing maltreatment and protecting children from it. The consequences of maltreatment pose a major social and economic burden to our society. This understanding of the state’s duty to protect children, and its duty to support more economically and socially appropriate policies to lessen the burden of maltreatment on fellow citizens, is now well-known.



Paige’s story reveals the massive gap between our understanding of the effects of trauma and the systems at the front line – the social workers, police, school staff and health care providers. Professional standards of care were not upheld in how Paige was treated. This raises intense concerns about the professional judgment of those in the system and the stewardship by governments of all levels of those duties. Her suffering is detailed in this report and it will sicken every reader to know that this happened in Vancouver, under the watchful lens of a social services system that should have done better.

Paige was not just another maltreated, abused or neglected child. She was an Aboriginal girl left in a known situation of danger – in Vancouver’s bleak and unforgiving Downtown Eastside (DTES), an environment where even some of those working in social services refused to venture because it was not safe for them.

The treatment Paige received will shock British Columbians. What is more tragic is that hers is not the only case the Representative has seen and it will not be the last one unless we seriously change our approach from one of indifference, massive spending without corresponding results and no consequences or accountability for further traumatizing already maltreated children.

Child welfare systems exist to protect individual children from harm. They do not exist to place children in danger, or to further punish those children by allowing them to continue down a path of psychological trauma leading to complete self-destruction. Sadly, Paige’s story makes the Representative wonder if, in the case of children in the DTES, child welfare has been turned upside down. Paige’s passing went without any scrutiny. Any opportunity for learning from her life would have been lost without this report.

This is one of the most troubling investigations the Representative’s Office has ever conducted. It is a startling example of a collective failure to act by multiple organizations and individuals within those organizations who should have helped Paige and in fact had multiple opportunities to do so. Instead, far too often, social workers and the child welfare system in B.C. failed to protect her from her own mother and harsh environments in the DTES; educators failed to keep this bright child, who showed so much early promise, attached to school; health care workers, police officers and the legal system often failed to follow up and in some cases even notify her social workers. For this girl, the system and those who work in it failed as a whole in their duty to care for and protect her.

In essence, Paige’s story is one of how professional indifference to her life circumstances continually left her – and at times even actively placed her – in harm’s way. This indifference contributed directly to her untimely death.

This is a child who should have been permanently removed from her mother’s care at an early age. She was the subject of no less than 30 child protection reports during her 19 years, involving allegations of domestic violence, neglect and abandonment. Her mother was actively using alcohol and drugs and there were no signs of that behaviour abating. Paige was repeatedly returned to her mother by the Ministry of Children and Family Development (MCFD) despite glaring and unavoidable evidence that this was not a healthy, nurturing or safe environment for any child and wasn’t ever likely to be.

As a result, Paige’s life was a case study in chaos. By the time she was 16, she had moved no less than 40 times, between residences with her mother, foster homes, temporary placements and shelters. After her mother moved them to the DTES in September 2009, Paige lived with her in toxic environments and moved another 50 times, living in various homeless shelters, safe houses, youth detox centres, couch-surfing scenarios, foster homes and a number of Single Room Occupancy (SRO) hotels.

From the time of her birth she felt the effects of a mother troubled by severe substance use issues. Despite this, Paige showed compassion toward others from an early age, reaching out to one foster parent's special needs child and helping other classmates in school. However, not surprisingly, she began abusing alcohol and drugs at a young age herself. Both mother and daughter eventually succumbed to overdoses, with Paige's mother dying on Oct. 30, 2014.

But before Paige's death, there were many opportunities for child welfare to intercede and to alter her otherwise predictably tragic life trajectory. Sadly, most of those opportunities were not seized upon.

School might well have made a difference in Paige's life, had she been able to remain attached to one long enough for its positive influences to take hold. She was evaluated early on as a bright student with promise, but after 16 school transfers through multiple communities in B.C., and with a chaotic home life that limited her attendance to sporadic at best, her education stalled in Grade 10.

The justice system might also have helped find a solution, or at least started Paige down a new path. During the first three years after moving with her mother to the DTES, she was involved in more than 40 police files, mostly for public intoxication or disturbances involving alcohol. One officer told the Crown counsel that Paige needed *“some form of intervention, hopefully by the court, or she may be hurt or killed while on a binge.”* That intervention never came.

Paige also had many contacts with the health care system – when she ended up in the Emergency ward or detox after being found unconscious or incoherent at least 17 times and also during her visits to Vancouver-area hospitals to terminate unplanned pregnancies on three separate occasions. Follow-up care was spotty at best and communication among hospitals, police and MCFD was inconsistent, at times non-existent. She was often discharged without an after-care plan, back to a place of danger, with incredible physical and emotional suffering.

Social workers and MCFD as a whole had by far the most and best opportunities to help Paige as well as the lead responsibility in law and policy. The ministry mishandled her file from the very beginning, failing to adequately assess the risk to her as an infant and then continuing to return her to her mother's care rather than pursue other more viable options. One of the best options – an aunt and uncle who were actively interested in caring for her and with whom she had developed a bond – were inexplicably never seriously considered as a placement option, even though they could have offered Paige connection to family, culture and stability – her rights under child welfare legislation in B.C. Indeed, she left her cats in their home because her own homes in the DTES were not safe enough for pets.

The role MCFD played in Paige's life could best be described as haphazard. A total of 17 different social workers across B.C. had responsibility for her file before she aged out of care at 19, fearful and utterly unprepared for what lay ahead. Despite her involvement with MCFD for virtually her entire life, only one ministry worker developed what could be considered more than a rudimentary relationship with Paige. There was little trust or connection between this girl and the multitude of MCFD staff who intersected with her.

Social work practice seemed to overlook the obvious risks that Paige's mother posed to her well-being, even leaving Paige in her mother's care when her mother was being sought by police for extortion, unlawful confinement and uttering threats. And once Paige was moved to the DTES, files and interviews with workers show that actual contact with her or her mother was minimal. The MCFD approach to Paige placed the responsibility on her to seek help, rather than the ministry actively seeking opportunities to intervene on her behalf. This approach – of noting the dangers, but not intervening – left her to live in squalid SRO hotels, potentially dangerous shelters or on the street.

The Representative finds it incomprehensible that MCFD could somehow determine that shelters and SROs in the DTES were suitable for any child, in particular Paige. This was a girl with little to no support from her mother. In fact, she was often forced into the role of being a young carer – looking after an addicted parent – with no resources and no help. Her pathway through trauma after trauma is especially deplorable because everyone knew how dangerous the situation was for her. They chose not to act.

More to the point, Paige was an Aboriginal girl, living in a neighbourhood which has been notoriously cruel to Aboriginal women and girls. Her mother was drawn to the DTES from the Interior of B.C., following a pathway well known to child welfare and police agencies. At the very same time Paige resided in the DTES, Justice Wally Oppal was conducting his inquiry into the victims of Robert Pickton, a serial killer who preyed on girls and women from this downtrodden and dangerous place, many of them Aboriginal. The SROs in which she lived were avoided by some workers as too dangerous to visit. This was a place of “known harms,” and a place to which Paige was continually allowed to return.

Aboriginal children are disproportionately represented in the B.C. child welfare system, comprising more than 50 per cent of children in care despite making up only about eight per cent of the child population. Aboriginal children are seven times more likely to come into care than non-Aboriginals. As such, B.C. has strong legislation and policy in place to offer special protection to Aboriginal children. But this was not enough to help Paige.

Indeed, the Representative believes that despite this strong legislation and policy, there is too often a distinct lack of strong follow-through by professionals when it comes to Aboriginal girls such as Paige. This has been evident in other recent RCY reports detailing the plight of Aboriginal children, including *Lost in the Shadows* (2014), *Out of Sight* (2013) and *Who Protected Him?* (2013), all stark examples of Aboriginal children receiving far less than the standard of care called for by law and common decency.

Paige's files are rife with examples of situations in which workers seemed to throw up their hands and declare: ‘What can we do?’ rather than doing everything that was within their power. When one considers the trends exposed in the Representative's prior reports, this professional indifference is evidently ingrained and needs to be immediately changed.

If a parent in B.C. had treated their child the way the system treated Paige, we may be having a debate over criminal responsibility. Yet there appears to be systemic resistance to naming this problem. The Representative speculates whether this is the face of institutionalized racism and a system that discounts the value of some children's lives in B.C.



# Methodology

The *Representative for Children and Youth Act (RCY Act*, see Appendix A) requires MCFD to report all critical injuries and deaths of children who have received a reviewable service in the year leading up to the incident.

The Representative conducts an initial screening of these incidents to determine if they meet the criteria for review under the *RCY Act*. If an incident meets the criteria, it is reviewed to determine if a full investigation is warranted.

## Downtown Eastside (DTES)

The DTES is one of Vancouver's oldest neighbourhoods and home to many of the city's most vulnerable populations, including the mentally ill, people who use drugs and survival sex workers.

The 2014 City of Vancouver Social Impact Assessment for this community noted *"High rates of mental illness and addiction persist and are difficult to treat – a problem exacerbated by poverty, homelessness, poor housing conditions, histories of trauma and the lack of a continuum of care that emphasizes choice and client-centred care."*

The most recent census data shows that the area has one of the lowest per capita incomes of any urban area in Canada, along with the highest homeless population in the city. SRO housing is often the last option before homelessness, and this form of housing is concentrated in the DTES.

High levels of crime and violence are also a persistent problem. Violent crime in the DTES increased by 36 per cent between 2006 and 2011. In 2012, 16 per cent of all reported sexual assaults in Vancouver occurred in the DTES, although the area only houses three per cent of the city's population.

Aboriginal women remain particularly vulnerable. The Missing Women Commission of Inquiry noted in 2012 that more than 60 missing and murdered women were taken from this neighbourhood, one-third of those being Aboriginal.

Maternal health outcomes in this neighbourhood lag behind the provincial averages, and more than half of all children in the DTES begin Kindergarten with vulnerabilities that impact their readiness to start school.

Two reports of critical injuries to Paige were received by the Representative. The first was received on May 10, 2011, shortly after the injury had occurred. This report triggered a broader review of Paige's circumstances by the Representative. The second critical injury report, sent to the Representative on Oct. 29, 2013, after the investigation had already begun, concerned an injury that had occurred 17 months earlier. The review of the first incident resulted in the Representative determining that a reviewable service or the policies or practices of a public body may have contributed to her injury and that a full investigation was necessary.

Paige had involvement with MCFD from birth until she aged out of care in May 2012 at 19. This investigation, however, has focused on her later years and particularly the three-year period during which she lived in the DTES.

Numerous files and documents were reviewed in the course of this investigation. Records were sought and obtained from MCFD, the Royal Canadian Mounted Police (RCMP), the Vancouver Police Department (VPD), schools, physicians and community agencies. (See Appendix B for a detailed list.)

Interviews with members of Paige's family, MCFD social workers and staff, police, school district staff, physicians, foster parents, youth resource staff, community agency staff and the managers and staff of emergency shelters and SRO hotels were conducted in accordance with s. 14 of the *RCY Act*. The recorded evidence was either sworn or affirmed. More than 100 interviews were conducted. (See Appendix C for a detailed list.)

The Representative's Multidisciplinary Team<sup>1</sup> was briefed on the progress of the investigation, and provided advice and guidance. Additional experts in the field of child protection and child and youth development were also consulted.

In the interest of administrative fairness, agencies and individuals that provided evidence to this investigation were also given an opportunity to review the draft report and provide feedback on the facts.

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<sup>1</sup> Section 15 of the *RCY Act* provides for the appointment of a Multidisciplinary Team (see Appendix D) to assist in this function, and a regulation outlines the terms of appointment of members of the team.

# Chronology

## Birth to Age Three

Paige was born in May 1993 in Kamloops when her mother was just 16-years-old. The mother's own childhood was chaotic. Her parents struggled with substance use and domestic violence issues. She was frequently cared for by other family members, shuffling from place to place when her parents were unable to look after her. She left home at 14 and lived with multiple partners before Paige was born.

Paige and her mother lived with Paige's father on an on-again, off-again basis. MCFD was involved with the family as soon as she was born and removed her from her mother three times during the first year of her life.

## Supervision Order

This is a court order that allows a social worker to supervise a child's care in the family home. An MCFD social worker can apply to court for an order that the ministry supervise a child's care if the ministry has grounds to believe that the child needs protection and that a Supervision Order would be adequate to protect the child. A Supervision Order usually has a provision for removal of a child if the parent is unable to follow the expectations of the order. The safety from harm that a Supervision Order provides is only as effective as the actual social work supervision component when the child is back in the home.

The first removal took place when Paige was five-months-old, after she had been left alone locked in her mother's apartment while her parents were having a fight out on the street several blocks away. She was returned less than a month later under a Supervision Order, but was removed temporarily and returned to her parents twice during the next seven months. Protection concerns centred on the parents' transient lifestyle, drug and alcohol use and domestic violence.

Despite further child protection reports made to the ministry about neglect, alcohol use and domestic violence, MCFD did not conduct an in-depth assessment of the mother's capacity to parent.

In January 1995, when Paige was 19-months-old, MCFD offered an Intermittent Care Agreement to her mother. This permitted the mother to leave Paige with a ministry foster parent for a few days each month if she was feeling stressed by pressures of parenting. Although the mother used this service for nine months, and Paige had been enrolled in a local daycare program, there were no supports in place to assess or address her mother's substance use problems. Her mother appeared to be focussed on completing her high school graduation requirements, but not improving foundational parenting skills.

In December 1995, when she was 2 ½-years-old, Paige was referred to pediatric specialists at BC Children's Hospital (BCCH) by her family physician because of concerns about her vision. She underwent eye surgery several months later. While she was first at BCCH, Paige was diagnosed with symptoms consistent with Marfan syndrome, a genetic disorder of the connective tissue that affects the skeleton and

many organ systems including the lungs, eyes, heart and blood vessels. She was referred to the BCCH Cardiac Clinic, where she was diagnosed with heart problems related to this syndrome.

### Voluntary Care Agreement (VCA)

A Voluntary Care Agreement supports and assists parents to care for a child when they are temporarily unable to do so. A VCA ensures a child is in safe care without legally removing a child from a parent's custody. The parent with custody retains guardianship while MCFD provides the day-to-day care of the child and has the parent's agreement to place the child in an approved child care resource, such as a foster home. The parent agrees to take certain steps to remediate the problems that have caused the parent's inability to care for the child. Time limits are in place regarding the amount of time a child may remain in care via a VCA. A parent may withdraw the child from MCFD's care at any time, regardless of any promises the parent may have made and subsequently not followed. It is therefore critical for the social worker to review whether the conditions of a VCA have been met when the parent removes the child from the MCFD placement as, frequently, a condition of a VCA is for a parent to improve his or her capacity to provide adequate and safe care for the child when returned home.

When Paige was three, her mother called the MCFD office in Kamloops and requested that Paige be taken into care under a Voluntary Care Agreement (VCA). She told the ministry that she did not have anything to offer her daughter, and wished to have her adopted into a home that would provide her with more opportunities than the “*welfare life*” that she would give her.

This first VCA collapsed almost immediately when her mother changed her mind and pulled Paige out of care, a pattern that would repeat itself over the next several years.

### Paige's Father

Paige's father was 20-years-old when his daughter was born. Paige's young mother had already been living away from her family for two years and the young parents had moved in together before their daughter was born.

The parents' relationship was rocky. The mother stopped drinking alcohol when she became aware of the pregnancy, but the father continued to use both alcohol and drugs. Their fights often became physically violent, with neither parent seeming able to disengage, even with their baby in the home. Police were called to the home several times after complaints of either loud partying or fighting.

The father moved out of the home during the first year of Paige's life, but continued to visit. It is believed that the couple reconciled many times only to repeat the same pattern of fighting and separating.

The father was never identified to MCFD as having First Nations ancestry, although there is some indication that he moved on and off an Interior First Nation reserve. His alcohol and drug use precluded the ministry from considering him as a possible long-term caregiver. He did have access to his daughter and occasionally cared for her for a few hours at a time during her early years when he was staying in his sister's home. He agreed to enrol in parenting and relationship counselling, but did not follow through.



When Paige was still less than one-year-old, her father assaulted her mother. The mother fled the home, leaving Paige with her father. He took Paige to a local women's shelter right away, saying he could not care for her. He was later charged with assault and convicted. Paige was removed from her mother's care for the second time.

Paige's father remained on the sidelines for the remainder of his daughter's life. There was sporadic contact but, with his substance use continuing and the mother and daughter's continual moves, he did not take an active part in caring for her. During the periodic court proceedings, the father was served with court documents and legally represented whenever he could be found. By the time Paige was 10-years-old, her father had effectively disappeared and had very little further involvement in her life.

## Further Protection Reports

Prior to Paige entering school, her day care made a protection report to MCFD that she was arriving unkempt and with poor hygiene. The daycare also noted that she was using sexualized language and acting out in a sexualized manner with her peers. The daycare staff observed that Paige seemed preoccupied with her mother's health and well-being and had told daycare staff, *"I'm worried about mommy."* Paige was just two-years-old when she first expressed this anxiety.

In February 2000, when Paige was almost seven, the MCFD office in Kamloops received a report that her mother was using crack cocaine in front of her daughter and that there was no food in the home. Social workers found that the report was accurate and

## Young Carers

One of the aspects of growing up in a family where there is parental mental illness and/or problematic substance use is the additional responsibility a child may be forced to take on as a caregiver for the parent. Paige felt a deep responsibility for the well-being of her mother. As one worker involved in the child's life after her move to the DTES put it, staff were aware that the child's role was *"to kind of look after her mom."* She said this was not an uncommon dynamic amongst parents and children in the DTES:

*"I can't tell you how many kids ... come to look after their parents and want to be with their parents – who else is there? I mean... there is nobody. They want to be with their parents and they look after their parents. And rightly or wrongly, you cannot prevent that. We've talked a lot with kids about 'When your mom or dad starts using, where can you go? What are your plans?' Now, most of them want to stay and make sure [their parent] doesn't die. That's the big fear – 'my mom, my dad, my aunt is going to die.'"*

Children in these young carer roles must deal with the issues of growing up in a family where there is a great deal of disruption and distress. They also learn early that their own needs are often secondary to the needs of their parent. This can have serious negative consequences for a child's self-image, teaching them that they are not important. The stress of taking on this responsibility can contribute to school difficulties even in bright children, high levels of anxiety and depression, a lack of a sense of self, social isolation, feelings of helplessness and hopelessness and the misuse of substances. Children in these circumstances spend more time worrying about their parent and less time learning the skills they need to successfully negotiate their transition into young adulthood. They rarely receive the support they require.

## Child in the Home of a Relative program (CIHR)

Prior to March 2010, MCFD social workers used this program to provide financial assistance to a relative in whose home a child had been placed when the child's family was unable to care for the children in their own home. In most cases, the parent would remain the legal parent and guardian of the child. In June 2010, the Representative released her report *No Shortcuts to Safety: Doing Better for Children Living with Extended Family*, which recommended significant changes to the CIHR program, including more extensive screening of adults in a prospective home. The CIHR program stopped accepting applications in March 2010 and was replaced by the Extended Family Program. Criminal checks of all adults in a relative's home where a child is placed are now mandatory.

The Representative notices a significant decrease – almost 50 per cent – in the numbers being served through the new out-of-care options that replaced CIHR and questions the reasons for this decrease.

Paige was removed from her mother's care. Paige was placed with her maternal grandmother in a ministry-supported Child in the Home of a Relative (CIHR) arrangement. This arrangement was made despite the ministry's awareness of previous substance use and domestic violence issues in this home – issues that had previously led MCFD to dismiss using the grandmother's home as a safe home for Paige.

Even with these documented concerns, MCFD file records do not show any safety checks on the other adults known to be sharing the grandmother's residence at the same time, including the grandmother's boyfriend.

After Paige returned to live with her mother in February 2001, MCFD received a report that the grandmother's boyfriend had molested her during the time Paige and her mother had been living together in the grandmother's home. In response to this allegation, Paige faced anger and disbelief from a key family member. The report was investigated by police and MCFD, but no charges were laid after Paige recanted her initial disclosure of abuse.

Three further child protection reports were made between 2000 and 2003, alleging that Paige was being exposed to her mother's drug use. The ministry repeatedly closed the file based on the child being assessed as safe in the CIHR arrangement with her grandmother, even though her mother, regardless of her substance use, had unsupervised access to Paige in the home.

Altogether between June 1998 and June 2003, a total of five separate reports were made to MCFD about the mother's ongoing issues with alcohol and drug use and Paige's exposure to situations of family violence.

## Multiple Moves

Paige moved between her mother's care, family placements and various foster homes in Kamloops and Fort St. James 15 times between the ages of three and 13.

On Oct. 15, 2002, MCFD entered into a second VCA with the mother, who was in crisis again and presenting as agitated, hostile and impulsive. The mother said that she wanted Paige in care for two months in order to access a treatment program for her own drug and alcohol issues.

Seven days later, the mother went to Paige's school and took her home. Despite recognizing that the mother suffered from chronic substance use issues and that she had been unable to commit to treatment, Paige was again assessed as being safe and MCFD

closed the family file. Her mother's inability to stay in treatment was a pattern repeated throughout Paige's life.

In March 2003, Paige, now nine, came into MCFD care by means of a VCA for the third time so that her mother could attend an alcohol and drug treatment program. Her mother abandoned the treatment program within 24 hours and again took Paige out of care a few days later. Despite the obvious risk, MCFD conducted no immediate child safety assessment.

Paige was removed again from her mother's care six months later after her mother left her with a former foster parent. Paige was placed in a different foster home, but this placement was also short-lived. Within weeks, the mother fled with her to the mother's aunt's home in Fort St. James. Paige's ministry file and *CFCS Act* court file were in the process of being transferred from Kamloops to where she and her mother had since moved. The Kamloops social worker wrote to the new social worker:

*"[The mother] continues to struggle with her drug addiction. I'm wondering if she has the capacity to change over the next short while. We continue to see [Temporary Custody Orders] and extensions but it's becoming, at least in my view, a situation where a CCO may be in the child's best interest. That's your call obviously but given my short involvement with the mother and her history, I just don't hear anything that indicates she's actually on the path to wellness."*

Although initially content to leave Paige with the aunt, MCFD subsequently agreed to the mother's request to return Paige to her care under a six-month Supervision Order in September 2004. This occurred in spite of MCFD's awareness that the mother had not attended a treatment program for her addictions.

Prior to the expiry of the Supervision Order in March 2005, MCFD completed a risk assessment that concluded the mother was abstaining from alcohol and drug use. This conclusion was based solely on the mother's statements to this effect. Social workers completed no collateral checks (inquiries directed at others, including professionals, with knowledge of the family) and did not request a drug test. Paige was now 11-years-old.

On Jan. 13, 2006, the local police department in Kamloops called MCFD to report that a warrant had been issued for the mother's arrest for extortion, unlawful confinement and uttering threats. Police told MCFD that the mother was using crack cocaine and had been residing with her daughter in a known crack house. During that time, Paige had been withdrawn from school and the family's whereabouts were unknown to MCFD. MCFD records fail to document what, if any, efforts were made to locate Paige following this police report.

Another report was made to MCFD on March 1, 2006, indicating that Paige and her mother had stayed overnight with an acquaintance because they were homeless. According to the report, the mother was cooking crack cocaine over the stove in the presence of her daughter. MCFD could not locate Paige at this time.

In early March 2006 a photograph of the mother was placed in the local Kamloops newspaper in which the mother was identified as being on “Canada’s Most Wanted” list. Shortly afterwards, she was located and arrested. Paige told her teacher that when police had come to arrest her mother, she had hidden because she did not want to be sent to a foster home. The teacher gave Paige the phone number for Aboriginal Family Services and asked that she pass it on to her mother.

Three weeks later, her mother again left Paige with her former foster parent in Kamloops and disappeared before MCFD staff could come to the home. The mother and child had been staying wherever they could, as they had once again been homeless. Paige was interviewed and said that her mother had been using crack cocaine for a long time and that she had kept this information from social workers in order to protect her mother. Paige was once again removed from the custody of her mother and placed in an emergency foster home, pending the development of a more permanent plan.

The stability of this emergency foster placement was immediately jeopardized when the mother located the home and began to keep a constant watch on the property. She sat on a park bench facing the foster home and spent hours each day watching the foster home, displaying erratic behaviour and yelling threats to the foster family and her daughter. She would lie down on the lawn outside Paige’s window at night and be found sleeping there in the morning. She appeared oblivious to the terrifying effect that her behaviour was having on the other children and family members in the foster home.

Despite the circumstances, Paige formed a significant attachment to this foster family. However, when her mother’s behaviours made this placement unsafe and unmanageable, MCFD moved her to another foster home four months later. The move and separation further traumatized Paige, who had been enjoying a short interval of stability. She was now nearly 13-years-old.

While in the foster home that her mother had been watching, Paige had told her First Nations school counsellor that she was feeling depressed, having thoughts of self-harm and thinking of suicide. She also revealed that she had been using alcohol and illicit drugs but wanted to quit. She reported that she was experiencing sleep problems, anxiety and continual worries about the well-being of her mother. These concerns were reported to MCFD, but failed to trigger any response.

### **Mental Health Act (MH Act)**

S. 28 of the *MH Act* authorizes police to apprehend a person who is acting in a manner likely to endanger that person’s safety or the safety of others and who is apparently suffering from a mental disorder. Police must immediately take the person to a physician (most often the Emergency department of a local hospital) for further assessment and possible involuntary committal, referred to as “certification” under the *MH Act*.

The mother was seen in a hospital Emergency room in July 2006. The attending physicians noted that she had a lengthy history of poly-substance dependence (heroin, cocaine and methadone) and appeared to present with a substance-induced mood disorder. She was also showing symptoms of a severe personality disorder with anti-social traits. Physicians noted she had self-reported that she was supporting herself through sex work and the collection of drug debts. The prognosis for her recovery was assessed as poor. She was involuntarily committed to hospital

and certified under the *Mental Health Act (MH Act)* a number of times over the following three months.

Near the end of 2006, Paige's mother persuaded her to leave her foster placement and accompany her to Fort St. James without the knowledge of MCFD. They moved into the mother's aunt's home. Confronted with this new reality, MCFD agreed to place Paige with the aunt in an out-of-care arrangement under s. 41(1)(b) of the *CFCS Act*. This arrangement included an agreement that Paige would return to live with her maternal grandmother if living with the mother's aunt did not work out. MCFD agreed to this arrangement despite the 2001 report alleging that the grandmother's boyfriend had molested Paige in this home.

MCFD records indicate that, during early March 2007, the mother was living on the streets in another northern community and was unable to maintain a stable residence due to her addictions. Six weeks later, on April 22, 2007, Paige's placement with the aunt broke down when Paige and her mother alleged that the aunt was abusing Paige.

On June 27, 2007, MCFD in Kamloops again returned Paige to the custody of her mother under a six-month Supervision Order. The mother had been able to rent an apartment and assured her social worker that she had not used crack cocaine since the end of March. Efforts to verify this assurance were stymied by her refusal to attend mandatory drug screening. This refusal failed to trigger further follow-up by MCFD.

A few days after being returned to her mother's care, Paige and her mother met with an alcohol and drug counsellor. The counsellor believed the mother was impaired and observed that she was highly agitated. The mother yelled at her daughter that she was smoking too much marijuana and Paige yelled back that her mother was spending all her money on crack.

Following this meeting, the counsellor advised MCFD of her high level of concern for Paige. The counsellor concluded that: *"The child is going to follow in her mother's footsteps if she remains living with the mother."*

In July 2007, when Paige was 14, she told her mother that she was hallucinating after smoking marijuana. Her mother took her to the local hospital to be assessed.

Two weeks later, Paige was again taken to the hospital by her mother. Her mother had found her late at night, partially unclothed and passed out in some bushes surrounded by a group of young males. Paige was highly intoxicated. Hospital staff were concerned she might have been sexually assaulted, but she denied that any assault had occurred.

In August, the mother advised MCFD that her daughter was getting *"drunk and stoned"* and that they were again moving to another community. This contact was noted in ministry files, but no action was taken to assess Paige's safety.

The following month, MCFD received a report from a homeless shelter in Fort St. James advising that it had just evicted the mother and child, now 14, after finding a crack pipe in the mother's belongings. The mother had previously been banned from this shelter due to her aggressive behaviour and drug use.



Paige and her mother had been living on the street prior to their stay at the shelter. They had shuffled back and forth among several Interior and Northern communities in the previous four months. MCFD records indicate that their whereabouts were unknown for several weeks and that the social worker responsible for their case had left the ministry during the same time period. Due to staffing issues, there was no social worker assigned to this high-risk file between Oct. 16, 2007 and Nov. 26, 2007. The report from the homeless shelter was concluded when a courtesy home visit and file transfer request was made to the Northern ministry office in Fort St. James, where the mother and daughter had again landed.

On Nov. 28, 2007, the MCFD social worker responsible for the file observed:

*“The mother is most likely using, has not complied with services, has moved and not planned with the ministry. However the child has been removed in the past and this was not successful. The mother was aggressive, difficult to work with; sabotaged every available placement for the child. The child wanted to be with her mom and so a supervision order was sought ... but has not been effective or reduced section 13 [CFCS Act child protection] concerns.”*

## Youth Agreement

A Youth Agreement is a legal agreement between MCFD and a youth, most typically between the ages 16 to 18, who is affected by an adverse condition such as severe substance abuse or sexual exploitation and is unable to live at home or with another family or adult. The purpose of the agreement is to help such youth gain independence, return to school, or gain work experience and life skills.

However, there are six criteria that must be filled in order for a youth to proceed with a YA. As such, these criteria are not attainable by many vulnerable youth who may have the capacity to live independently. Conversely, many youth who are assessed as eligible are placed on YAs before they are ready to live independently.

Despite these articulated concerns, MCFD closed the file in December 2007.

On June 24, 2008, Paige, now 15, was placed with another female relative in the Fort St. James area following a report that her mother had again physically abused and abandoned her. In an exception to MCFD policy, a Youth Agreement (YA) was put in place as the relative was not eligible under the CIHR program because of previously-documented safety concerns. Paige had expressed an unwillingness to stay in any other ministry placement. A YA arrangement allowed the ministry to fund some of Paige’s personal and medical needs, including transportation to specialist medical appointments in other communities, while Paige lived in a home that had been proven to be unsafe in the past.

While she resided in this home, MCFD was notified of Paige’s increasing use of alcohol and other substances; in one case, this resulted in her hospitalization. The social worker reminded Paige of the strain the drinking placed on her internal organs and she agreed to work on abstinence. Paige was attending counselling with a local community service agency focused on this and her other social/emotional issues.

While Paige was being supported by the YA, her social worker took the opportunity to ensure that her medical needs were reviewed and treated. Over the six-month period of the YA,

Paige was taken to cardiology and ophthalmology appointments at BCCH in Vancouver, medical geneticist appointments in Prince George and dental and optometry visits in Vanderhoof. This social worker was also instrumental in obtaining funding for Paige to obtain a new heart medication that was not available under the Medical Services Plan. In keeping with the cardiologist's recommendation, the social worker also ensured that a Medic Alert bracelet was obtained for Paige.

In November 2008, Paige told her social worker that she had spoken to her mother who was now living in Penticton. Her mother told her not to visit her at Christmas, as she was *"not doing well."*

Paige visited her mother three months later. During the visit, she made the decision to return to live with her mother and her teenage uncle, who was also living in the home.

With Paige returning to her mother, the YA was terminated on March 12, 2009. MCFD's only further involvement was the creation of a safety plan directing Paige to stay with relatives in Penticton or contact MCFD if living with her mother became unsafe.

The reunification lasted only a few days. Paige came home to find her mother was gone and that all of the family's possessions and clothing were piled on the front lawn of the apartment building. Her mother had been evicted for failing to pay the rent. Paige contacted an aunt who arranged bus tickets for the two teenagers to come to her home in Fort St. James. The mother's whereabouts were unknown.

On July 18, 2009, the ministry was contacted by the hospital in Penticton. Paige had been taken there by ambulance after being found extremely intoxicated. The hospital was unable to locate her mother. Paige told hospital staff that her mother was on a *"bender"* because her own mother (Paige's maternal grandmother) had recently died from a drug overdose.

Paige discharged herself from hospital when she was told that her mother was coming to get her. No efforts had been made to engage the mother or Paige in any services to address their respective drug and alcohol dependencies. With her return to live with her mother, Paige's YA was cancelled, and the file was closed.

On Sept. 1, 2009, the mother advised her financial assistance worker that she was planning a move to the Vancouver area.

## Paige and her Mother Move to the Downtown Eastside

On Sept. 5, 2009, Paige, now 16-years-old, and her mother relocated to Vancouver's DTES. At this point, the mother had moved at least 84 times since Paige's birth. Continuing this pattern of transience, Paige would move more than 50 times during the next three years, among homeless shelters, safe houses, youth detox centres, temporary accommodations with relatives and friends, two MCFD foster homes and various DTES hotels.

On Sept. 19, 2009, Paige was abandoned by her mother at a safe house in East Vancouver. An MCFD After Hours social worker came to the house and, rather than

## Taking Charge (of a child/youth)

A Take Charge Notice is a less disruptive measure whereby, under s. 25 or s. 26 of the *CFCS Act*, MCFD can provide time-limited care of a child or youth without parental consent or a formal removal in the following circumstances:

- When a child is found without adequate supervision and it is determined that he or she requires immediate supervision and care
- When a child or youth is lost or has run away from his or her home and the individual responsible for the child cannot be located or the child refuses to return home.

When MCFD is taking charge of a child, all reasonable efforts must be made to notify or locate his or her parent(s). When necessary, a child is taken to a safe place such as the home of a family member or friend, a day care, a foster home or a hospital. MCFD must inform the parent(s) that it has been looking after the child under a Take Charge Notice and has consented to any necessary health care services. A child must be returned to his or her parent(s) as soon as possible and, in most cases, within 72 hours.

The child or youth is not required to be returned to the parent(s) if an agreement has been made with the parent(s) under another plan to provide day-to-day care of the child or youth to ensure his/her safety or if there is a removal order because the child or youth would be unsafe if returned to his or her parent(s).

removing Paige from the custody of her mother, completed a temporary Take Charge Notice and took her to a local Aboriginal youth safe house.

The After Hours social worker interviewed Paige at this time and described her as “*a very polite young woman.*” Paige told the social worker that she wanted to get her life back on track by going to school and getting an education. She said that she was not currently using alcohol or drugs and that she was tired of moving all over the province with her mother. She had all of her belongings as well as her mother’s in suitcases, backpacks and garbage bags.

The family’s closed MCFD file was transferred to the Vancouver ministry office and re-opened for more comprehensive follow-up. A social worker went to the safe house to speak to Paige and further assess the situation.

This worker also heard from Paige that she was tired of the frequent moves and her mother’s drug use, and that she wanted to go to a local high school. She indicated that her mother was on the methadone program, but that relatives had recently seen her in the DTES on a regular basis and were concerned about her drug use. Paige acknowledged being stressed about the current situation with her mother and admitted to having had thoughts of suicide 18 months earlier.

Paige suggested several family members in Vancouver with whom she could potentially stay. An aunt and uncle who she felt particularly close to were not considered appropriate. This determination was based solely on an allegation that the aunt and uncle had an adult son with alcohol dependency and violence issues. No further exploration of this potential placement occurred. Paige returned to her mother, who was now living in a transition house in New Westminster.

On Sept. 21, 2009, a few weeks into the school year, Paige and her mother went to the office of a local high school and requested that Paige be registered for Grade 10. The school counsellor who registered her described her as a very charming girl who was excited to start school.



During the registration process, the mother told the school that her daughter suffered from a heart condition. The school counsellor told RCY investigators that she was shocked that there was no documentation in Paige's school file of her having any medical issues. She described the child's education history as a "*traumatic school experience*" and stated:

*"The file is unbelievable, the amount of times she was sent home, doing drugs at about grade five, smoking pot, and, you know, a couple of times she's come into school, I think, late, and when we talked with her, mom's boyfriend had been arrested at the apartment, or mom had been. You know there was just turmoil after turmoil."*

This counsellor said that school records showed multiple calls to MCFD and she questioned why there had been such minimal legal intervention to protect Paige, who she described as being "*really keen to be a student, but attendance was an issue because mom would act out wherever they were staying.*"

On Sept. 24, 2009, After Hours was advised that Paige had been discharged from a local youth safe house after she returned to the facility intoxicated. Police took her to Vancouver Youth Detox. A social worker called her mother, who said that she was willing to remain at a local homeless shelter with her daughter. When interviewed by the Representative's investigators, the social worker responsible for the file had no specific memory of why he did not go to the shelter during this time to speak to the mother or to assess Paige's safety.

Paige and her mother subsequently moved to a transition house in New Westminster. Paige travelled each day from the transition house in New Westminster to her school in East Vancouver until she was forced to leave the transition house because her mother's frequent absences had lost them their placement.

There was no contact between the ministry and Paige in October or November 2009.

The high school Paige was attending completed an Individual Education Plan (IEP) for her on Oct. 29, 2009. The plan described Paige as being resilient, hardworking, independent and having a positive attitude. But by now, she was attending school less than 25 per cent of the time.

On Nov. 20, 2009, Paige went to BC Women's Hospital to have an unplanned pregnancy terminated – her first of three pregnancy terminations during the next three years. In each of these instances, an adult in her life accompanied her to these appointments, including her mother, a foster parent and a DTES outreach worker. The Representative can only imagine how devastating these experiences would have been for Paige.

Sometime shortly after the November 2009 pregnancy termination, Paige and her mother went to Royal Columbian Hospital where Paige received emergency care for bleeding and severe abdominal pain.

In early December 2009, MCFD received a call from a youth safe house. Paige had arrived there indicating that she had been left alone for several days and did not know

## Single Room Occupancy (SRO)

An SRO is a form of housing in which one or two people are housed in individual rooms (sometimes two rooms, or two rooms with a bathroom or half-bathroom) within a multiple-tenant building. The term is primarily used in Canadian and American cities. SRO tenants typically share bathrooms and/or kitchens, while some SRO rooms may include kitchenettes, bathrooms, or half-baths. Although many are former hotels, SROs are primarily rented as permanent residences for adults on low income or those who were formerly homeless. Although SROs are adult-only facilities, Vancouver's DTES SROs have been known to turn a blind eye to age.

directing that her immediate safety be assessed, the social worker asked the Reconnect worker to: *“Tell her to call me if she is interested in looking at independent living options, other supports, or referrals to services.”*

MCFD talked to the mother on Jan. 26, 2010. She said that Paige had been living with her at the SRO hotel. The ministry had a telephone conversation with the mother summarized in the file as: *“Mom claims to be clean and looking for housing outside the DTES.”* No social worker met with Paige or her mother and the report of the active crack cocaine use was not addressed. Paige was not interviewed and her mother was not asked to complete a drug test. She and her mother then relocated to a shelter in New Westminister and the file was closed. Documentation by the team leader in the file states: *“Close file. Mom and daughter are accessing community supports in New Westminister. No request for MCFD services.”*

On April 25, 2010, the ministry received a report from another transition house in New Westminister relaying that the mother had been discharged due to abusive behaviour towards her daughter and shelter staff. The caller stated that the mother had called her daughter a *“fucking little bitch”* and threatened to *“beat”* her.

her mother's whereabouts. Later that same day, she told staff that her mother had been arrested and was in cells at the Vancouver Police Department. Two days later, Paige left the safe house to search for her mother and consequently lost her spot in the facility.

On Jan. 14, 2010, MCFD received a report that the mother was now residing at an SRO in the DTES. Paige's whereabouts were unknown. The manager of the hotel indicated that the mother was actively using crack cocaine and they would not allow Paige into the hotel. The caller said that the mother had left Paige standing out on the street in front of the hotel. A social worker spoke with staff at the youth safe house where Paige had previously been staying and was told that she had not been at the shelter since Dec. 6, 2009.

Six days later, the ministry social worker responsible for this intake requested that a Reconnect social worker attempt to find Paige at the SRO hotel. Rather than

## Reconnect

Reconnect is the name for a weekly group meeting of community youth outreach workers. Youth outreach staff share information about and identify high-risk youth living in or frequenting Vancouver to develop safety plans for these youth. The group facilitator (from the Yankee 20 program – see text box) then connects with field social workers, service providers, police and parents (who are often in communities outside Vancouver) to coordinate and implement safety plans and services for individual youth.

The caller said she believed Paige and her mother might be back living at the SRO hotel in the DTES.

MCFD classified this report as requiring a response within five days, but no action was taken until almost two weeks later when a report was received from another DTES transition house. Staff advised that Paige and her mother had been staying there but had failed to return the previous night. The mother subsequently phoned to say that she had spent the previous night in jail; as a consequence she had been discharged from the transition house. A staff member at this transition house advised the ministry of their concern for Paige as she seemed to have assumed a care-giving role with her mother. Staff described the mother as unstable and volatile.

A social worker found Paige and tried to explore alternate living arrangements with her. Paige agreed to stay at a women's transition house without her mother and this plan was supported by MCFD. Paige was interviewed about her living situation, but there was no indication on the ministry file that the reported maltreatment by her mother was explored. The social worker responsible for the file had no recollection of having asked Paige about her mother's threat of physical abuse.

MCFD file documentation stated: *"The youth is unwilling (except on one occasion) to improve her living situation. Unfortunately the child prefers to stay with her mother."* The team leader stated: *"Youth not willing to leave situation with Mom and not open to any ministry services."*

## Yankee 20

Yankee 20 is the police call sign for a unit staffed by a police officer and an MCFD social worker. The unit attends to situations involving high-risk youth in Vancouver and operates during daytime hours, four days a week. The Yankee 20 unit collaborates with other youth-serving professionals and parents of missing and high-risk youth to develop intervention strategies and safety plans for youth. Yankee 20 also assists child protection workers in applying for protection orders.

The ministry advised the joint Vancouver Police Department and MCFD response team (known as Yankee 20), Under Age Income Assistance and the Reconnect program of Paige's situation, and closed the file. The social worker involved at this time noted in the file:

*"Youth has no fixed address, moving between transition houses with her mother for many months. Mother battling drug and alcohol issues. It is very unlikely that the mother's situation will change."*

During the course of this ministry assessment, medical records from St. Paul's Hospital indicate that Paige arrived at the Emergency department on May 10,



The Balmoral SRO hotel

2010 with an infection and severe stomach pain. These symptoms were attributed to unsanitary and dangerous living conditions and her heavy alcohol use.

Chart notes from the hospital social worker indicate that Paige and her mother had been homeless since December 2009 – a period of five months. The hospital social worker attempted to locate housing for them by calling all the shelters for females in the area. Due to the mother’s history of violent behaviour in each of these shelters, they were denied admission.

On June 10, 2010, an email was sent from one DTES community agency to another, copying MCFD, providing an exact location of where Paige was now living and advising MCFD that:

*“We have some concerns about a youth that has been seen around the DTES lately. Mom deals crack and has a room at the Balmoral (#223) as of today.”*

MCFD did not respond to this report.

On June 22, 2010, Paige was formally withdrawn from her high school because she had not been attending and the school had been unable to locate her.

On July 7, 2010, after sharing Paige’s photo at a Reconnect meeting, MCFD was again contacted by a community agency and told of Paige’s whereabouts: *“Mom is a known crack user. The child is living with mom at the Balmoral. The child looks after mom.”* A week later, the reporting agency contacted the MCFD social worker and asked: *“Any word from the child in the past week?”* The social worker replied: *“No word from the child at all. The child never reached out to MCFD directly nor has her mother. I closed my file due to no contact/no accessing of services.”*

Despite the MCFD file being closed in July 2010, community agencies went to the Balmoral Hotel on several occasions in August in an effort to find Paige. She was “profiled” – meaning information about her was shared – at a Reconnect meeting on July 14, 2010. A DTES youth-serving agency report to the MCFD social worker on Aug. 26, 2010 stated: *“Outreach has been trying to look for her and an outreach worker stopped by the Balmoral but she wasn’t home. I will keep encouraging people to look for her and hopefully at some point get her into your office.”*

## The Mother Overdoses

On Aug. 31, 2010, MCFD received a report that Paige was still living with her mother at the SRO hotel in the DTES. The caller reported that the mother had been taken to St. Paul’s Hospital 17 days earlier for a possible drug overdose.

Medical records show that this overdose actually occurred on July 26, more than a month prior to this report. Paige and her teenage uncle had called 911 saying they had found Paige’s mother unconscious on the floor of her hotel room. The mother had been smoking crack cocaine and injecting heroin. The uncle started CPR until paramedics



arrived to find the mother not breathing and without a pulse. She was defibrillated three times on the way to St. Paul's Hospital and admitted to the Intensive Care Unit.

There are references in the hospital chart to Paige being present at her mother's bedside during her admission and to Paige being frustrated and overwhelmed by the situation. Her mother was aggressive and physically threatening to hospital staff while in ICU and Paige would intervene to encourage her mother to cooperate. Although the social history on the chart documented that the mother lived at the Balmoral Hotel with her daughter, hospital staff did not report this information to MCFD.

On Aug. 5, 2010, the mother was certified under the *MH Act* by the attending psychiatrist who noted:

*“33-year-old female with history of poly-substance abuse who presents with personality changes and organic brain injury syndrome post arrest. Patient is inappropriate and disinhibited. Would be a safety risk if she were to leave the hospital.”*

The final discharge report completed by the hospital on Aug. 13, 2010 concluded that the mother had suffered a hypoxic brain injury during her overdose episode. Despite this, she left the hospital against medical advice and before any long-term follow-up treatment could be arranged. The discharge summary stated:

*“[the mother] left the hospital against medical advice; we hope that she will follow up at some point with her family physician.”*

The next day, the mother was located by Vancouver Police and was again certified under the *MH Act*. Meanwhile, Paige was left living with her teenage uncle at the Balmoral Hotel during the month her mother spent in hospital.

When the Aug. 31 report to MCFD was initially received, the team leader directed Paige's social worker to find her and assess her safety. Despite this direction, no efforts were made to find Paige. On Sept. 13, 2010, MCFD received another report advising that Paige and her mother had been evicted from the hotel. Pet cats had been left behind and Paige had called extended family to help care for them.

On Sept. 19, 2010, Paige agreed with an MCFD proposal that she stay in a youth home in North Vancouver and attend an addictions treatment program. The following month, MCFD sent a letter of support to the Ministry of Human and Social Development (now known as the Ministry of Social Development and Social Innovation) stating:

*“MCFD strongly recommends that the child receive underage income assistance at this time. This youth has been staying with her mother for approximately one year in a series of transition homes, and hotels such as the Balmoral Hotel, in the DTES. For the first time since I started to work with this youth one year ago, this youth has shown a willingness to leave her mother and make a better life for herself.”*

The intake was closed with the following notation from the social worker: *“As there has been no work done with the mother and all indications have been that the mother will not work with MCFD or its services, this family service file will be closed and all work with the child will be done through the child service file.”*

On Oct. 11, 2010, Vancouver Police found Paige on East Hastings Street in the DTES, extremely intoxicated. Police took her to Vancouver Youth Detox, which advised MCFD that it could only hold her bed temporarily. MCFD response to this is unclear, but it appears that Paige stayed temporarily at a North Vancouver safe house for several days after this incident.

## Support Services Agreement Signed

On Oct. 15, 2010, Paige’s mother signed a Support Services Agreement providing consent for MCFD to provide services to her daughter. Under the terms of this agreement, Paige remained in the legal custody of her mother.

Three days later, Paige was required to leave the North Vancouver safe house because she was not a North Shore resident. She moved to a safe house in East Vancouver. Two days after this, she went to Emergency at Vancouver General Hospital with a severe skin infection on her right hand, untreated scabies and head lice. Although notified, MCFD did not see Paige at the hospital. She was later discharged to an outreach worker.

On Oct. 28, 2010, Paige was again found by police staggering alone along a sidewalk on East Hastings Street. Police escorted her to Vancouver Youth Detox, who advised MCFD. The ministry did not come to speak to Paige or assess her safety and well-being.

The lack of personal contact between Paige and her social worker characterized MCFD involvement from September 2009 until Nov. 5, 2010, when the file was transferred to a new social worker. When asked about the frequency and quality of contact, her first social worker stated: *“Very, very little and it’s typically just reviewing the memos that were coming in or on the file at the time. It wasn’t direct contact.”* This social worker could not recall meeting with Paige’s mother once during the 14 months he was responsible for her daughter’s file.

On Nov. 5, 2010, North Vancouver RCMP reported to the ministry that Paige had been found highly intoxicated and would be kept in police cells. Her new social worker picked her up from cells and placed her in a DTES youth safe house.

There was then no documented contact between Paige and her social worker until three months later on Feb. 15, 2011, other than a few notes placed on her Reconnect file.

Reconnect minutes from Nov. 10, 2010 state:

*“Was seen drinking at Oppenheimer Park. Concerns that she is drifting further away from being able to engage in a youth agreement. Encourage her to come and see her social worker at Cambie.”*

Paige's case was again discussed at a Reconnect meeting on Nov. 17, 2010. Notes from this meeting state:

*“Try to get her in to see her social worker at 550 Cambie. Concern that her intervals of drinking are becoming closer together. Was seen drinking in Oppenheimer park.”*

A Jan. 12, 2011 file notation supports Paige in an effort to obtain Underage Income Assistance. The MCFD social worker states:

*“This youth has a mom who is on the street and has basically abandoned her. The child was also living on the street for a long time. She is a sweet girl with a major alcohol problem.”*

During this three-month period without any documented ministry contact, police were again involved with Paige, although this was not reported to MCFD. On Jan. 22, 2011, police received a call from a gas station attendant advising that Paige came in saying that she had been assaulted by six unknown females. Paige suffered bruising to her face and was examined by paramedics at the scene. Police spoke to her uncle, who they mistakenly believed was her guardian, and advised him of the incident. Paige was told to call police if she was able to remember the incident the following morning. She was sent to her uncle's home in a taxi, and the police file was concluded. The confusion around Paige's guardianship meant that MCFD was not advised of this incident, and no follow-up or support was offered.

On Feb. 9, 2011, the following information about Paige was distributed to outreach workers and community agencies at a Reconnect meeting: *“Be aware that she has a medical condition Marfan syndrome. Can create heart stress so be aware that if she is drinking or if you find her unconscious to call 911.”*

A ministry Integrated Case Management meeting, involving professionals representing a number of child- and youth-serving agencies, was organized for Paige on Feb. 15, 2011. At this meeting, Paige requested a seven-week addictions treatment program at a DTES youth-serving agency, followed by an alternate education program at a local high school. Notes from this meeting state that her social worker would be following up on this request. Paige was still moving between relatives, friends and a youth safe

## Kith and Kin Agreement

Under s. 8 of the *CFCS Act*, a Kith and Kin Agreement may be made with someone who has an established relationship with a child or has a cultural or traditional responsibility towards a child. This person must have been given care of the child by the child's parent. The agreement may provide for MCFD to contribute to the child's support while the child is in the person's care.

house. MCFD records indicate that her maternal aunt and uncle were in attendance at this meeting and expressed an interest in having Paige live with them.

A community professional advocated on the family's behalf for a Kith and Kin Agreement to be explored, but they were told by the social worker: *“That's really hard to do. That's not going to happen.”* Paige stayed with her aunt and uncle frequently as they were caring

for her pet cats. When she wasn't staying with them, she visited them on an almost weekly basis during her three years in the DTES. There is no indication that the option of residing with this family permanently was further explored by the MCFD social worker.

On March 10, 2011, Paige was found passed out on a sidewalk in East Vancouver. She told paramedics she was 17-years-old and that her parents lived in the Prince George area. She was assessed as having acute alcohol intoxication, was given IV fluids and discharged to a DTES youth shelter. The incident was reported to MCFD, but no record could be found of MCFD taking any action with respect to this incident.

Less than a month later, on April 6, 2011, MCFD heard from a youth detox centre that Paige had completed a seven-day detox program and was again living at a youth safe house. MCFD did not attempt to contact her.

On April 15, 2011, Paige was located by paramedics in a basement suite in East Vancouver after neighbours called 911. The police report indicates that Paige was found slumped over, slurring her speech and heavily intoxicated. She was with a 14-year-old friend, who was naked and covered in blood. Paige was treated at VGH Emergency and then discharged to her friend's parent.

She gave the police information about the 23-year-old male who provided the alcohol and assaulted her friend. Later, she expressed concern that her safety would be jeopardized for being a "rat." A Yankee 20 social worker suggested that the MCFD worker responsible for the file meet with Paige to talk about this incident. There is no indication that such a meeting occurred.

On April 30, 2011, Paige was registered in an Aboriginal alternative school in East Vancouver in an attempt to salvage her Grade 10 academic year. She attended just three times before the end of the school year.

On May 8, 2011, Vancouver Police received a 911 call regarding Paige. A young female complainant advised that her uncle had brought home three very intoxicated females from the DTES and wanted to "take advantage" of them. The complainant said that her uncle was an employee at a DTES hotel and regularly brought home girls from the DTES. The complainant initially stated that one of the girls had been assaulted.

By the time police arrived at the residence, the three girls had left in a cab. The cab was located and paramedics found Paige covered in vomit. She was taken to VGH by ambulance to be treated for extreme intoxication. Police interviewed one of her companions who denied that a sexual assault had occurred. Police then went to VGH and were advised that Paige did not appear to have been sexually assaulted. Police did not interview the subject of the complaint, nor was Paige interviewed about the incident due to her level of intoxication. The file was concluded with no follow-up interviews of the three girls.

Police told the Representative's investigators that they did not complete these interviews because the complainant stated she was not certain a sexual assault had occurred. The



complainant recanted her initial sexual assault complaint when police attended the residence to question her uncle.

On May 9, 2011, MCFD forwarded a reportable circumstance report – the only one the Representative’s Office received prior to the commencement of this investigation – which stated: *“Paige is trading sex for alcohol with older men.”* It is unclear from file documentation where this information came from or what efforts were made to assess this reported exploitation. The report also stated that Paige’s mother *“is still on the streets and presently lives at the First United Church.”*

Paige was also living from shelter to shelter with her mother *“until she decided to do her own thing. Paige is trying to get on a youth agreement but has a serious alcohol problem.”*

On May 10, 2011, MCFD met with Paige and a family friend with whom she had been temporarily living. Paige was asked about attending treatment. She said that she would think about this, and MCFD concluded its involvement with respect to the reportable incident. Later the same day, Paige was again found by paramedics passed out on a sidewalk on East Pender.

### Reportable Circumstance Report

This is a report provided to the RCY by a public body responsible for providing a reviewable service to children and youth, as required by sec. 11 of the *RCY Act*. A Reportable Circumstance Report is made after a critical injury or death of a child who was receiving, or whose family was receiving, the reviewable service at the time of, or in the year previous to, the critical injury or death.



First United Church homeless shelter

Three days later, the family friend called MCFD to report that she had dropped Paige off at the First United Church, as she wanted to look for her mother. MCFD After Hours called the church to advise them that Paige had been dropped off there. They also contacted a standby youth worker from a local youth agency to request that they follow-up with Paige to find her alternate shelter accommodation. Later that same night, the Vancouver Police Department called to notify After Hours that they had located Paige intoxicated and would be taking her to Youth Detox.

On June 1, 2011, MCFD heard that Paige was living at an SRO hotel located above a DTES bar. The next day, the ministry held an Integrated Case Management meeting with Paige's youth worker, social worker, Yankee 20 youth social worker and workers from various community agencies. The notes from this meeting state: "*Social worker to get mom's consent to bring the child into care and find appropriate housing.*" Conflicting MCFD file information shows Paige staying with her mother at the First United Church homeless shelter intermittently between May 13, 2011 and June 12, 2011 although this would have been contrary to shelter rules.

On June 16, 2011, Paige went to BC Women's Hospital for her second pregnancy termination. Four days later, Burnaby RCMP found her highly intoxicated and sleeping on a sidewalk. Paramedics took her to Burnaby General Hospital. Neither the police nor hospital advised MCFD of this incident.

Two days later, Paige entered a local Aboriginal youth recovery program, where she remained until Aug. 27, 2011. This two-month period was the most stable living situation she had experienced since her move to the DTES almost two years earlier. It lasted until she went out on a day pass and met up with one of her "*bros,*" a former associate from the DTES. He gave her \$300 and told her that her mother was homeless again. Staff at the recovery program said that Paige went to find her mother and gave her the money she had received from her street friend, keeping only \$10 for herself. After this incident, she left the recovery program and did not return.

For the next two months, there was no documented ministry contact with Paige, despite there being an open file and a Support Services Agreement in place.

### Paige Asks to Come into MCFD Care

On Nov. 7, 2011, Paige called MCFD asking if she could come into care. Her mother was now homeless and living on East Hastings Street. One week later, the mother agreed to a VCA and Paige was placed in foster care. The social worker who met with the mother to sign the VCA observed that she was "*high on drugs.*"

Paige's first placement lasted only a week. On Nov. 19, 2011, the foster parent called MCFD to advise that Paige and a friend were outside her residence intoxicated and fighting. She said she was feeling very embarrassed about this scene happening outside her home and was worried about the neighbours' reaction. Police arrived and determined that the girls were not fighting but were intoxicated and yelling at each other. They took Paige to police cells due to her level of intoxication and later called her foster parent to

make arrangements to release her back to her care. This foster parent called After Hours saying that she was not prepared to have Paige back and that plans would need to be made to move her out.

Between Nov. 22 and Dec. 9, 2011, Paige was listed on MCFD records as missing. However, medical records show that during this time, she was admitted to the Emergency departments at two hospitals for severe intoxication, neither of which were reported to MCFD. Also during this time, Paige applied to a local alternative school, attended sporadically, and was eventually removed from the program.

On Dec. 3, 2011, paramedics found Paige on the ground in a park in East Vancouver, after she reportedly drank two 26-ounce bottles of vodka. The Emergency physician made the following assessment:

*“This young woman is dangerously intoxicated and has significant medical concerns. She is unable to make independent decisions without putting herself in jeopardy. She requires medical care, and ongoing assessment and treatment for her own safety.”*

Paige was given antipsychotic medication and Ativan and discharged the following day with no treatment plan. Although MCFD was informed of this incident, there is no documented response.

Almost two weeks later, on Dec. 16, the social worker sent the following alert:

*“The child is in care via a VCA, Mom is homeless on skid row. The child has been awol for approx. 3 weeks. The child is staying at her aunties house but if things break down she may call. Safe Houses are also familiar to the child. The child has a severe drinking problem.”*

Transit police found Paige two days later at a downtown SkyTrain station severely intoxicated and unconscious. She acknowledged consuming a mickey of vodka and an unknown quantity of methamphetamine and was taken to hospital by paramedics. She was discharged the following day to her uncle, who was listed on her chart as next of kin. There is no indication that MCFD was notified, despite her social worker’s contact information clearly documented in her medical chart.

On Dec. 19, 2011, a DTES youth safe house advised After Hours that Paige had arrived there and was planning to spend the night. MCFD did not go to the safe house, despite the earlier alert sent by Paige’s social worker.

From this date until early January 2012, Paige drifted between detox centres and safe houses while in MCFD care. It is unclear why her social worker did not attempt to contact her and assess her safety on the occasions when information about her location was received. When asked about this, the worker told the Representative’s investigators that she would usually just wait until Paige came into the ministry office to meet with her, which would typically occur a day or two following an incident or report of her whereabouts. Since Paige was on a VCA, the worker was able to offer her food vouchers and bus tickets.

## Paige Placed in a New Foster Home

On Jan. 4, 2012, Paige was placed in a new foster home. Ten days later, staff at Vancouver Youth Detox called MCFD to report that police had brought her to the unit after finding her passed out on a transit bus. The foster parent agreed to keep her home available for Paige, but was concerned about the impact that her behaviour would have on the other children in the home. Detox later advised that Paige had started to yell and scream at staff, bang on walls and continue to escalate. Police took her to cells for the night.

Emails between Paige's social worker and other MCFD staff on Jan. 17, 2012 discussed the appropriateness of Paige's placement with this particular foster parent. Her social worker wrote: *"I told her [the foster parent] that I did not want to place the child in a resource and then be told that her behaviour was too problematic and that she would have to move. This caregiver seems to be unprepared in very many ways."*

Despite these concerns, this placement proved to be the most stable environment that Paige experienced during this period. Even with continued drug and alcohol use and absences from the foster home, it appears that Paige felt safe enough with this foster parent to talk about her fears and to always return home. She would advise her foster parent when she was using drugs and always asked to go back to her foster home when she was discharged from detox or treatment.



DTES street with Balmoral Hotel

On Jan. 21, 2012, Paige was found by North Vancouver RCMP unconscious on a transit bus. She was arrested for being intoxicated in a public place and was carried off the bus. She regained consciousness once she was in the fresh air, but was unable to tell police her name or where she lived. While being walked to police cells, she kicked the police officer who was accompanying her in the leg and was subsequently charged with assaulting a police officer and released. MCFD was notified of this incident, but there is no documentation of any response.

In his Crown narrative, the police officer stated:

*"[The child] has been involved in more than 40 police files since September 2009. All of these files are disturbances, most of which involve liquor. [The child], by all accounts, is an alcoholic. She is often found sleeping in public places, semi-conscious from alcohol consumption. [The child] does not appear to be able or willing to take care of herself. [The child] needs some form of intervention, hopefully by the court, or she may be hurt or killed while on a binge."*



Eventually, in the summer after she turned 19, Paige received a conditional discharge with 90 days probation.

On Feb. 9, 2012, Paige went to BC Women's Hospital for her third pregnancy termination.

A week later, a complainant called New Westminster Police to say that Paige was intoxicated and passed out in the hallway outside his apartment door. She was arrested for being intoxicated in a public place.

On Feb. 28, 2012, Paige was referred to the Vancouver Inner City Youth Mental Health Program through St. Paul's Hospital. This referral was made by an outreach worker through a local youth day treatment program. Paige requested mental health support for severe alcohol-induced anxiety, but was unable to follow through.

A week later, Paige was found intoxicated and unconscious on a Vancouver street. She had consumed an unknown quantity of alcohol and cocaine, and was later certified by an Emergency physician under the *MH Act*. Paige's foster mother came to the hospital and sat with her at her bedside. The Emergency physician recorded the following observations about Paige: "*So severely intoxicated is a high risk to self and I am unable to assess mental status.*" MCFD was notified, and Paige was later discharged and escorted by Vancouver Police to cells.

On March 28, 2012, Yankee 20 was advised that Paige was missing from her foster home and could possibly be at an SRO hotel with her mother.

On April 6, 2012, Merritt RCMP informed After Hours that they had found Paige intoxicated in the middle of a road. She had travelled to Merritt to reconnect with family. Paige was taken to hospital and later sent back to Vancouver.

A new MCFD social worker was assigned to Paige's file in April 2012. This worker contacted a local youth outreach agency and Yankee 20 on April 17 with the following information:

*"The child is about to turn 19 and she is quite unstable right now ... if you see her please encourage her to go home and plan for transition ... Youth had a one month transition period with this worker. Youth has serious addiction issues. This worker is new to her case and he has three weeks to open an underage income assistance file and secure housing for her post 19."*

Some efforts were made to help Paige during her last few months in MCFD care. A transition worker from a local youth agency was asked to help her find an appropriate place to live when she left care. Reconnect minutes show that efforts were being made to get her a mentor and to encourage her to attend an appointment with a drug and alcohol counsellor. The new social worker who had inherited the file advised the Representative's investigators that Paige had a drug and alcohol counsellor through the Nexus program, although it was later discovered that she had not actually attended any appointments with this counsellor. The referral to this addictions counsellor was made by Paige's outreach worker from a local youth-serving agency.

An MCFD closing recording on Paige's file stated:

*"The child is one month from turning 19 and unfortunately she is still binge drinking heavily and appears not to be overly concerned about having anywhere to live at age 19."*

However, an email from the foster parent to the MCFD social worker on March 5, 2012 stated that Paige's "*anxiety builds as her move out date approaches.*"

## Paige Ages Out of Care

Paige remained in her last foster home for four months until she turned 19 on May 1, 2012. The next day she moved from her foster parent's home to accommodation for Vancouver-area youth at risk. No ministry social worker attended to check the appropriateness of this living situation, and Paige's file was closed.

The last social worker to have her file told the Representative's investigators that he was not aware of any MCFD practice standards that required a worker to observe the living circumstance of a child leaving care.

After Paige was discharged from care at age 19, there was a marked deterioration in her ability to cope.

Outreach staff told the Representative's investigators that Paige began using crack cocaine and meth in June 2012, about a month after her exit from MCFD care. In February 2013, she began injecting heroin. She confided in her outreach worker about her drug use, but hid it from everyone else.

According to this outreach worker, Paige did not want to tell her mom she was injecting heroin because she didn't want to disappoint her. She also disclosed to this outreach worker that she was dealing drugs for some older males she referred to as her "*bros,*" had run up a costly drug debt and had to "*work off*" this debt.

A psychiatric assessment of Paige was completed on March 7, 2013, the result of a referral to the Inner City Youth Mental Health Team. Paige met the criteria for generalized anxiety disorder and was possibly also experiencing Obsessive Compulsive Disorder traits. Paige was prescribed Citalopram to assist with the management of her anxiety and Quetiapine to address her insomnia. This was the first and only psychiatric assessment Paige ever received.

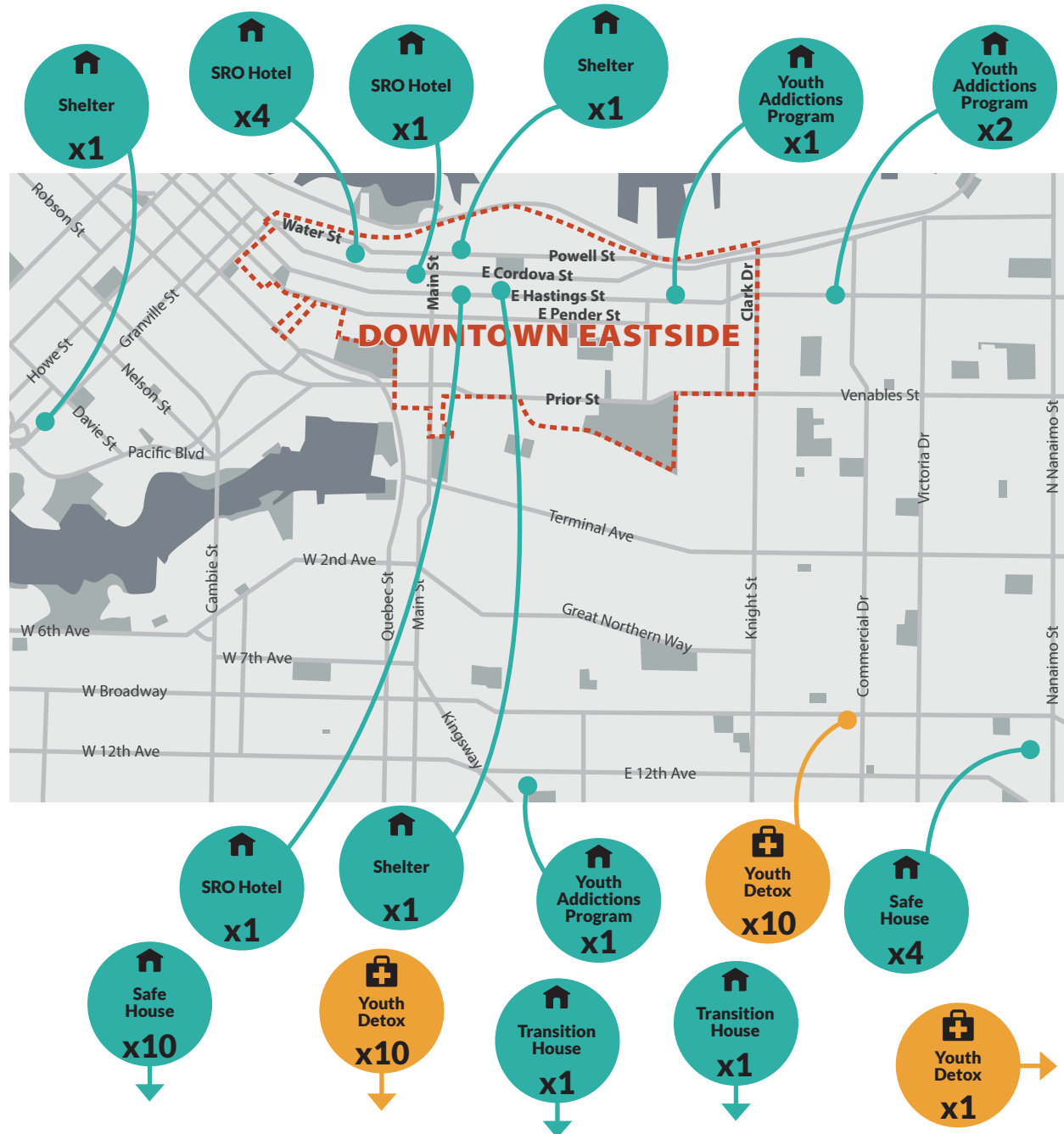
A follow-up appointment was arranged for April 4, 2013. Paige did not attend this appointment. She died of a drug overdose 20 days later in the communal washroom of a supportive housing complex adjacent to Oppenheimer Park in the DTES.

Between leaving MCFD care and her death just 11 months later on April 24, 2013, Paige had been admitted to Emergency on four occasions for extreme intoxication.

Eighteen months later, Paige's mother died in her DTES SRO hotel room of a drug overdose.

## Constant Turmoil: 50 moves in 2½ years

September 2009 to May 2012



### Additional Accommodations:

Paige also spent several days in Vancouver police cells, Merritt RCMP cells and hospital Emergency wards, and for periods of time was missing all together.

# Analysis

**Overall Finding:** Despite the absolute predictability of this tragedy, the child protection system, health care system, social service agencies, the education system and police consistently failed in their responsibility to this child and passively recorded her life's downward spiral. The social workers tasked with caring for Paige clearly foresaw what would inevitably happen to her but seemed unable or unwilling to do what would have been necessary to alter the trajectory of her life. They failed to register or respond to the compounding trauma in her life and provided no meaningful assistance, leaving her in a dangerous situation that led to her death. Any supports offered were utterly inadequate to address the scope and scale of her life challenges, which included being the victim of regular abuse, neglect and maltreatment, having serious mental and physical health needs largely unmet and high-risk use of alcohol and substances to self-medicate her horrific pain.

The Representative is unable to understand the pervasive system-wide professional indifference to this young Aboriginal girl when the challenges to her vulnerable cohort were so well-known to the ministry and other professionals. The system has no learning from this tragic death and shows little insight into its responsibility for her or other youth in similar circumstances.

During the first three years of Paige's life, the ministry received seven child protection reports involving domestic violence, neglect and child abandonment. Paige was removed from her mother's care three times, only to be returned under varying degrees of ministry supervision.

## Assessment of Risk

MCFD is mandated to ensure that the children of B.C. are provided with protection from abuse and neglect and supported in alternate living arrangements when parents are unwilling or unable to protect or provide safety for their children. Accurate assessment of risk is a crucial foundation to ensuring that adequate interventions are provided. Risk assessment considers the likelihood that severe maltreatment will occur over the longer term (see box).

## Risk Assessment

MCFD Risk Assessments measure specific risk factors such as:

- Nature and severity of previous maltreatment
- Characteristics of the family environment (e.g., domestic violence)
- Caregiver characteristics (e.g. substance abuse)
- Child characteristics (e.g. age, problem behaviour)

Some children in a family may be at higher risk for maltreatment due to their age, gender, or disabilities. Each risk factor is given a rating and social workers consider the combination of ratings to assess overall risk. Then overall risk is generally classified into levels such as low, moderate and high.

Source: Knoke, D. & Trocme, N (2004). *Risk assessment in child welfare*. Centre of Excellence for Child Welfare. Retrieved from <http://cwrc.ca/sites/default/files/publications/en/RiskAssessment18E.pdf>



Paige suffered extreme trauma throughout her life as a result of MCFD's failure to adequately investigate the more than 30 serious child protection reports it received and intervene effectively. Assessment of risk was minimal, deeply flawed and either ignored or totally misjudged the ongoing and chronic jeopardy which characterized Paige's day-to-day life. The risk factors were overwhelming and yet the ministry interventions were either absent or entirely inadequate to protect her.

Assessment of risk to a child must be thorough and take into account a variety of markers and indicators that help predict future risk of harm. If the assessment is not comprehensive in scope, its accuracy will be in doubt. Risk assessments are used as a prime predictive tool to accurately inform a social worker's decision-making when determining the risk of harm to a child and what interventions are necessary to mitigate the risk.

When Paige was five-months-old in October 1993, as part of the protection investigation, the social worker completed the ministry-required risk assessment which informed the decision to remove Paige from the legal custody of the parents. Yet with no apparent change in the circumstances, she was returned a few days later.

A further risk assessment was undertaken when Paige was again removed in March 1994.

Three months later, in June 1994, another assessment was completed leading to Paige once again being removed. All three removals were characterized by Paige being abandoned by her parent or parents, along with family violence, alcohol abuse and continuing transience.

Nevertheless, despite Paige's vulnerability, her history of abandonment, her mother's own history of being brought up in an alcoholic and abusive home and being abandoned by her parents, and the multiple other indicators of risk of harm, Paige's mother was described by the social worker as follows:

*“When she parents the child she does a superb job of meeting her emotional and physical needs.”*

The Representative fails to understand how any rational person charged with protecting a child could reach this conclusion. It is as if the worker had no understanding of child development or the pathways for Aboriginal children impacted by neglect, family distress, mental illness or addictions, and demonstrated willful ignorance or indifference, or both.

In May 1995, following a further report of neglect and Paige's concerning behaviour, another investigation was opened and a further risk assessment was completed. Paige was seen in her daycare. Her mother indicated that domestic violence continued to be present in the home.

The risk assessment touched upon the previous concerns. But once again, the chronic dysfunction in Paige's home, although alluded to in the assessment, did not result in a closer look at the plight of this child and the capacity of the mother to safely parent.

In December 1995, another report was made to the ministry and a further risk assessment completed. Once again, the context of Paige's life was overlooked in the face of the mother's denial that anything was seriously amiss. The risk assessment form was completed but the risk of harm was neither comprehensively assessed nor actively managed.

Another protection report made by the RCMP in March 1996 again led to a risk assessment. But in the face of the mother's unwillingness to accept ministry services and her denial of the documented protection concerns by the RCMP, the risk assessment, while highlighting the ongoing nature and pattern of the safety issues, completely failed to spark any ministry action beyond an offer of protective services. As Paige was inexplicably found to be "*immediately*" safe, potential ministry protective action was curtailed.

In June 1998, the mother contacted the ministry requesting support. She was feeling "*worn out*" with caring for Paige and asked that her daughter be placed in a foster home. This followed the mother having expressed feelings of depression the previous year. She had also been referred by the ministry to a mental health counsellor. The request for support once again did not launch a fuller assessment even though the mother did acknowledge sporadic drug use in addition to her alcohol use. The mental health status of the mother was also not considered, nor was her ongoing capacity to provide adequate care and emotional support for Paige.

Opportunities to rigorously assess past and current harm to Paige continued to be missed as the social work focus remained on keeping Paige and her mother together, regardless of the cost of a lost childhood.

It was known by the ministry in February 2000 that the mother was being prescribed methadone. A report was also made to the ministry at the same time alleging that the mother was smoking crack cocaine while her daughter was in the house sleeping.

The ensuing protection investigation found that Paige was in need of protection and that her parent was unable to care for her. Paige was placed with her maternal grandmother under a CIHR agreement. A comprehensive risk assessment was not completed despite the overwhelming jeopardy that Paige had faced while in the care of her mother.

The ministry was advised by the mother in early 2001 that she had been in a treatment program for her substance dependencies. She wanted her daughter back and was seeking financial assistance. This information did not result in the ministry reassessing the risk of harm to Paige if she again lived with her mother, nor did it require an assessment of parental capacity. Thus Paige was again reunited with her mother with no ongoing safety plan to monitor the status of her mother's substance use.

In October 2003, the assigned social worker in Kamloops completed a risk assessment in the wake of Paige being removed from her mother's care again. The social worker used a newer and more thorough assessment tool, the Comprehensive Risk Assessment (CRA). This tool required a deeper scrutiny of the factors that informed the risk of harm to children than the earlier one. Though narrative in scope, it also attempted to weigh the various influences that had been found to predict susceptibility of harm to children.

Paige's removal was triggered by her mother's abandonment of her, her ongoing substance use issues and her avoidance of the assigned investigating social worker.

The CRA, completed Oct. 27, 2003, found Paige to be at high risk of further harm if she was returned to her mother's care.

Two more CRAs were completed during the following year in Fort St James. They concluded that the risk had significantly diminished, as the mother had gained enough stability to engage somewhat with her social worker and had briefly found employment. She also attended a few sessions with an addictions counsellor.

However, the mother did not enter an addictions treatment program, and avoided substance use screening. There were reports of her active use of crystal methamphetamine during this time. When Paige was legally returned to the mother in September 2004, the mother stopped going to counselling. The family file was closed the following March when the Supervision Order expired. The Representative's investigation found no documentation in the MCFD files that the mother ever complied with drug-testing requirements.

The next CRA was completed in Kamloops in July 2007, with a finding of Paige being at medium risk of further harm.

The last risk assessment on the file from July 2008 was never fully completed. Nevertheless, there is a telling comment in the mental/emotional ability to care for child category. The social worker wrote:

*"It is uncertain if the parent has any mental/emotional deficits and to what extent they may impact parenting. The parent displays very erratic behaviours; one day she is reasonable to communicate with and the next she is yelling obscenities."*

The parent had by this point remained the primary caregiver to her daughter for more than 15 years.

The Representative fails to understand how, based on the ministry's own standards and policies, and knowing what it already did about the mother's behaviours, that this situation was allowed to continue.

## Child Safety Investigations

The ministry investigations into Paige's safety focused on using what the ministry terms "*less disruptive measure*," or a desire to not use removal and attempt to work with a parent on a child's safety. When Paige was removed, she was speedily returned to the parents or solely to the mother with inadequate means of ensuring her ongoing safety.

The mother presented as hostile and evasive to the investigating social workers. Multiple times, the social workers closed off the investigations with the threat that more intrusive action would be taken the next time a report was received. Meanwhile, Paige continued to be left with, or returned to, her mother by MCFD without any comprehensive plan of

monitoring or ensuring her safety. It was as if each subsequent worker ignored previously gathered information, however limited, in earlier reports.

It is evident that scant use was made of collateral information to inform risk assessments and risk decisions. The Representative's investigation noted only one *CFCS Act* s. 96 request for information in MCFD files. Information respecting the mother's request for crisis grants, her evictions, loss of damage deposits, changes of residence, rent monies not being paid to landlords and aggressive behaviour in income assistance offices was never obtained and reviewed by the ministry.

The mother's arrests were frequently unknown to MCFD as police reported only a fraction of the contacts they had with the family. The ministry did not request crucial information that would have revealed the extent of her police involvement.

Paige was rarely seen or interviewed by the ministry and access to the places where she lived was frequently blocked by the mother. Risk decisions were made with little appreciation of the ongoing trauma to which Paige was exposed.

During her childhood and early adolescence, there was a constantly changing complement of social workers investigating the many protection reports. By the time Paige aged out of care, 17 different workers across the province had been responsible for her. Only one social worker spent enough time with her to develop a more than rudimentary relationship. The absence of a long-term and trusting connection would prove a consistent barrier to Paige's acceptance of any suggested interventions.

As her mother's mental and physical condition deteriorated, Paige felt an increasing responsibility to care for her, while at the same time neglecting her own needs. For Paige to be safe and to benefit from any placement, she needed to know that her mother was being helped.

One of the changes to B.C.'s child welfare legislation in 1996 was the inclusion of the concept of "*likelihood of harm*." This change permitted social workers to assess and act upon not just an immediate evidence of harm to a child, but to include an analysis of past parental behaviour to better assess the potential for ongoing child abuse and neglect. Time and again, Paige was left with or returned to her mother with no evidence of diminishment of risk to her. Files were closed prematurely and the mother was permitted by default to continue placing her daughter in increasing jeopardy.

That the mother was not immediately under the influence of narcotic drugs or alcohol appeared to be assessed as an indication that Paige would be safe. Thorough and fact-informed investigations of the protection reports and family circumstances could have brought an end to this revolving door and the irreversible harm to Paige.

Paige's mother disrupted and sabotaged Paige's placements, both those with extended family and those with ministry foster families. This behaviour should have triggered a number of ministry responses that would have protected the placements and provided longer term stability. Instead, the mother was allowed to terrorize the foster parents

with no apparent consequences. Although her motivation may have been a desire to reunite with her daughter, she appeared to have little ability to regulate her emotions and actions. This presented a chronic risk to Paige's safety and well-being and often placed on her responsibility to manage her mother's behaviour and protect herself.

Prior to concluding intake reports and closing files, best practice requires evidence that the risk of harm to the child has diminished and that an adequate safety plan is in place to identify if or when a child requires safety interventions and further planning.

While it may have been the ministry's view that it was preferable to ignore or overlook the mother's evasive or obstructive behaviour in an effort to elicit her cooperation, the mother's parenting remained dangerous and destructive. It is incomprehensible that this could be ignored time and again over the years.

Between January 1997, when Paige was four-years-old, and October 2002, when she was nine, 10 child protection reports and requests for family services were made to MCFD.

The mother's alcohol and drug use was a factor in almost every intake report and family services request and yet the impact of these addictions on Paige was rarely given more than a cursory look. Although the ministry repeatedly asked the mother to take dependency treatment programs, she was unable to stay clean and sober for more than a few days. No confirmation was found in the MCFD case files that she was ever able to complete a treatment program. By framing her mother's problems as solely addictions related, MCFD ignored her substantive mental health and trauma-related challenges and the abuse Paige experienced by being exposed to the behaviour of a parent who is an active and chronic substance user.

MCFD Child and Family Development Service Standard 17: Concluding a Child Protection Investigation states:

*“To conclude an investigation, decide whether the child needs protection, by:*

- *Considering relevant information collected during an investigation*
- *Examining the strengths and risks of the family, using a standardized culturally appropriate assessment tool*
- *Considering what role natural helpers and informal supports can play in keeping the child safe, and*
- *Consulting with others who are familiar with or have specialized knowledge of the child's circumstances.”*

With no safety measures in place, and MCFD intake files prematurely closed, there was no mechanism to reassess child safety despite what was clearly ongoing high-risk circumstances. Paige and her mother were thus frequently out of sight, their circumstances and place of residence unknown until another complainant stepped forward to furnish a new set of concerns to MCFD.

**Finding:** Health care professionals, hospitals, police, outreach workers and staff at shelters and SROs repeatedly failed in their duty to report child protection concerns to the ministry, as required by s. 14 of the *CFCS Act*, when a child is in need of protection.

Despite the cynicism expressed by some witnesses about the ministry's ability to effectively respond, failure to report is an offence under the *CFCS Act*. The repeated failures to act on this legal duty meant that critical information was not made available to the ministry workers responsible for Paige, even though this information could potentially have triggered some intervention or response.

**The ministry repeatedly failed to provide reports to the Representative as required by s. 11(1) of the *RCY Act* about the multiple critical injuries sustained by Paige while she was in ministry care or receiving ministry services.**

The Representative has previously drawn attention to the widespread non-compliance with the legal duty of all citizens to report to MCFD if they believe a child needs protection as defined in s. 13 of the *CFCS Act*.

In *Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl*, the Representative made a recommendation directed to the College of Physicians and Surgeons and the College of Registered Nurses about reminding their members of this statutory responsibility. This recommendation has been taken and seriously implemented. The Representative also recommended that the Attorney General of B.C. review the reasons for the lack of enforcement of these provisions of the *CFCS Act* and that steps be taken to promote compliance. There has been no implementation of this recommendation.

One glaring example of this failure to report in this case involves the then-named Ministry of Social Services (now known as Ministry of Social Development and Social Innovation), which provided financial assistance to both mother and daughter during the periods when Paige was not in MCFD care. The financial assistance workers were aware of the mother's medical condition and disability designation including her depression, neurological issues and addictions. They were aware of the continual evictions due to non-payment of rent, moves from community to community and the mother's chronic cycle of addictions, erratic and violent behaviours and attempts and failures to complete treatment programs. However, income assistance workers never made a protection report to MCFD, despite knowing that the mother was responsible for the care of her vulnerable child.

The more serious pattern is that of front line professionals failing to report to MCFD. One specific such example occurred in April 2010, after Paige and her mother fled the DTES to a transition house in Surrey. Transition house staff had concern for Paige after she had spoken to counsellors in their program for children who witness abuse. A staff member later told the Representative's Office "*we didn't phone [MCFD] this time – in this particular case. I asked everyone, why hadn't we done that – and I think once this woman left, it just got totally like missed.*" The justification given was that there were other more high-



risk situations happening in the transition house at the time, and obvious concerns around Paige's safety went unreported.

Multiple contacts with health officials, hospitals, police, community service agencies, emergency shelters and others did not result in reports to MCFD as required by s. 14 of the *CFCS Act*. Non-professionals likewise appeared unaware of their responsibilities to report under the same section. S. 11 of the *RCY Act* places a duty on a public body that is providing a reviewable service to report to the Representative of any critical injury or death of a child who is receiving such a service (see Appendix A). In this case, this would put primary responsibility on the ministry to be reporting the repeated traumatic events in Paige's life to the Representative.

To have received only a single such report prior to the commencement of this investigation is deeply disturbing to the Representative, as it demonstrates neglect of a fundamental part of the oversight mechanism for child welfare in this province. Had the Representative been receiving even a fraction of the reports that should have been generated, these would have been carefully reviewed and brought forward to the attention of senior ministry staff. Without this information, the Representative was unable to perform her statutory duties.

**Finding: Repeated changes in child protection policy and expected practice often left social workers confused about what actions they should take in order to ensure this child's safety. For Aboriginal children and youth in particular, politically influenced changes to the ministry's agenda contributed to an institutional reluctance to provide effective interventions, resulting in predictably disastrous consequences for the children they were supposed to serve. This includes an acceptance of the DTES as an acceptable venue to raise a child – a completely unconscionable choice with the level of known harm and danger in that location.**

Paige was born in 1993. To provide a more complete picture of what was occurring for her, it is helpful to understand the changes to child welfare practice that were occurring at the same time. During her life, the guiding principles and philosophy of MCFD oscillated between the light touch of the "least intrusive" approach and a child-centred approach that emphasized child protection.

The child welfare legislation in force at that time in B.C. – the *Family and Child Services Act (FCS Act)* – had been under intense scrutiny and review and was in the process of being rewritten. The *FCS Act* was to be replaced by new legislation that incorporated evolving social work practice with an emphasis on the rights of children, families and Aboriginal peoples.

The *FCS Act* was replaced by the *CFCS Act* in 1996. The philosophical underpinnings of this new legislation encouraged the building of new relationships based on family strengths and community engagement. This reflected the broader institutional realization of the immense damage that had been done to Aboriginal families as a result of the residential school system and apprehensions of Aboriginal children.

The *CFCS Act* emphasized the rights of children and parents, mandated the use of the “*less disruptive measure*” in child welfare interventions and recognized the unique needs of Aboriginal families. Although its guiding principles made the safety of children the paramount consideration, it also emphasized the use of support services to the family unit as the preferred environment for the upbringing of a child.

Following the legislative changes, the ministry introduced a revised policy and procedures manual in 1996. This highlighted the legislative requirements for the ministry to explore and access extended family and kinship as well as Aboriginal communities as alternatives for caring for Aboriginal children who could not remain in their own homes. These same principles were enshrined in ministry standards in an attempt to ensure clarity around the duty and responsibility of working with Aboriginal families and communities.

Ministry social workers involved with Paige and her family during the early years of her life characterized the child welfare system as being in disarray as the ministry struggled to adopt these new practices. Around the same time, the ministry introduced a new computer system that many workers found initially challenging.

Ministry workers involved with this child and her family during this period of time recalled the over-riding practice concern during Paige’s early years as being focused on the use of the less disruptive measures. They also remembered a court environment that they perceived as reluctant to support the removal of children from their families, preferring instead the use of Supervision Orders to protect child safety. One worker said:

*“I do recall that ... the child would be returned because the judge wasn’t happy with the way things went down or the person had a good lawyer and – the Report to Court was basically dismissed and the judge would say ‘I’ll return under a supervision order’.”*

There were also significant external factors that had a profound influence on child welfare practice. In 1995, the *Gove Inquiry* into the death of five-year-old Matthew Vaudreuil offered a stinging critique of the ministry’s child protection work and concluded that the “*protective*” services offered to the family were directed more to the benefit of the mother than the safety of the child. One social worker observed:

*“... and then post-Gove, I think social workers removed more [children] under, I’m going to say, some degree of apprehension about not removing, and what you heard a lot of was ‘I’ll remove the child and let the judge make the decision’.”*

Although the *Gove Inquiry* may have again shifted the practice focus from family support to a more activist and child-centred approach, the ministry was also bolstering other less intrusive measures, including family group conferencing and mediation. This was followed in 2003 by the introduction of the Family Development Response as an alternative to investigation in ministry child protection issues. Another new set of Child and Family Development Service Standards was developed and released to staff in 2003 and then a revised edition was released the following year.

## Family Development Response

This is an approach to child protection reports that may be taken after the results of an assessment show the risk of harm can be managed through the provision of intensive, time-limited support services. It includes a strengths-based assessment of a family's capacity to safely care for a child and provision of support services, instead of a child protection investigation.

It is impossible for the Representative not to conclude in this investigation that there was a direct connection between MCFD's repeated failures to intervene to provide safety and stability for Paige and these significant swings in provincial child protection practice. Repeatedly, numerous deputy ministers, chiefs and others have stated their desire to reduce the number of Aboriginal children in care. Paige's short life should be considered a stinging rebuttal to that political posturing – the real issue is to eliminate or reduce the abuse and neglect of Aboriginal children. The well-being of children should remain the ministry's – and indeed everyone's – focus. Finding placements within extended families is an essential tool, as is a real working relationship with communities.

What is clear is that workers during key periods in Paige's life were confused by the shifts in emphasis in child welfare and uncertain about what they were expected to do. One worker told the Representative's investigators simply "*We don't know where we stand.*" The Representative believes many still remain utterly confused about how to support children such as Paige.

## Permanency

**Finding:** The ministry's ongoing failure to appreciate the profound risks to this child resulted in her experiencing compounding abuse and trauma. Rather than leave her to experience continuing abuse and neglect, the appropriate child welfare response would have been to remove her permanently in her early years or to provide long-term and meaningful support that would have connected her to extended family, her culture and school. These connections could have disrupted the pathway she was on leading to her death.

Of particular concern to the Representative is the lack of action by the ministry to pursue a potential family placement offered by Paige's aunt and uncle in East Vancouver.

This option was not explored by the ministry despite the fact that these family members were prepared to provide a home. As members of her Aboriginal community, they would have been better able to provide key cultural support that was not provided in Paige's eventual non-Aboriginal foster care placements. These placements were contrary to existing ministry policy which mandated the placement of an Aboriginal child with an Aboriginal family whenever possible. This type of cultural support would have strengthened Paige's resilience.

After Paige and her mother were evicted from the Balmoral Hotel, the aunt and uncle cared for Paige's pet cats. Paige visited her cats at their apartment on a weekly basis during her three years in the DTES. The aunt and uncle were rare constants in her life, as evidenced by their ongoing relationship.

## MCFD CHILD AND FAMILY DEVELOPMENT SERVICE STANDARDS

### *CFS Standard 2: Children and Families from Aboriginal Communities*

To preserve and promote a child's Aboriginal heritage and connection to his or her Aboriginal community, the following must be involved in all significant decisions when determining the child's Aboriginal connections, heritage and descent, and when assessing, planning and providing services for the child:

- the child
- the child's family
- the child's extended family
- the child's Aboriginal community
- the identified delegated agency and any other community agencies involved with the child and family, and
- any significant people identified by the child and his or her family or Aboriginal community.

### MCFD POLICY

*From initial contact and throughout the period of involvement with a child and family, involve the Aboriginal community to:*

- identify the strengths within the Aboriginal community and heritage of the child and family
- identify extended family members
- identify, plan and deliver services that are culturally appropriate and accessible
- provide information to help strengthen and support the Aboriginal child's home and in turn help ensure his or her safety and well-being
- participate in the development and implementation of plans of care that will preserve the child's cultural identity
- ensure that review processes are sensitive to cultural perspectives and are carried out in ways that are culturally appropriate
- identify and develop an appropriate out-of-care living arrangement for the child, and
- reunify Aboriginal children who have been removed from their homes and communities with their extended families and communities.

When interviewed, the aunt and uncle told the Representative's investigators that they had met with Paige's social worker and suggested a plan to get a larger apartment so Paige could live with them. The worker made a cursory visit to their apartment and provided grocery vouchers when Paige stayed there.

The aunt and uncle were treated only as an informal placement, called when Paige was picked up by police or released from hospital.

When asked about the rationale for not supporting this family placement, the assigned social worker told the Representative's investigators that the aunt and uncle were not proactive in requesting this. She described the aunt as timid and soft spoken, and said that was common among her Aboriginal clients. She interpreted this as meaning that the aunt was not overly interested in having Paige reside with her. The social worker had no recollection of the family ever requesting financial support to obtain a larger apartment so Paige could live with them, although file notes made at the time include this statement: *"Aunt and Uncle would like to move into a two bedroom with her."*

A senior staff member at a DTES non-profit agency told the Representative's investigators that this social worker was resistant to placing Paige in this home. She noted consistent *"pushback"* from MCFD, recalling that the social worker suggested that the *"family's just sort of – seems to be asking for money, this isn't the best place, and*

## CFS Standard 20: Placements When a Child Comes into Care

Give priority to placing a child with extended family, consistent with the child's best interests and need for stability and continuity of lifelong relationships.

In addition to the above, if a child is Aboriginal, always give priority to placing the child within the child's Aboriginal cultural community. If the extended family or community cannot safely assume the child's care, give priority to placing the child with another Aboriginal family outside the child's Aboriginal cultural community.

If these placement priorities are not possible, make every effort to place the child in a location:

- where he or she can maintain contact with relatives and friends
- in the same family unit as the child's brothers and sisters
- that will allow the child to continue in the same school, and
- that will allow continued contact with his or her cultural community.

If an Aboriginal child is placed in a non-Aboriginal home, provide him or her with opportunities to maintain positive contact and involvement with the Aboriginal community or establish relationships with an alternative Aboriginal community or urban Aboriginal organization close to where the child lives.

*it's better for her to go into care or go into a day type program or some other program."* The rationale provided by the social worker was that she did not want to put the effort into formalizing this family placement for Paige until she had addressed her drinking problem. The agency staff member advocated for the family placement and suggested, to no avail, that a day program for Paige would not address her basic need for stable housing.

Instead of being placed with her aunt and uncle as a core placement with additional supports for education and treatment, Paige spent three years shuffling between shelters, detox facilities and SRO hotels, an outcome apparently acceptable to her social workers.

The Representative believes that the Aboriginal community will be deeply troubled with the almost non-existent cultural supports and connections for this child and the gross disregard for the legislation,

standards and policy that were put in place in 1996 in response to serious historical practice issues. The inability to work effectively with this Aboriginal family demonstrates the continuing failure of the ministry to implement these long-standing standards and policy in a meaningful way for families and workers. Clearly, effective oversight and accountability are lacking throughout the child protection system, resulting in ineffective and inconsistent application.

Having strong and enduring cultural connections is an important protective factor. It is likely that if Paige had been supported in retaining strong connections to her culture and extended family then her physical and mental health would have improved. The importance of a child remaining connected to his or her culture must not be overlooked by service providers.

Paige lived with her Aboriginal family, mother, grandmother and extended family for some significant periods of time. She attended an Interior Indian Friendship Centre day care and was referred to First Nations school counsellors and special programs while in elementary school and beyond. However, Paige's frenetic life and continual dislocations

## Young Wolves Lodge

Young Wolves Lodge was a five-bed, 16-week voluntary residential treatment program in the Vancouver area (closed in March 2015). Clients were young Aboriginal women ages 17 to 24 who had substance misuse issues and were homeless, or at imminent risk of homelessness. Young Wolves Lodge embraced First Nations ceremonies, traditions and teachings, incorporating them with a holistic clinical approach to best support youth by guiding, teaching and empowering them. This program was a service of the Urban Native Youth Association and provided a comprehensive range of services to youth, including:

- Alcohol and drug education, Alcoholics Anonymous and Narcotics Anonymous meetings and other relapse prevention resources
- On-site counsellor and post-treatment planning
- Planning and transitional support towards independent living.

would have made it impossible to develop any sense of continuity, predictability and deep rootedness.

During her years in the DTES, Paige had one very short period of attachment to a resource service that appeared to understand the needs of the cohort and be a positive reflection of culture. She lived at the Young Wolves Lodge from July 12 to Aug. 27, 2011, participating in a residential treatment program.

A supervisor of this program told the Representative's investigators that Paige responded positively to the First Nations healing modalities used in the program and he was struck by the fact that she functioned so well in the program:

*"We have a structure and I was really surprised that she stayed ... people say she stayed at the Wolves longer than any place else. I think it was the engagement between her and the staff ... and the spirituality part."*

The program supervisor sensed that Paige had a deep pull towards her mother and talked about facilitating visits with her mother at the Lodge.

*"We talked about her mom coming up to the Lodge and spending time with her, but we never got to that point because of the incidents that happened next."*

While on a day pass from the Young Wolves Lodge, Paige was told by a street person that her mother was homeless. This news completely destabilized her. Her mentor at the program told Representative's investigators that:

*"A guy who she met up with said that her mother was homeless ... I think it snowballed from there because she felt that she needed to take care of her ... that's how strong the bond was."*

Despite the culturally relevant stability offered by this program, it was not sustainable for Paige. She left the program to find her mother and never returned. This could have been a source of resilience if she had remained there. This program was not sufficiently supported in the health, education or child welfare system. It was closed in March 2015 due to withdrawal of funding.



## Education

**Finding:** The education system’s passivity mirrored that of the child protection system. School could have been a protective factor that changed this child’s life pathway. Instead, despite her potential and motivation to learn, she was allowed to drift away from her connections to school with predictably negative outcomes.

All indications are that this child was bright and motivated to learn. Her early school years showed real signs of promise. Unfortunately, her mother’s transience and her chaotic home life meant almost constant disruption to her education. Paige experienced 16 school transfers in multiple communities before finally abandoning school entirely.

Paige’s educational achievement was sabotaged by her life. From a bright, engaged and creative small child who achieved remarkably well in school, there was a gradual lessening of her ability to engage. Her quiet calls for help are documented in her behaviour. The schools she attended worried about her. They identified the barriers to her success, her lack of academic gains and her gradual social disintegration. Her teacher wrote the following comment on her Grade 7 report:

*“It is with heavy heart that we write the child’s report card. Her numerous absenteeism and frequent tardiness makes it difficult to grade her with any accuracy.”*

While there is documentation that indicates that the ministry was advised of particularly egregious situations that Paige disclosed about the events in her home life and about her personal safety, there is little to suggest that the ministry and the school system ever collaborated beyond the immediate presenting situation on a plan to keep Paige safe.

Grade 7 appears to have been a watershed year for her. In her first term, her teacher commented that despite her frequent absences she was still able to keep her grades at a C+ to B level. Her Grade 7 report card comments neatly captured her situation:

*“The child is a bright student whose life outside school makes it almost impossible for her to reach her academic and behavioural potential.”*

Violence at home, police involvement and the arrests of both Paige’s mother and her mother’s boyfriend put even further pressure on Paige. She began coming to school exhibiting signs of drug use. Her Aboriginal school counsellor asked MCFD for a mental health referral for her and, in the meantime, an assessment conducted by the school resulted in Paige being designated as having “*moderate behaviour/mental illness*,” which resulted in the creation of an IEP for her.

A review completed a few months after the creation of the initial IEP reflected Paige’s increasingly challenging behaviour and resulted in her being re-designated as being in need of “*intensive behaviour support*.” The lack of documentation suggests the requested mental health referral did not take place, possibly because the mother took Paige back to their home community in the meantime. Paige’s circumstances meant that a referral was unlikely to ever actually occur. Meaningful and accessible mental health supports being present in the school itself could have provided some of the assistance she required.

In the context of continual moves, Paige was unable to firmly re-establish herself in any school setting for the next three years. After she and her mother arrived in the DTES, subsequent attempts to re-enter the school system were unsuccessful. Although a Vancouver high school counsellor described the girl as “charming” and “excited to start school,” and her teachers found her “resilient, hardworking and independent,” her life circumstances quickly overcame her. Even enrollment in an alternative program focused on Aboriginal students failed to engage Paige and allowed her to drift away.

Although education should have been a primary concern for MCFD and an easy predictor of Paige’s future success, her prolonged absence never triggered a response appropriate to the seriousness of the situation. No one went to find her and the Representative is of the view that this cohort of Aboriginal children living in unstable situations is seen on the school grounds but is too often allowed to drift away from actual learning.

## Service Delivery and Child Protection Practice Issues in the DTES

**Finding: Despite the expenditure of hundreds of millions of dollars annually by more than 200 health and social service agencies in the DTES (a community of only 18,000 people), no one familiar with this dangerous and disordered environment could conclude that living here would have anything but disastrous consequences for this vulnerable young Aboriginal girl. Paige was left for three years in conditions that no reasonable person would find acceptable for their own child. Tolerance of this situation represents an abject failure of leadership and policies by governments at all levels.**

On Sept 27, 2010, Wally Oppal QC was appointed to head The Missing Women Commission of Inquiry, examining police practices in relation to women, many

Aboriginal, who had gone missing from the DTES between 1997 and 2002. This Inquiry would repeatedly highlight the enormous risks faced by girls and women such as Paige. Despite this, the ministry took no meaningful action to safeguard her from these well-documented risks.

Between the ages of 16 and 19, Paige drifted through more than 50 locations, mostly in the DTES – among homeless shelters, safe houses, youth detox centres, temporary accommodations with relatives and friends, two ministry foster homes and various DTES SRO hotels.



Looking down a DTES street

## Service Delivery

Paige had three different child protection social workers during her time in the DTES. A lack of personal contact and meaningful engagement typified the relationship between her and her social workers during this time. When asked about the frequency and quality of contact, her first social worker said:

*“Very, very little and it’s typically just reviewing the memos that were coming in or on the file at the time. It wasn’t direct contact.”*

This social worker could not recall if he ever met with the mother during the entire time he was responsible for the case, a period of 14 months. A review of the file shows no indication that this ever happened.

The second ministry social worker who was assigned to the case clearly articulated to the Representative’s investigators that she did not attempt to engage the mother in any parental risk-reduction services.

The Representative’s investigators were advised by this social worker that she met with Paige about 50 times and with her mother at least five times. However, minimal documentation of this was found in the file despite clear requirement of social workers to document all contacts. This particular lack of documentation reflects negatively on the workers and the quality of their supervision. Accurate documentation is essential for continuity of care as workers routinely change. Meetings with Paige were characterized by the worker as centred on asking her if she was interested in coming into care or attending treatment. Paige typically responded with indifference and focused on ongoing concern about the well-being and whereabouts of her mother.

Also concerning was that shelter staff told Representative’s investigators that they failed to make reports on a number of occasions, in part because of Paige’s age (then 16), but primarily because of the perceived lack of response from the assigned social worker. Personal contact with her assigned social worker was rare and the responsibility for initiating that contact was inappropriately placed almost entirely on Paige. One shelter worker said:

*“They didn’t come to the shelter, everything was done through letters and correspondence – they never visited the program or met the staff to find out what was going on. They didn’t seem that interested.”*



Entrance to the Stanley Hotel

The Representative notes that this pattern of repeated failures to report child protection concerns to MCFD is a chronic problem across the province, most recently highlighted in her February 2014 report *Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl*. The *CFCS Act*, which governs child welfare in B.C., places a legal duty on every citizen who believes that a child needs protection to report that concern to MCFD. The repeated failures to report glaring child safety concerns involved health, police, community service agencies and DTES SRO hotels.

The incomplete picture of Paige's situation created by these repeated failures to report was exacerbated by the ministry's over-reliance on contracted outreach service providers to monitor her circumstances.

MCFD social workers advised the Representative's investigators that they designated primary responsibility for face-to-face contact with their youth clients to contracted outreach staff. However, they advised of an ongoing concern with lack of reporting back by some of these designated workers responsible for direct service delivery.

One social worker stated:

*"I think the problem may be the coordination of my eyes on the street ... and ensuring that information gets back to me, is that process of disseminating information – and receiving it back – and so they may have been sighting either the mother or the child, but not necessarily communicating it back."*

The ministry Yankee 20 social worker only physically met with Paige on one occasion, after she had turned 19. When interviewed, social workers confirmed that it is not uncommon for specialized units such as Yankee 20 to be aware of a high-risk youth's presence in the DTES, but to not physically ever see them. Youth cases could be discussed at Reconnect meetings, but those same youth may not be directly served or seen.

Paige appeared to be served by multiple services and agencies, yet in reality she was missed and not served. Multiple agencies were "involved" with her, some directly, but many on only a superficial level as a referral. Repeated references were made throughout the file to Paige having various counsellors, and it was later confirmed by Representative's investigators that she had actually never met with any of these people.

On occasion, outreach workers were asked to attend DTES SROs to search for Paige, in lieu of the delegated social worker. These requests were neither frequent nor timely. Nobody made consistent efforts to search for and directly observe Paige and her situation.

When responsibility for physically searching for Paige was delegated to outreach workers, this approach was hampered by worker concerns about their own safety inside many of the SRO hotels. The Representative's investigators were told:

*"We try not to go into hotels because it is such a safety concern."*



*“You’re sending us into some kind of situation where we have no idea what’s going on. That’s not our job, and a lot of passing off their job onto us.”*

The Representative finds it appalling that workers would be reluctant to enter certain hotels because of well-founded concerns about their personal safety while having the knowledge that Paige was living there.

Equally problematic was that responsibility for initiating contact with her assigned social worker was placed almost entirely on Paige. Given the known danger she faced and the daily struggle for survival she was facing, this approach was cruel and essentially shifted blame for her abuse onto her.

Multiple reports were made to the assigned MCFD social worker by contracted agency staff, police and After Hours advising of her current location. It is unclear why the social worker with responsibility for her did not attend to these locations to speak to her and assess her safety each time. When asked about this, her worker stated that she would usually just wait until Paige came into the ministry office to meet with her.

The ministry file was closed at one point during Paige’s first year in the DTES with the following reasoning:

*“No word from the child at all. The child never reached out to MCFD directly nor has her mother. I closed my file due to no contact/ no accessing of services.”*

Regardless of the ministry file being closed, community agencies went to the Balmoral SRO hotel on several occasions in an attempt to locate Paige, and she was “profiled” at a Reconnect meeting. The Reconnect worker indicated that this did not mean contact; it simply meant sharing of information about Paige. A DTES youth-serving agency report to the last assigned ministry social worker stated:

*“Outreach has been trying to look for her and an outreach worker stopped by the Balmoral but she wasn’t home. I will keep encouraging people to look for her and hopefully at some point get her into your office.”*

During interviews with contracted agency staff, the Representative’s investigators found that there were no formal written reporting requirements between outreach and MCFD. Outreach workers were only required to record “contacts” with clients, which could



A man walks past an SRO hotel in the DTES

include just a brief sighting of a client in the DTES. Paige's primary outreach worker stated to investigators:

*"We don't do [daily] reports ... we only do critical incident reports, so if the child were to go to the hospital or I called an ambulance for her. We only contact social workers if there's a concern for a kid. We do stats, but there's nothing – specific."*

Over-reliance on contracted outreach service providers and sporadic ministry engagement with Paige continually left her at risk in what can only be described as dangerous conditions with known harms. This was a downloading of child welfare responsibility to a youth-serving agency unburdened by the legislative requirements of the *CFCS Act*.

### Child Protection Practice

The ministry's perception that DTES SRO hotels were in any way appropriate living conditions for a child was nothing less than shocking. The Representative's investigation found that there was an element of "norming" of these deplorable living conditions by social workers assigned to this child's case.

When the mother and her child arrived in the DTES, the ministry advised Yankee 20 that Paige was staying with her mother at the Regent Hotel. This worker described the hotel as:

*"... a nightmare"... some rooms have doors, some don't ... I can't even describe it. You wouldn't let animals live in there. It's so dangerous and it's so many people in a room and like a room with just a mattress on the floor and no door. You know, and bathrooms that don't work. Like all manner of things in bathtubs that you don't even want to look. So we went in there and I mean, people will always say, 'Oh, yeah, there are a mom and daughter here,' but nobody can tell you what room."*

Paige's MCFD social worker in the DTES noted that she had met with the mother at Pigeon Park, the First United Church and at an SRO hotel. The same social worker had observed the room that Paige and her mother stayed in and described it as an eight-foot by 10-foot room with a small hot plate and a single bed that Paige and her mother shared. There was a communal bathroom down the hall that was shared with the other residents.

Shelter staff also reported that Paige stayed at the First United Church with her mother on a number of occasions prior to new rules coming into effect in 2010 that prohibited minors. Conditions at the First United were described by ministry staff as overcrowded and dangerous. Shelter staff advised that there could be upwards of 300 people sleeping there per night lined up in rows along the floor and sleeping on top of and under the church pews. Despite shelter policy to the contrary, residents often engaged in intravenous drug use and, on one occasion, a dead body was found under a blanket.



Staff advised that there was no policy at the time with regard to minors:

*“There was probably a number of minors that went through there without us knowing because basically we didn’t take names – the doors were left open, you could just walk in.”*

Shelter staff were very familiar with Paige’s mother, and observed her mental health deteriorating to the point where she talked about hearing voices. The mother was found on one occasion curled up in a corner hiding under a bunk bed, afraid that someone was coming to kill her. The mother later became involved in an incident in which she stabbed two shelter resource workers with a used needle when they intervened in a fight between the mother and another resident.

Staff advised that although Paige did not stay overnight with her mother after the rule change, she visited the church shelter multiple times looking for her mother. She was described as “... innocent – she just looked so sweet – she just didn’t belong there.” Staff said that when Paige came looking for her mother, she appeared anxious and worried.

When interviewed by the Representative’s investigators, several shelter and SRO hotel staff acknowledged under-reporting and reluctance to report child safety issues. Reports were made to MCFD only because they were mandatory, not because they believed Paige would be well-served.

Family members related that on one occasion Paige was hidden in a large suitcase and transported into a room in the Regent Hotel in order to avoid detection by front desk staff.

*“They put her in a big suitcase, and they lugged her up the stairs – they had to get a man to help, and he said, ‘What have you got in here, a body?’ not knowing that the child was in there.”*

The use of transition houses and shelters as the sole protection response in isolation of primary risk factors was wholly inadequate and continued to leave this child at risk.

A pattern of delayed response time to protection reports, a lack of attention to the mother’s mental health and addictions issues, and premature closing of the file, typified service delivery to Paige during her years in the DTES.

When the mother and daughter first arrived in the DTES, an initial report was received indicating that Paige had been left by her mother at an East Vancouver safe house. A cursory interview of Paige was completed. She disclosed that her mother was using drugs and that she was tired of the frequent moves and her mother’s drug use.

This was clearly a child who needed and wanted a stable place to live, yet there is no indication in file documentation that a foster care placement was discussed with her. The only risk that was addressed in this instance was the reported abandonment. A social worker called the mother, who said that she was willing to remain at a local shelter with

her daughter. No social worker attended the shelter to speak to the mother about her addictions or to assess Paige's safety. This involvement was concluded with the following notation by the social worker:

*“No further contact with youth and/or mother. Neither appeared very interested in accessing services. MCFD's contact is generally at the initiative of MCFD, not the youth or mother seeking assistance. This intake to be closed.”*

This thinking is confusing and contrary to basic practice standards. This report was not a request for support by the mother or youth, but rather a protection report from a homeless shelter that a child had been abandoned by her mother. Furthermore, when there are outstanding protection concerns, a parent refusing service is not grounds for concluding a protection report – in fact, this actually heightens the risk.

Following this first contact with the family in the DTES, there was a hiatus of two months with no contact between the ministry and Paige until she resurfaced at a safe house saying that she had been alone for several days and did not know her mother's whereabouts.

This was now the second time that Paige had been abandoned during this social worker's involvement with the mother, who was demonstrating a continuing inability to care for her daughter. Paige herself was articulating a desire for a more stable life. This would have been an ideal time for a social worker to engage her in a stabilization plan as she had not yet become entrenched in the DTES.

During 2010, MCFD received three child protection reports concerning Paige while she shuffled between two SRO hotels, six transition houses and five safe houses. She was also listed as having no fixed address on eight occasions.

These child protection reports detailed active drug and alcohol use by the mother, abandonment and physical and verbal abuse. Two of these reports were inappropriately coded as a request for support services, and therefore did not trigger a child protection response. Reports to the ministry included her mother leaving Paige standing out on the street in front of the Regent Hotel while her mother was using crack cocaine inside, and another report of the mother overdosing in the Balmoral Hotel. MCFD response to these reports was delayed and Paige was never interviewed.

The one child protection report that was properly coded was not investigated with any adequacy. This report from a shelter advised that the mother had been discharged due to abusive behaviour towards staff and her daughter. The caller stated that the mother called her daughter a *“fucking little bitch”* and stated that she was going to *“beat”* her. The mother went on to tell Paige that she should just put her in foster care or leave her at a transition house.

The caller reported that during their stay the mother had abandoned Paige on numerous occasions despite warnings from the staff not to leave her alone. The mother was clearly using drugs and alcohol. On one occasion, she admitted to staff that she had been drinking in the shelter bedroom and handed over an empty bottle of vodka to

staff. Observations were also made of the mother having difficulty getting out of bed, appearing exhausted, and falling asleep in her food.

This intake was given a five-day response time, yet no action was taken until two weeks later. Paige was interviewed about her living situation, but was not asked about the reported maltreatment by her mother. The mother was never seen or interviewed.

All three 2010 child protection reports were concluded without a solid plan for Paige, and not once was the mother asked to complete a drug test. In one instance, the ministry concluded its involvement after a telephone conversation with the mother. File documentation notes: *“Mom claims to be clean and looking for housing outside the DTES.”* Another report was concluded with the following notation in the file: *“Youth has no fixed address, moving between transition houses with her mother for many months. Mother battling drug and alcohol issues. It is very unlikely that the mother’s situation will change.”*

A further social work practice issue identified by the Representative’s investigation was the minimal attempts made by MCFD to engage this child’s mother.

When interviewed about this case, the first DTES social worker stated that he saw Paige’s allegiance to her mother as a significant barrier to stabilizing her. He stated that he focused his efforts instead on trying to stabilize the mother, given that he believed Paige wasn’t going to leave her mother. Despite this rationale, minimal efforts were made to actually work with the mother. This strategy to engage the mother in services consisted of a few phone calls and a referral to an addictions counsellor, which the mother did not follow through on. The social worker responsible for Paige held the belief that, given her attachment to her mother, removing her would be pointless due to the high likelihood that she would abandon a foster placement. This social worker had no specific memory of ever meeting with the mother, despite the mother continually being labelled by this worker and others as “resistant to services.”

Minimal attempts were made to engage Paige’s mother, resulting in Paige feeling she alone was responsible for her mother’s care. The Representative believes this dynamic could have been averted if Paige saw the ministry social worker reaching out and providing supports to her mother, thereby freeing Paige from this responsibility.

A DTES outreach worker articulated this dilemma to the Representative’s investigators as follows:

*“We have to make relationships with parents even though they don’t really want to make relationships with you.”*

Youth-serving agencies all spoke of the desire felt by many of the youth they were working with to remain connected to their biological parents, regardless of the personal risk to themselves in the DTES. Social work practice that recognizes this would likely prove more successful in enhancing the outcomes of vulnerable children and youth. Although the parental bond and the requirement to work with parents is recognized and embedded in policy, this doesn’t always transpire in actual practice, as was the case with Paige. A lack of

clarity about a social worker's role with parents can create a situation where removal of a child is potentially over used or supports are inadequate when children are not removed.

### Transition Planning

When youth in care reach their 19th birthdays, they are considered adults and no longer eligible for protection under the *CFCS Act*. In April 2014, the Representative released a report on the need for youth to have improved longer-term support as they move from care to independence. *On Their Own: Examining the Needs of B.C. Youth as They Leave Government Care* examined the challenges for youth leaving care and the poor outcomes for many of these youth.

It was made clear in that report that successful transition depends on thoughtful and timely development of a plan that fully takes into account the needs of the child.

While successfully transitioning to adulthood is important for every child in contact with the ministry, it is even more so for youth such as Paige, struggling with a lifetime of adverse experiences and trauma. Unfortunately, the planning for her transition can at best be described as rushed and cursory. At a time when it was critical for her well-being that Paige be actively assisted in making the transition to adulthood, she was virtually ignored, provided with only minimal support.

One of the early problems with providing effective services to Paige and her mother was their transience in the DTES and the challenge this appeared to pose for the social workers who were responsible for Paige. In describing this challenge to the Representative's investigators, one social worker stated:

*"You know, it's one of those things with the Downtown Eastside that it's basically you – you drive around. I mean you've done that and it just – they appear and they don't appear. And as quickly disappear and you have no idea where they went."*

This worker also advised the Representative's investigators that it was "absolutely" common for her and her team to be aware of high-risk youth in the community for an extended period of time and yet never actually see them.

As it got closer to Paige's 19th birthday, this worker explained that MCFD's primary focus was to escalate its attempts to actually locate her, and then arrange for housing and other supports.

Just prior to aging out of care, Paige was able to achieve some stability via a VCA. In her first Vancouver-area foster home, she was placed in a semi-independent living situation with a foster parent who was unwilling to work with her on her alcohol use, having stated that, "One of the caveats about placement in our home was that we needed it to be a sober home." The foster parent agreed to the placement despite her admitted awareness that Paige had a history of alcohol use; that she had just left a residential treatment program prior to successful completion; and that, at the time of the placement, she was not receiving any

support whatsoever for her substance use. This foster parent also told the Representative's investigators that she agreed to the placement even though she thought Paige *"would be better served in a treatment program where she could really – where she'd be contained during the day and night."* The placement ultimately broke down in less than a week.

Paige achieved some stability in her final Vancouver-area foster home, having been placed with a foster parent who was aware of her substance use issues and was more willing to provide support. Although the foster parent confirmed her willingness to care for Paige, she told the Representative's investigators that she *"got blindsided"* by the extent of the issues related to her alcohol use. She also told investigators that the social worker failed to provide much background information on Paige's childhood and the possible root of her issues.

This foster parent cared for Paige for the four months leading up to her 19th birthday and corresponding exit from ministry care. As a key participant in Paige's brief transition-planning process, the foster parent believed *"there was a real immaturity that I saw there,"* and that Paige *"definitely was not ready"* to live independently as of her 19th birthday.

The foster parent described Paige as being very anxious about her upcoming departure from ministry care, advising the Representative's investigators that:

*"I was reminded a lot to, you know, put up a calendar and remind her that she had a timeline and I'm still a little bit conflicted about that. On the one hand you want the youth to know that they've got to do some things to get prepared to move out. On the other hand you're literally reminding them every day of the pending doom ... and some of them are absolutely petrified."*

When discussing his role during this crucial period of time, Paige's MCFD social worker stated that it was standard practice (at least in his ministry office) to delay transition-planning for high-risk youth. He advised that *"If someone is quite high-risk we leave it 'til last three months or so or the last month to plan,"* and noted that *"we didn't have any social housing [for this child], and then we finally got it near the end."* When asked by the Representative's investigators what would have happened if housing had not been secured, he stated *"that's the scary part of it all"*, and explained that transitioning youth without housing *"usually couch surf"* or stay in adult shelters.

The foster parent advised that her resource worker was strict about the 19th birthday service withdrawal, and *"kept saying, okay, you know, this youth is done, this is finished you know, this is the cut-off day."*

An MCFD closing recording on Paige's file stated: *"The child is one month from turning 19 and unfortunately she is still binge drinking heavily and appears not to be overly concerned about having anywhere to live at age 19."* However, Paige told the foster parent that she was still receptive to seeing a therapist or psychiatrist and commented again on her night terrors, sweats and sleep paralysis. She also said she felt extremely anxious a lot of the time. An email from the foster parent to the MCFD social worker on March 5, 2012 stated that Paige's *"anxiety builds as her move out date approaches."*

When asked whether Paige was offered any counselling for her anxiety about leaving care, this foster parent told the Representative's investigators that although she requested this from the social worker, Paige "*didn't get anything.*" The foster parent said that the transition-planning process was primarily focused on securing housing for Paige, rather than on her emotional or mental well-being, noting: "*I'm not pointing fingers. I'm just saying I said, you know, that she needs some help and she wants it. But I think the push was just like, you know, she's going to turn 19, let's get her an apartment or, you know stabilize her first.*"

Paige's social worker said he had limited knowledge of her mental health or well-being beyond her substance use issues, and advised the Representative's investigators that her mental health "*was not a theme*" that stood out to him during his involvement in her life, and that "*it wasn't worrisome.*" This ignorance of the trauma and maltreatment she faced, and her likelihood of having serious health consequences in adulthood, is stunning.

When asked whether she thought it would have been beneficial for Paige to remain in foster care beyond her 19th birthday, the foster parent said "*yes, absolutely,*" and noted that she would have been willing to continue to provide a home and ongoing support for her if such an option had been possible.

On the day Paige was to move from the foster home to her own apartment, at the direction of MCFD, the foster parent packed up all of her belongings in garbage bags and left them at Paige's school. School staff members were not privy to this plan, and were surprised at being asked to store the belongings.

Paige moved from her foster parent's home to an apartment in a building for Vancouver-area youth at risk. No ministry social worker visited to check the appropriateness of this living situation, and her file was closed.

The social worker responsible for Paige during her last weeks in care told the Representative's investigators, correctly, that he was not aware of any ministry practice standards that required a worker to observe the living circumstance of a child exiting from care. He also said that he would not have been able to visit Paige's housing placement because the move happened the day after her 19th birthday, when he was no longer responsible for her file.

Paige escalated to using crack cocaine and methamphetamine in June 2012, about a month after she left MCFD care.

Shortly before her 19th birthday, the ministry assigned a designated transition worker to help the girl prepare for the upcoming withdrawal of MCFD services. The transition worker described her mandate to Representative's investigators as "*to get them independent as soon as possible,*" but noted that this goal was problematic for Paige because "*there would be so many ups and downs in her planning because of her addiction and because of behaviour, that it was very difficult to plan for her, or keep a plan.*"



This worker discussed the structural limitations of the youth-serving system, noting that: *“The ministry and all the youth supports out there are really just trying to – are really just maximizing what’s available to them. There’s so little. Like everyone is just fighting over scraps.”* She also discussed the limitations of service withdrawal when youth reach the age of majority, describing this as follows:

*“But, like, we’re all gone at 19, right? There’s nothing we can – we can be there in the background for you, for, like, emotional support, but there’s nothing we can actually really do for you. And [Paige] and so many of the other youth are so relationship-based that it’s just like devastating for them, right? So I can see why [Paige] continued to slip further than she already was, right, because it’s not just housing, but all the supports and everything that go with it. They’re just kind of free-floating out there, you know what I mean? Like you kind of realize what you don’t have when it’s all been pulled out from under you. Was she able to really work on life skills and budgeting and all these kind of things when she’s shooting heroin? Like no, right, she’s just not there.”*

The child protection system failed utterly to prepare Paige for adulthood and her brief experience of adulthood was self-destructive and fully predictable. The transition process was not a process – it was a passing of responsibility and an indifference to her circumstances. The ministry’s hasty, last-minute attempts to plan for her transition left her abandoned and addicted with none of the crucial supports she desperately needed. It is impossible not to contrast this with the plans and expectations most British Columbians have for their own children to see them educated and well-prepared for independence.

# Recommendations

*The Representative is troubled by the fact many professionals and others involved on the front lines seem to regard poor outcomes for Aboriginal children and youth as inevitable, justifying this by blaming these children for being “service-resistant” or inappropriately placing the onus on the child or youth to seek help when they are already traumatized, abused and effectively abandoned to fend for themselves on the street. This normalization of unacceptable outcomes and indifference perpetuates the cycle of intergenerational trauma that characterizes the lives of many vulnerable Aboriginal children, including Paige. Even when they seek service, there is no coherent system of care available to them. The Representative has made numerous recommendations pertaining to Aboriginal children, families, communities and services in 15 previous reports (see Page 4). Based on Paige’s pathway, and the fact she did not receive the services that she required, the Representative makes the following recommendations:*

## Recommendation 1

That the Province of British Columbia, led by the Ministry of Children and Family Development, respond forcefully to the persistent professional indifference shown to Aboriginal children and youth by many of those entrusted to work in this field, including some social workers, police, health care workers and educators. The Province and MCFD must also show a greater commitment to permanency for Aboriginal children and renewed efforts to work with family members when a parent cannot provide stability or safety for a child.

### Details:

MCFD to take immediate steps to ensure that

- The Director of Child Welfare commence an immediate review of all the files of children and youth in care or receiving reviewable services who either reside in or frequent the DTES and immediately connect with those children, particularly those known to be living out of the parental home. A report from this review, including services offered, safety plans, and whether or not those working with these children and youth are aware of their duty to report to be presented to the Representative.
- Full and appropriate child protection investigations be conducted for children and youth identified in the above process as being at risk of harm, ensuring that family engagement reflects an Aboriginal-sensitive lens to supporting extended family members willing to assist.
- Structured Decision Making tools for Aboriginal children and youth be child-focused and that the desire to keep a child with a parent does not override protection concerns and the need for safety, which must be paramount.
- Mental health screening tools are immediately applied to assess the potential needs of any Aboriginal child or youth when taken into care, or with the consent of the parent during a safety assessment. Tracking and reporting on these children and youths' access to services to be made public.
- Timely decisions are made with respect to safety and permanency in the case of all Aboriginal children and youth in care. MCFD to develop a clear fund to support Aboriginal extended family members to allow them to do kinship care. This should allow for appropriate housing and adequate investment to ensure that a child at risk can be raised in safety and with adequate levels of food, shelter, clothing and readiness for school achievement.
- Enhanced transition planning is offered for Aboriginal youth who are aging out of government care, with the recognition that these youth may require particularly robust services including foster care and other supports that extend beyond the age of 19. Aboriginal girls in care who are at risk of drug overdose, involvement in survival sex trade, and poor school attendance to be offered extension of foster care to 24 years of age.
- Education on the effects of intergenerational trauma and evidence-based strategies to disrupt these patterns is added to the core training curriculum provided to all MCFD staff.
- MCFD provides an annual public report specifically on the reported abuse, neglect and maltreatment of Aboriginal girls and young women involved with the ministry for each year, with detailed breakdown by region, age and service provided.

Report from Director of Child Welfare to be presented to the Representative by Sept. 30, 2015.

First annual public report to be released by May 31, 2016.

*It is obvious to the Representative that, despite the expenditure of enormous amounts of public money in the Downtown Eastside, services for vulnerable children and youth in this area remain balkanized and do not function effectively.*

### Recommendation 2

That MCFD, the Ministry of Health, and the City of Vancouver conduct an urgent review of the current provision of services – including child protection, housing, health care and substance use treatment – to vulnerable children in Vancouver’s Downtown Eastside. This review should be informed by an accurate picture of the circumstances of children and youth living in or frequenting the Downtown Eastside and the social service agencies currently working with children in this area and it should be based on best research into the effects and mitigation of intergenerational trauma.

#### Details:

- The City of Vancouver, Ministry of Health, Vancouver Coastal Health Authority, BC Housing and MCFD to analyze numbers of children and youth in care in the area, needs of these children, an inventory of service providers currently working in the Downtown Eastside and the gaps in the services provided. Detailed lead service responsibility is necessary and a full accounting of this inventory is required to both the Representative and the public.
- The City of Vancouver, Health and MCFD to follow up that analysis with timely creation and implementation of an action plan, including detailed public reporting on outcomes for the children and youth in this area.
- MCFD to take immediate steps to ensure that no children or youth in care or receiving services from MCFD are living in SROs. The City of Vancouver, in conjunction with MCFD, to coordinate regular inspections of SROs to ensure compliance with these rules.
- MCFD to explore the creation of a form of secure care, with all appropriate legal safeguards, that would allow for the apprehension of vulnerable children and youth whose situation places them at an unacceptable level of risk and the subsequent safe placement of these children in a service that will respond to their trauma and high risk of self-harm.

Analysis to be presented to the Representative by Sept. 30, 2015.

Action plan to be presented to the Representative by Dec. 31, 2015.

*In her report *Lost in the Shadows*, the Representative called for the Attorney General to review the reasons for a lack of enforcement of the CFCS Act in B.C., and take steps to promote compliance, if necessary. The Representative fails to understand what action was taken at the level of the Attorney General as there has been no direct follow up on this issue since that report was issued on Feb. 6, 2014.*

### Recommendation 3

That the Attorney General of British Columbia provide the public with a clear explanation as to why agencies and service providers are persistently permitted to fail to report harm and abuse, as was the case in Paige's experience, contrary to the *CFCS Act*.

#### Details:

- The Attorney General to report annually on the number of investigations and prosecutions for this offence, as well as other actions taken to ensure compliance with the legislation.
- The Attorney General to detail the number of cases brought forward by the Director of Child Welfare for attention and investigation.
- Individual professional bodies governing those who work with children and youth – including but not limited to social workers, health care workers, educators and police – to begin applying professional sanctions to members who have failed to report instances of neglect or abuse.
- The Attorney General and Director of Child Welfare to embark on a substantial and meaningful public awareness campaign emphasizing that no person should fail to report suspected child abuse. The campaign should educate the public on what specifically constitutes child abuse and promote an active approach rather than one which allows bystanders and professionals to continue to accept the status quo.

First annual report to be presented to the Representative by Sept. 30, 2015.

Draft public awareness campaign to be presented to the Representative by Oct. 31, 2015.

#### Legal Duty to Report

S. 13 of the *CFCS Act* sets out when a child is in need of protection. In cases where any member of the public has reason to believe that a child needs protection, s. 14 of the *CFCS Act* is in effect:

14 (1) A person who has reason to believe that a child needs protection under section 13 must promptly report the matter to a director or a person designated by a director.

14 (6) A person who commits an offence under this section is liable to a fine of up to \$10,000 or to imprisonment for up to 6 months, or to both.



### Recommendation 4

That MCFD, the Ministry of Education through its own initiative and with its partners, and the First Nations Education Steering Committee work together to create a system that ensures attendance at school by all Aboriginal children in the care of MCFD is closely monitored and encouraged, that MCFD actually fulfills its role as an active and engaged parent with regard to the education of these children, and that the Ministry of Education and school districts ensure that a flexible and adaptive system, including active outreach to vulnerable Aboriginal children not currently attending school, is in place and appropriately funded.

#### Details:

- School districts to be required to monitor the attendance of Aboriginal children in care and report any unexplained absence to MCFD.
- If an Aboriginal child in care has an unexplained absence of two days, MCFD to be in contact immediately with the caregiver or family to determine the reason and share this with school authorities so that a plan can be developed to quickly reconnect the child with school.
- Every school district to report annually to the Ministry of Education on Aboriginal children in care who have missed more than five days without an explanation for their absence, and also report to MCFD for those children who are in care, on Youth Agreements or on independent living arrangements through MCFD.
- Schools to develop a comprehensive plan for the successful enrolment of Aboriginal children after extended absences.
- MCFD to reinforce that education is a major component of a child's Care Plan and that any prolonged absence or lack of achievement is monitored and addressed on a yearly basis.
- The Ministry of Education to explore the feasibility of offering monetary incentives to school districts that improve the attendance and graduation rates of vulnerable Aboriginal children.

The first annual reports to the Ministry of Education by school districts to be completed by July 1, 2016.

## Recommendation 5

That the Ministry of Health, working with the First Nations Health Authority, take immediate steps to enhance services to vulnerable Aboriginal children and youth, particularly in the Downtown Eastside and within the City of Vancouver.

### Details:

- Proper reproductive health services and reproductive education to be provided by Health, ensuring that termination of unplanned pregnancy does not become the substitute for effective contraception in this group.
- Adequate after-care planning and follow-up services to be ensured by Health, including the expansion of outreach initiatives targeted at vulnerable Aboriginal children and youth.
- Female children in care to be offered follow-up appointments with a medical doctor (preferably a family physician) after the termination of a pregnancy so that follow-up service can be provided, including accessible and supportive reproductive education and birth control.
- Intensive drug and alcohol services with an Aboriginal trauma lens and a family-centred model be provided, identifying and creating an appropriate service pathway that involves best practices and avoids further stigmatizing and traumatizing of these vulnerable populations.
- Aboriginal youth addiction services, including secure short-term care, be provided at a high professional standard, with strong after-care, and a focus on education and resilience.

## Recommendation 6

That the Ministry of Aboriginal Affairs and Reconciliation, with support from MCFD and Justice, prepare a detailed annual report for the Minister's Advisory Council on Aboriginal Women on every unexpected death of an Aboriginal girl or woman in care, or formerly in care, in B.C. and that a review of urban Aboriginal program funding is conducted.

### Details:

- The annual review to be conducted with the goal of identifying the role that neglect, abuse and maltreatment of these women played in their deaths and to make recommendations to government on appropriate actions to mitigate the risk to future generations, with a goal to protect Aboriginal girls and women from the pathways that Paige experienced.
- The annual review to be accompanied by an annual public report of sufficient detail to demonstrate that a serious and meaningful review was conducted, what improvements were identified by members of the Advisory Council and how these recommendations would enhance supports for Aboriginal girls and women.
- Consistent with the Premier's public commitment of June 2014 to end violence against Aboriginal women and girls, the Ministry of Aboriginal Affairs and Reconciliation lead a rigorous review of urban Aboriginal program funding and report to the public on the model, expenditures and services to ensure that provincially supported initiatives are addressing the need for specific services and improving outcomes for the cohort of youth such as Paige.

The first report to the Advisory Council to be completed by Dec. 31, 2015.

Report of urban Aboriginal program funding to be released by Dec. 31, 2015.

## Conclusion

Given the significant child welfare concerns raised by this investigation into the short life of Paige, the Representative believes that MCFD, and the provincial government as a whole, should do their utmost to ensure that lessons are learned – and that learning is incorporated into approaches and services going forward.

The Representative believes that MCFD should require all staff to read this report and also provide ministry-wide training opportunities to encourage learning from Paige's story. The Ministries of Health, Education, Justice and Aboriginal Relations and Reconciliation, as well as Vancouver Police and social service agencies that work in the DTES are encouraged to do likewise.

Professional indifference will only change when we actively challenge the practice of turning a blind eye to the abuse and neglect of Aboriginal children and youth. This should not, and cannot be allowed to occur.

The negative and dangerous pathways for Aboriginal girls that the Representative has witnessed and reported on in her work can be changed, but only if we change our expectations, practices and outcomes. That change will never truly come if indifference remains the standard of care.

# Appendix A: *Representative for Children and Youth Act*

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

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

- (1) After a public body responsible for the provision of a reviewable service becomes aware of a critical injury or death of a child who was receiving, or whose family was receiving, the reviewable service at the time of, or in the year previous to, the critical injury or death, the public body must provide information respecting the critical injury or death to the representative for review under subsection (3).
- (2) For the purposes of subsection (1), the public body may compile the information relating to one or more critical injuries or deaths and provide that information to the representative in time intervals agreed to between the public body and the representative.
- (3) The representative may conduct a review for the purpose of identifying and analyzing recurring circumstances or trends to improve the effectiveness and responsiveness of a reviewable service or to inform improvements to broader public policy initiatives.

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

- (1) The representative may investigate the critical injury or death of a child if, after the completion of a review of the critical injury or death of the child under section 11, the representative determines that
  - a. a reviewable service, or the policies or practices of a public body or director, may have contributed to the critical injury or death, and
  - b. the critical injury or death
    - i. was, or may have been, due to one or more of the circumstances set out in section 13 (1) of the *Child, Family and Community Service Act*,
    - ii. occurred, in the opinion of the representative, in unusual or suspicious circumstances, or
    - iii. was, or may have been, self-inflicted or inflicted by another person.
- (2) The standing committee may refer to the representative for investigation the critical injury or death of a child.
- (3) After receiving a referral under subsection (2), the representative
  - a. may investigate the critical injury or death of the child, and
  - b. if the representative decides not to investigate, must provide to the standing committee a report of the reasons the representative did not investigate.
- (4) If the representative decides to investigate the critical injury or death of a child under this section, the representative must notify
  - a. the public body, or the director, responsible for the provision of the reviewable service, or for the policies or practices, that may have contributed to the critical injury or death, and
  - b. any other person the representative considers appropriate to notify in the circumstances.

# Appendix B: Documents Reviewed for the Representative's Investigation

## **Ministry of Children and Family Development Records**

- Mother's family service file
- Child's child service file
- Grandmother's family service file
- Foster parent resource files
- Child's aunt's family service file
- Child's reportable circumstance reports

## **RCMP and Police Records**

- Vancouver Police records
- North Vancouver RCMP records

## **Medical Records**

- Child's medical records – 7 hospitals, medical clinic
- Mother's medical records – 3 hospitals
- Child's PharmaCare records
- Mother's PharmaCare records

## **Ministry of Social Development Records**

- Mother's file
- Child's file

## **BC Coroners Service Records**

- Coroner's report for child

## **Ministry of Education Records**

- Child's school records, Kindergarten to Grade 10

## **Legislation, Regulations, Standards and Policy**

- *British Columbia Child, Family and Community Service Act* (1996), Victoria, B.C. Queens Printer
- *Child Protection Response Policies, Chapter 3* (April 2012 & July 2014 Revisions)
- *The Risk Assessment Model for Child Protection in BC* – MCFD
- *Mental Health Act* (1996) Victoria, B.C. Queens Printer
- *Child and Family Development Service Standards* – MCFD
- *Guidelines for Provision of Youth Services* (October 2002)
- *Standards for Youth Support Services and Youth Agreements* (August 2013)



## Appendix C: Interviews Conducted during the Representative's Investigation

- Family Members (6)
- MCFD child protection and management staff (22)
- MCFD foster parents (7)
- Vancouver Police Department (3)
- School staff (2)
- Community agency staff (5)
- Safe house staff (2)
- Corrections staff (1)
- Community agency management staff (12)
- Community mental health clinician (1)
- SRO hotel staff (4)
- Outreach workers (8)
- Regional health authority staff (2)

## Appendix D: Multidisciplinary Team

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

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

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

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

### **Multidisciplinary Team Members at time of report review, Feb. 2014**

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

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

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

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

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

**Sherri Bell** – Ms. Bell is the Deputy Superintendent of Schools for School District 61 (Greater Victoria), and chairs Board subcommittees on Public Engagement, Professional Relations and Curriculum Implementation. She has more than two decades of experience working in education, including assignments as a District Principal, Director of Instruction and Associate Superintendent of Schools. She has a Bachelor of Education degree and a Masters of Administration and Curriculum Development.

**Dr. Christine Hall** – Dr. Hall is the Medical Director of Trauma Services for the Vancouver Island Health Authority and an Associate Professor at the University of Calgary and a Clinical Assistant Professor at the University of B.C. In addition to her training in emergency medicine, Dr. Hall has a Masters degree in clinical epidemiology.

**Derren Lench** – Chief Superintendent Derren Lench is currently the Deputy Criminal Operations Officer – Core Policing, working at “E” Division RCMP Headquarters in Surrey. He has several Provincial Programs that report to his position including Traffic Services, Critical Incident Program, Operational Communications Centers, Aboriginal Policing, Crime Prevention, West Coast Marine Section, Occupational Safety Officers and the Operations Secretariat. In his role, he works closely with RCMP District Commanders across the Province and liaises with the Province on key issues and priorities. C/Supt. Lench has 33 years of service with the RCMP. He is the Vice President of BC Association of Chiefs of Police, is the Pacific Region Vice-Chair of the National Joint Committee of Senior Justice Officials, and is on the Canadian Association of Chiefs of Police Victims of Crime Committee.

**Cory Heavener** – Ms. Heavener is Assistant Deputy Minister and Provincial Director of Child Welfare for the Ministry of Children and Family Development. She is the former Head of the Provincial Office of Domestic Violence. She was previously the Director of Critical Injury and Death Reviews and Investigations for the Representative for Children and Youth. Cory has a lengthy career in child welfare in British Columbia and began her career as a child protection social worker 25 years ago.

**Pat Cullinane** – Mr. Cullinane is the Deputy Chief Coroner of Operations for the BC Coroners Service. Prior to joining the Coroners Service in 2011, he was the Executive Director of Employment Standards for BC. Mr. Cullinane commenced his career as a child protection social worker and has been involved in both conducting and leading complex investigations in various ministries and programs since 1984.

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## Legal Duty to Report

S. 13 of the *CFCS Act* sets out when a child is in need of protection. In cases where any member of the public has reason to believe that a child needs protection, s. 14 of the *CFCS Act* is in effect:

14 (1) A person who has reason to believe that a child needs protection under section 13 must promptly report the matter to a director or a person designated by a director.

14 (6) A person who commits an offence under this section is liable to a fine of up to \$10,000 or to imprisonment for up to 6 months, or to both.

