



REPRESENTATIVE FOR
CHILDREN AND YOUTH

Honouring Kaitlynnne, Max and Cordon

*Make Their Voices
Heard Now*

March 2012

March 1, 2012

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

Dear Mr. Speaker,

I have the honour of submitting the report *Honouring Kaitlynn, Max and Cordon: Make Their Voices Heard Now* to the Legislative Assembly of British Columbia. This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of deaths and critical injuries of children receiving reviewable services.

Sincerely,



Mary Ellen Turpel-Lafond
Representative for Children and Youth

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

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



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Executive Summary

This Representative's investigation examines the lives and deaths of Kaitlynn, Max and Cordon, three B.C. children killed by their father, Allan Schoenborn, on April 6, 2008.

These children were 10, 8 and 5 when they died. During their short lives, they lived with the upheaval and anxiety caused by domestic violence, untreated parental mental illness and addictions. The interplay of these issues brought Ministry of Children and Family Development (MCFD) social workers and police into contact with the family numerous times over several years. Many different workers were involved with the family in two different communities.

In a search for safety, the children's mother at times took them and fled from their home, or moved to a new community entirely. The actions meant more instability for the children, especially in the months before they were killed.

Schoenborn's mental health problems were identified early on, but since 1999 were left untreated and never addressed, leaving the family to struggle alone with the devastating impact.

While many individual professionals had involvement with the family, there was very little interaction between MCFD workers and the children, so it was difficult during this investigation to gain a full picture of the children themselves. Some community members who knew the children best did not want to share personal information about the children with the Representative's investigators, as they themselves continue to struggle with the difficult emotional impact of the children's deaths.

The children were described by all as quiet, polite and kind to other children. Despite witnessing violence and their father's obvious mental health problems in an often-chaotic home, they did not publicly exhibit behaviour problems.

Their father's violent behaviour attracted the attention of the child-serving and criminal justice systems, but through it all, the children did what children around them were doing – they went to school, tried to fit in to their community, and sought out friendship and support from others.

MCFD's first contact with this family was in June 1999, when a report was made to the ministry by the local hospital that Schoenborn was speaking and behaving irrationally. He said he had been driving with his daughter asleep in the back seat. He caused two car accidents, and claimed his daughter had been poisoned and sexually abused. His daughter, at the time just a toddler, was found to be in good health.

Schoenborn was admitted to the hospital on an involuntary basis and eventually discharged with a diagnosis of delusional disorder, persecutory type and prescribed an anti-psychotic medication. It was his last known contact with the mental health system until his arrest for the murders of his children in 2008.

In September 2002 MCFD investigated a child protection report about Schoenborn. That investigation was closed with no child protection concerns and MCFD had no further contact with the family until 2007, although Schoenborn came to the attention of police several times in 2003 and 2004.

In 2007 police were called to the home due to a violent episode, with an intoxicated Schoenborn breaking and throwing things around the house. The children's mother also told police that he had sexually assaulted her several days earlier.

He was arrested and charged. MCFD began a third investigation. MCFD developed a safety plan with the children's mother that included conditions that the mother was not to allow the father in the home and if the father wanted to see the children he had to contact MCFD who would set up supervised visits. A week later, the mother told police that Schoenborn was visiting her and the children, and failing to comply with his bail order/ release conditions to have no contact with her or the children. Police did not act on this.

The incident began an escalating year-long involvement with the criminal justice system, the child protection system and others. This year was marked by domestic violence incidents, violent or threatening confrontations involving Schoenborn and others, miscommunication among the various systems, ineffective case management, and passive responses by those charged with protecting the mother and children. In the week leading up to the children's deaths, Schoenborn was arrested three times. The escalation ended with the deaths of three children.

Too often, ministry social workers did not apply a domestic violence lens or use their own domestic violence guidelines in dealing with this family. As well, there was little or no effort made by MCFD in the Interior to connect the children's mother to support services in her new community. The children's mother was sinking into depression, despair and anxiety. She was not given concrete suggestions or strategies or connected with appropriate supports on how to protect her children or how to keep Schoenborn away from the home, except to call police if he showed up. Workers repeatedly told RCY investigators that they had no training in working with families experiencing domestic violence, and this is evidenced in the poor practice and approach they took with the children's mother.

The Representative believes that Kaitlyne, Max and Cordon's right to safety was compromised by a lack of collaborative, professional child protection practice. MCFD failed to appropriately meet its mandate to protect children. Gaps and shortcomings in the mental health system similarly failed this family.

A number of times throughout the course of MCFD's involvement with Schoenborn, he exhibited concerning behaviours. Those situations should have alerted the workers to the significant need for a mental health assessment. Opportunities to better understand his mental health and the risk he posed to his family were lost, as were chances to have orders put in place that could have required the father to undergo a psychiatric assessment as a condition of access to the children. His substance abuse also went untreated.

The various systems involved with the family were not aware of the severity of Schoenborn's mental illness and substance abuse because he was not interviewed from these perspectives by police, corrections or child protection. Also, there was very little collaboration or information sharing among these systems.

Another aspect of the criminal justice system of note is the importance of supervision of bail orders. Several of Schoenborn's bail orders did not include a condition that he report to a bail supervisor, and it is not clear that Crown asked for such conditions. Without these reporting conditions, opportunities for a bail supervisor to engage actively with Schoenborn, police, Crown Counsel, MCFD or the children's mother were lost.

A supervised bail order could have provided opportunities for the bail supervisor to contact the children's mother to provide support and encouragement in ensuring compliance with the terms of the order, and provide her with important information about support available from victim services. Contact with MCFD could have provided additional information that would have been central to the decision-making process so crucial to keeping these children safe.

A key question throughout the Representative's investigation is: Were the deaths of these children preventable? This question must be asked so that insight can be gained regarding changes that could prevent this tragic outcome from happening to other children, and for the purposes of public accountability for what happened in this case.

In answering this question, it is obvious that the cause of the deaths of Kaitlynn, Max and Cordon was their father, as established by a criminal trial.

However, the Representative concludes that the answer to the question of whether the killing of these children was preventable is clearly "yes." If the social safety net comprised of child protection, justice and mental health had worked appropriately and in partnership in this case, there is a high likelihood that the deaths of these three children would have been avoided.

A key message of this report is this: each arm of the system of supports and protections for vulnerable children and adults in B.C. must be attuned to the risks for their clients, especially to children, and be prepared to refer to and accept referrals from other services. A call for more integration and coordination is hollow if all it means is that child protection workers

Executive Summary

bear the full burden of responsibility when other systems fail to respond. At the same time, it is recognized that until necessary reforms are in place, social workers must make their decisions based on the realities of the resources that are available.

Today, almost four years after the deaths of these three children, a collaborative, systemic approach to complex cases across B.C.'s child-serving, mental health, and criminal and civil justice systems still does not exist. More work and much change are urgently required to protect other children and families from injury and death.



Introduction

This investigation focuses on the contact these children and their parents had with and services received from MCFD, income assistance (now the Ministry of Social Development, MSD), the police and judicial system, the school system and the mental health care system.

The Representative's investigations of child deaths are rooted in a systemic approach, as recommended by international leaders in this area:

A systemic approach to reviewing a child's death provides a change of focus from the conduct of an individual social worker to the more complex factors and interrelationships that invariably surround a child at risk. Child death reviews, regardless of their focus, can be used to improve services or they can be misused to search for a scapegoat....

Rethinking our responses to child homicide has the potential to increase understandings of the dynamics that place children at risk, and to foster a culture of service improvement. It could be that using a systems framework of review that places practice in a wider context is more likely to contribute positively to the strengthening of services for children overall (Connolly, M., Doolan, M., 2007, p. 10).

This investigation involved a review of records relating to each of the three children and their parents. Experts on the Representative's Multidisciplinary Team provided valuable advice to the Representative on issues addressed in this investigation. Transcripts and materials from criminal justice proceedings were reviewed and a wide variety of service providers interviewed.

Any in-depth analysis of the difficult work done by staff on the front lines of the child protection system cannot help but generate a deep respect for the commitment and heart these people put into their jobs, and the Representative extends her appreciation to them. This investigation benefited from discussions with front-line social workers and others in the child-serving system, and it is hoped that this report is received as a respectful opportunity for learning.

In addition, the Representative's investigators interviewed family and school staff with connections or knowledge relating to the case.

The Representative is deeply honoured by the trust the children's mother has placed in her investigation, through her honesty and willingness to share information and insight despite her grief over the loss of her three children.

The mother and extended family of these children require our continuing compassion and support. Ensuring that the death of their loved ones not be invisible is essential to improving the child-protection system, but the Representative strongly urges that the privacy of these stricken family members be respected by all. They are enduring the unthinkable, the devastating loss of an entire family, and it is only respectful to ensure there is no further loss of their privacy at this time.

As in all reports investigating the critical injury or death of a child, the Representative has carefully weighed the privacy of the individuals involved against the value of sharing some of their personal details. A primary consideration is the privacy of the immediate family. For this reason, although previously widely reported, the mother's name is not used in this report.

The names of the children were also reported extensively in the media and the mother has told the Representative's investigators that she does not object to the use of their names in this report. To provide glimpses of what these children were like, to focus us all on the heart of this investigation – three young British Columbian lives whose voices are no longer heard – and to honour them, the Representative has determined that using their names and sharing limited details about them is appropriate in these circumstances.

Because the father, Allan Schoenborn, has been the subject of extensive and public criminal proceedings, including two publicly available Supreme Court judgments arising from his criminal trial, his name is also used in this report.

This investigation learned a great deal about the depth of this family's struggles in the months and years prior to the murders of the children, and has examined the actions of those responsible for keeping children safe. In doing so, the Representative does not apply a standard of perfect 20-20 hindsight vision when considering what officials did or did not do. The standard applied to these questions is whether actions of officials were appropriate given the information and circumstances, within existing and known practice and policies in place at the time.

The use of the word "appropriate" is deliberate. It is very important that this report not use the same terminology that courts use, so that readers do not confuse this report with the standards that courts use to find facts and liability in civil and criminal cases. A Representative's investigation is not a court process, and the Representative's findings are not findings of legal liability. The Representative's investigation of appropriateness of practice is done with a view to making recommendations for learning and for better practice in the future.

This report examines a number of other specific issues. Was support provided to keep the children safe? Were the supports and services offered during episodes of domestic violence responsive to the mother's circumstances? Why did the mother withdraw from involvement

with the system? Were the complex dynamics of her relationship with her husband properly assessed? Were the realities of raising three young children with a partner who was violent and struggled with serious untreated mental health and addictions issues addressed? Was the mental illness of the father identified and adequately assessed and addressed? Were the safety and needs of these children kept squarely in focus? Were the policies and practices within and between the various systems (criminal justice and child-serving) involved with this family adequate? Were the challenges facing children living with a parent with a mental illness dealt with properly?

In this report there are situations where it becomes clear that errors or misjudgments by individual professionals or their supervisors are critical to how events eventually unfolded. There is no easy way around this, and it is an essential part of the learning process to address this when it arises, so that broader issues of supervision, quality assurance and overall functioning of the child protection system can be improved. The Hon. Ted Hughes addressed this specifically:

"...the primary purpose for reviewing injuries and deaths of children and youth who are in care or receiving Ministry services is to point the way to continuous improvements in policy and practice, so that future injuries or deaths can be prevented..."

"A secondary purpose...is one of public accountability...the government has a responsibility to account to the public as to whether it has met its responsibilities to that child. The purpose is not to assign blame to individuals but to learn from mistakes and understand what went wrong and what went right."

– Honourable Ted Hughes, QC, BC Children and Youth Review

To arrive at this public accountability, essential questions always drive any child death investigation. We not only examine how and why a child died; we also ask if there is anything that could have been done to prevent it, to look ahead and find ways to help prevent similar tragedies.

Examining these three deaths does not provide enough information on its own to make sweeping conclusions on the child protection system. A Representative's investigation moves from gathering the details and insights from individual cases, to examining these in light of an overall analysis of the system of supports. The Representative also analyzes if significant improvements have been made in the years following these children's deaths, and carefully considers what remains to be improved in the system. This process serves a crucial public accountability function – but only if government acts on what is found and what is recommended for improvement.



Methodology and Context

Legislative Context

The *RCY Act* requires MCFD to report all critical injuries and deaths of children who have received a reviewable service in the past year. These incidents receive an initial screening to determine if they meet the criteria for review under the *RCY Act*. If the incidents meet the criteria, they are reviewed to determine if a full investigation is required.

The Representative initiates a full investigation when the circumstances of an injury or death are unusual or suspicious, self-inflicted or inflicted by another person, possibly due to abuse or neglect, and services the child received may have played a role in events leading to the injury or death. Under the provisions of the *RCY Act*, the Representative has broad investigative powers and can provide full legal protection to witnesses who contribute evidence to an investigation.

The deaths of Kaitlynn, Max and Cordon were reported to the Representative by MCFD on April 7, 2008. This was the day after their bodies were found by their mother when she returned home. After completing a review of the family's files, the Representative determined that a reviewable service or the policies or practices of a public body may have contributed to the deaths of these three children, and a full investigation was initiated.

Under Section 13 of the *RCY Act*, any investigation by the Representative must await the completion of criminal investigations and criminal court proceedings relating to the critical injury or death of a child. In this case, the investigation commenced after the B.C. Supreme Court found that Allan Schoenborn was not criminally responsible for the deaths of his children on account of mental disorder. Once criminal proceedings and the appeal period passed, the Representative was able to begin her investigation.

Methodology

While the investigation into the deaths of these children focuses on the time frame between May 15, 2007 and April 6, 2008, information prior to 2007 and extending to Feb. 22, 2010 has been examined to fully understand the events leading up to the deaths of the children in 2008.

As stated, it is not the purpose of this investigation to find personal fault or to blame individuals. The objective is to understand what happened so that we learn lessons that can be applied to prevent such tragedies in the future.

Numerous files and documents were reviewed in the course of this investigation. Records were obtained from multiple sources, including police, MCFD, contracted service agencies,

schools, hospitals, BC Coroners Service and the ministries of Attorney General and Public Safety and Solicitor General (now combined into the new Ministry of Justice), Social Development, Education and Health. (See Appendix B for a detailed list.)

Interviews with MCFD staff, police, corrections staff and others, including both parents of the children, were conducted in accordance with Section 14 of the *RCY Act*. Witnesses were ordered to appear for interview, were sworn in and their evidence recorded. Thirty-one interviews were conducted.

The Representative also engaged the assistance of Dr. Peter Jaffe to review this report and provide his expertise. Dr. Jaffe is a professor at the University of Western Ontario and a recognized expert on children exposed to domestic violence.

In addition, the Representative relied on the assistance of Dr. Jennifer White and Dr. Grant Charles, who are both recognized experts in the field of mental health. Dr. White is an Associate Professor in the School of Child and Youth Care at the University of Victoria. Dr. Charles is the Associate Principal (Research) of the College of Health Disciplines and Associate Professor in the School of Social Work at the University of British Columbia.

Experts in the areas of police work, criminal justice, domestic violence, and victim services were consulted. Policies, records, reports, evidence and research pertaining to the involved ministries and public bodies were reviewed to further understand the system of services and supports to children and families facing domestic violence in general and to this family in particular.

A draft report was provided to the Representative's Multidisciplinary Team, which is established under the *RCY Act*. The Multidisciplinary Team reviewed the draft report and provided advice and guidance to the Representative based on the expertise of the professionals on the team. (See Appendix C for a list of team members.)

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

Terminology

In this report, "domestic violence" refers to the abuse or assault of an adult by an intimate partner. Domestic violence has been defined as the pervasive and methodical use of threats, intimidation, manipulation and physical or sexual violence by someone seeking power over their intimate partner (El-Bayoumi, Borum & Haywood, 1998).

While domestic violence is not gender specific, the vast majority of victims are female and in many cases the principal caregivers to their children. This dynamic can be particularly difficult when there are limited options for the victim to leave the relationship and when

one partner relies on the other for financial support (Anderson, Gillig, Sitaker, McCloskey, Malloy & Grigsby, 2003).

Children are exposed to domestic violence when they see, hear or are aware of violence against a parent by another parent (Centre for Children and Families in the Justice System, 2002). In these circumstances, children witness threats, aggression and violence between their parents, who are also their primary figures of caring and security. This means that children often experience confusion and conflicting emotions. It is easy to see how living this way can have a profound impact on children in both the short term and long term.

Mental illness (also called "mental disorders") can be defined as a variety of psychiatric conditions which typically show thought, behavioural or emotional impairments as a result of genetic, environmental, biological and psycho-social factors.

Mental disorders cause distress, can interfere with a person's ability to cope with daily life, and may disrupt their work, social and family life. Individuals experiencing a mental illness may have problems with behavioural and emotional control and communication, and their sense of reality may be distorted.¹

The Family

At the time of the children's deaths, their mother and father had been living in a common-law relationship for 14 years. Allan Schoenborn worked as a roofer and was the sole financial provider. For a period of time, he owned and operated a roofing company. The children's mother was a stay-at-home mom. Both report few problems in their relationship until the first child was born in 1998.

Schoenborn and his common-law wife had two more children: Max, born in September 1999, and Cordon, born in September 2002.

Who were Kaitlynne, Max and Cordon?

At the time of their deaths, Kaitlynne, Max and Cordon were adjusting to life in a new community and a new school.

Kaitlynne was 10 years old. She had blue-grey eyes and long, wavy blonde hair. She was in Grade 4 at the new school and appeared to have made an easy transition.

Staff at the school said that like her brothers, she was well-liked by everyone. Kaitlynne was very sociable, bubbly, friendly, engaging and enthusiastic. She loved singing and joined the choir. She was seen as a very caring person, always ready to lend a helping hand.

1 *Types of Mental Illness*, Canadian Mental Health Assoc., www.cmha.calgary.ab.ca/mentalhealth/Types_of_Mental_Illness/Index.aspx

School staff remember her as being very bright and a strong student. "She was really well-adjusted, and she didn't feel the need to belong to any particular group. If she liked what was going on, she was part of it. If she didn't, she was fine this time on her own," said one member of the school staff. "Everybody liked her because she was very kind. She often had insights into things in the classroom that her teacher would talk about that were wise beyond her years." This wisdom beyond her years was also noted by staff at her previous school. She was recognized as a child with wonderful artistic skills.

Kaitlyne, as the oldest, had a special relationship with her mother, who told RCY investigators that she also saw her daughter as being her best friend. They shared a bedtime routine every night that included tucking Kaitlyne into bed, who fell asleep to the same movie every night.

The mother also said that as Kaitlyne became older, she became more aware of her father's mental health and addiction problems. She became very protective of her mother and began to wish that her father would be kept in jail instead of being able to come home.

Max, 8, shared his sister's kindness to others. "He was also very kind, had lots of friends. Kids were drawn to Max. He loved to take the soccer ball outside at recess and play with the kids," a staff member said. The curly-haired blond Grade 3 boy loved being outside. He was always friendly and polite. School records show that Max was helpful, conscientious, always worked hard and tried his best.

Cordon, 5, with big brown eyes, was described by a school staff person as "just a little ball of joy" with a large group of friends, despite being new to the school. In kindergarten in his new school, he attended the half-day program in the mornings. "He would get very excited by the smallest of things and just sparkled that enthusiasm with everything that he did," staff said. School records note that he enjoyed listening to stories, interacted positively with others and participated with enthusiasm in music and dance activities. Like his older brother, it was noted that he always tried his best.

They were "three pretty precious kids," summed up a staff person at their school.

Knowing now what was going on in these children's lives at home – the violence, the fear they must have felt – it is hard to believe they maintained such sunny outlooks and genuine empathy and kindness to others. Children living in families where domestic violence is occurring can live in a whirlwind of terror, worry, guilt, embarrassment, sadness and feeling responsible.

It is known that children in a family where a parent is struggling with mental illness often experience anxiety due to chaos in their lives, and may develop depression and/or feelings of isolation. These thoughts and emotions can weigh heavily on them during the school hours and can affect their school work. Yet Kaitlyne, Max and Cordon maintained an outward appearance of all being fine, which may very well have contributed to adults overlooking or being completely unaware of the reality of the darkness of their home life.



Chronology

1999–2001: Lower Mainland

MCFD investigation

MCFD's first contact with this family was on June 14, 1999, when staff at the local hospital reported that Schoenborn was speaking and behaving irrationally. He said he had been driving with his daughter Kaitlynn sleeping in the backseat when he realized she had been poisoned. He also claimed that her mother had been sexually abusing her.

The MCFD files note that he said that once he came to the conclusion his daughter was poisoned, he raced to the hospital. On the way to the hospital, he caused two car accidents, the second one disabling his vehicle. When he arrived at the hospital by ambulance, he initially refused to allow medical staff to examine Kaitlynn. When she was later examined, she was found to be in good health.

MCFD social workers began an investigation. They interviewed the mother, at that time six months pregnant with Max. She stated that her common-law husband had become increasingly suspicious and paranoid over the previous few months. She said that they had been fighting because of his fierce jealousy. As well, he made persistent irrational accusations about her having affairs and drugging and hurting their daughter. She said that Schoenborn had been using marijuana along with increasing amounts of alcohol.

The children's mother told MCFD social workers that Schoenborn's behaviour had escalated during the previous week. She had taken him to a general practitioner, who prescribed tranquillizers. After taking a few, he stopped taking them, saying they made him feel foggy. Schoenborn was referred to mental health services, but he did not follow through.

The children's mother said that until shortly before the vehicle crash incident, she had been unaware of any past hospitalization.

The children's mother told MCFD social workers that she had not been able to prevent Schoenborn from taking their daughter in his truck earlier that day. She was afraid of his mental instability and did not know how to stop him without her daughter getting hurt or being injured herself. She described Schoenborn as becoming a "totally different man" from the man he usually was.

The MCFD social workers supported the mother's plan of taking Kaitlynn and staying with a relative in a nearby community. She agreed to call police if Schoenborn came to the house.

MCFD concluded the investigation on June 16, 1999, two days after it began, while Schoenborn was still in the hospital. The investigation found no child protection concerns.

It found the mother was willing and able to protect her daughter with the assistance of family members to help her stay safe until the conclusion of the father's assessment and recommendations for treatment. In a letter to the mother, the MCFD social worker wrote:

"I have concluded my child protection investigation, as required under the *Child, Family and Community Services (sic) Act* concerning a report that your daughter, Kaitlynn, may be in need of protection. The investigation findings indicate that your child is not in need of protection, therefore there is no need for Ministry intervention.

"I would have child protection concerns if your daughter's father were to have unsupervised access to his daughter without first receiving a mental health assessment and without following through with the psychiatrist's recommendations of medications and/or treatment. You have clearly shown that you are willing and able to protect your daughter and that you will not allow the father to take your daughter unsupervised until his mental health has significantly improved."

Hospital

On June 14, 1999, hospital staff in the emergency department noted that Schoenborn demonstrated extreme anxiety, paranoia and confusion. His behaviour was angry and volatile, and he showed signs of paranoid psychosis. He was certified under the *Mental Health Act* and transported by police to another hospital for an involuntary admission for psychiatric assessment. Once Schoenborn arrived at the hospital, he was again certified by an attending psychiatrist. He fled the hospital shortly after being admitted, but was arrested and readmitted.

Hospital records indicate that on the day of the father's admission, he said he was at work when he heard on the radio that 20 women in the city had gone missing. He felt compelled to go home and make sure everything was all right with his daughter and common-law wife. Once he arrived home, he took his daughter in his vehicle with him and left.

He said he suspected his wife was having an affair with one of his colleagues because his wife was not very affectionate with him. He said he had questioned her about this and tried to smell her to see if she had been with anyone else. He told hospital staff that he always had difficulty trusting people. He thought his co-workers were dishonest with him and cheating him. He did not believe he should be in hospital, and he was fearful of being institutionalized indefinitely.

He disclosed to medical staff that he had experienced a period of acute psychosis about 10 years earlier when he lived in another province. At that time, he was hospitalized for seven days and then discharged with a prescription for an anti-psychotic medication but no after-care plan. He did not continue with the medication.

In June 1999, for Schoenborn to be lawfully detained against his will and treated for up to one month, a second physician needed to issue a formal certification to this effect. The second examination was done three days later by a general practitioner, who concluded that Schoenborn was not certifiable.

The general practitioner found him to be completely calm, with normal speech, good insight and no signs of delusions or delusional paranoia. The general practitioner found that Schoenborn demonstrated awareness that he had previously been irrational and that he no longer believed his earlier paranoid delusions about his wife's infidelity or his daughter's condition.

The medical file notes that the general practitioner also interviewed the mother, who corroborated what her husband had said. She did not feel that her husband was a threat to her, their baby or anyone else, and she supported his wish to come home.

However, the mother told RCY investigators that she recalls that at that time, she had hoped that Schoenborn would have been kept in the hospital and been given the opportunity to stabilize with medication. She said that she agreed with the attending psychiatrist that there was no way that her husband could be well in just a couple of days. She was left feeling helpless and unsure of how to manage her husband's behaviour.

The hospital files note that staff were "thus left in a conundrum of what to do" because they had expected him to be certified.

On June 21, 1999, the psychiatrist had Schoenborn sign a waiver of responsibility form, acknowledging that he was leaving the hospital against medical advice. The waiver states that the consequences of Schoenborn's decision to leave against medical advice would rest solely with him rather than with the hospital.

The discharge diagnosis was delusional disorder, persecutory type. While in the hospital Schoenborn was prescribed an anti-psychotic medication. Upon release, he was given a prescription for an anti-psychotic medication. He was also prescribed medication for side effects.

Testimony from the children's mother at Schoenborn's criminal trial was that he did attend a scheduled appointment with a psychiatrist one week after leaving the hospital. From the mother's perspective, the session was not helpful and was "a waste of time." She felt that the psychiatrist supported Schoenborn's fixation on jealousy and infidelity.

There is no indication from records or interviews that Schoenborn had any further contact with the mental health system. He told RCY investigators that he had wanted to try to deal with his mental health issues on his own.

As noted previously, the MCFD social worker told the mother that "I would have protection concerns if your daughter's father were to have unsupervised access to his daughter without first receiving a mental health assessment and without following through with the psychiatrist's recommendations or medications and /or treatment." There is no evidence of any follow-up on the child protection concerns arising from Schoenborn's mental health admission.

MCFD had no further contact with the family for the next three years.

2002–2004: Lower Mainland

By September 2002, the family had moved to a different community in the Lower Mainland, and Kaitlynn had two younger brothers. Kaitlynn was four years old and Max was three. Cordon was a newborn.

On Sept. 26, 2002, a public health nurse called MCFD. This was the second child protection report to MCFD about this family (the first, in June 1999, was described earlier). It was coded by MCFD as an investigation. The public health nurse was concerned that the mother did not want a public health nurse visiting the home for a post-natal assessment, which was being pursued because the discharge report from the hospital noted concerns about the infant's low birth weight and exposure to second-hand cigarette smoke in the home.

On Oct. 3, 2002, an MCFD social worker conducted a home visit, accompanied by police because it was noted in the files that the father had a history of criminal involvement (although there had been no charges since 1993).

At the home visit, they learned that the public health nurse had successfully visited the previous day, Oct. 2, 2002. The children's mother told the MCFD social worker that she would be open to the nurse visiting anytime and that the nurse was helping her find a family physician. The mother also stated she wanted the older children in daycare and asked for the MCFD social worker's assistance in that regard.

The children's mother told the MCFD social worker that Schoenborn's mental health was no longer a concern as he had stabilized considerably. The mother said she believed the episode in 1999 occurred as a result of substance-induced psychosis. Her husband had been using a lot of marijuana, and she believed that this had caused his paranoia.

The children's mother told RCY investigators that she could not understand at the time why MCFD made the home visit. She recalls that the public health nurse did request a home visit but that the first home visit was on the same day that she was leaving the province to see a family member who was ill.

Doula

A doula provides non-medical support to women and their families during labour, childbirth and the post-partum period.

On Oct. 9, 2002, the MCFD social worker continued with the investigation, apparently because the public health nurse was once again unable to conduct a home visit. As part of a protection plan, the MCFD social worker requested funding for doula support for the mother but had not yet consulted with the mother on this.

On Oct. 11, 2002, the public health nurse advised MCFD social workers that she had made a second home visit, and this time the baby was doing well. The mother had also taken the baby to a physician. The nurse observed that the mother was very appropriate with all three of her children. The nurse said she had no further concerns.

On Oct. 15, 2002, the MCFD social worker phoned the children's mother offering doula support. The mother indicated that she did not want or need doula services and said that her own mother assisted her several times a week.

On Oct. 16, 2002, the children's mother phoned the MCFD social worker to say she no longer wanted help with finding daycare for her children. She said she had enough support from her family. She said she did not require any assistance from MCFD, and she believed the ministry was trying to spy on her family.

Following a consultation with the team leader, the MCFD social worker called the children's mother to invite her and Schoenborn to the MCFD office for a meeting to explain her rationale for offering services, including doula support. The children's mother replied that she was not interested in meeting with MCFD, adding that she felt MCFD was harassing her.

On Nov. 6, 2002, the MCFD social worker closed the investigation with a finding that there were no child protection concerns. Collateral checks with the family physician and the public health nurse resulted in no issues being raised. In the closing summary, the MCFD social worker wrote:

"The family is very clear about not participating in any services. Parents have stated that they will not cooperate with services and there are insufficient grounds to proceed with more intrusive measures...in any subsequent intakes whereby protection concerns are substantiated, it is recommended that MCFD proceed with more intrusive measures."

MCFD had no further contact with the family until 2007, four and a half years later.

The children's mother told RCY investigators that between 2002 and 2007, Schoenborn continued to show signs of mental illness and drank heavily. There were periods of stability, often when he was working less. She said that the more he worked, the more money he had to spend on alcohol. Schoenborn would come home from work and drink through the night. She was forced to stay awake with him. She would then get up and get the kids to school and manage throughout the day on very little sleep.

In 2003 and 2004, Schoenborn came to the attention of police several times. Police were called in September 2003. It was alleged that Schoenborn had threatened a worker. The police were unable to contact Schoenborn and believed the alleged victim was trying to press charges as a way of getting paid. There was no further investigation or charges.

Police stopped Schoenborn in his truck in April 2004 on suspicion that there might be known drug users in his truck. Schoenborn was asked to show registration. It was in his wife's name. After a brief search he was let go without incident.

On Sept. 23, 2004, the police were called to the family's residence by Schoenborn. The police records noted that this was the third 911 emergency call from the father in recent months regarding a dispute between Schoenborn and a downstairs neighbour. The downstairs neighbour was unhappy with the hot water/heating temperature, which was controlled upstairs by Schoenborn.

The police mediated over a two-hour period, and although they did not feel they came to any resolution, Schoenborn and the neighbour had calmed down considerably. The police advised Schoenborn that 911 was not to be used to settle disputes and asked him to refrain from calling unless there was an emergency. The other two disputes had ended similarly.

January 2007: Lower Mainland

On Jan. 6, 2007, police were called to the family residence on what police logged as "a domestic violence" call. Schoenborn and his brother had been involved in an argument. They were both very intoxicated and got into a physical altercation. The brother had a broken shoulder and facial bruising and was taken to hospital. Neither Schoenborn nor his brother was willing to pursue charges.

May 2007: Lower Mainland

Police and MCFD called

Late in the evening of May 17, 2007, police went to the family's home in a response to a call from the children's mother. She told police she had been bathing the children (who were then 4, 7 and 9), when Schoenborn came home intoxicated and started acting violently toward her. She said that he grabbed an alarm clock and threw it, breaking the patio window. This frightened the children, who screamed and ran to their bedrooms.

The children's mother said that Schoenborn yelled for the children to be quiet and continued on a rampage in the home. He confronted her and yelled at her. He continued to break and throw things around the house. He also punched out the kitchen window and told her she would be next. The children's mother fled the home and called police from a pay phone while the children remained in the home.

MCFD records indicate that when the police arrived, the children's mother told them she lived in fear of her husband and was worried he would have beaten her to death that

evening. She told police that she also feared for the safety of her children and she believed Schoenborn's anger was escalating. She said she wanted to end her relationship with Schoenborn and requested a restraining order.

Police reported this to MCFD After Hours early the next day. MCFD had not been involved with the family since November 2002.

Disclosure of sexual assault

While the police were at the home investigating the May 17, 2007 incident, the children's mother disclosed that a sexual assault had taken place two days earlier.

She said that on May 15, 2007, Schoenborn came home intoxicated and in a jealous rage. He demanded that she perform sexual acts against her will and that Schoenborn threatened to "beat her up until she turned black and blue" if she did not comply. The mother reported that the incident went on for three or four hours.

The children's mother said that Kaitlynne could not sleep and was crying, and she came into the parents' room. She believed that the two boys were sleeping in their rooms. Schoenborn continued to yell and gave the mother a push on the side of the head. The children's mother had Kaitlynne go back to her room.

As discussed later in this report, the children's mother wrote a letter to Crown Counsel several weeks later recanting the sexual assault allegations and insisting that Schoenborn not face charges for these allegations. She told RCY investigators that the allegations were in fact true but that she was pressured by Schoenborn to recant them.

Arrest of Schoenborn for uttering threats and sexual assault

Community-based Victim Services

These programs are contracted services funded by the Ministry of Public Safety and Solicitor General (now part of the Ministry of Justice). Programs are located in community agencies and are mandated to support all victims of power-based crimes. In some communities, programs for survivors of sexual abuse are targeted specifically to women, children, youth, men, Aboriginal peoples or ethno-specific communities (PSSG, 2007).

After the mother disclosed the sexual assault to police, Schoenborn was arrested in the early-morning hours of May 18 and charged with uttering threats against a person and sexual assault. The mother and the children then left the home and stayed with a relative.

Schoenborn was told by police that he would not be allowed contact with the children's mother once he was released from custody. He replied to police that he would go back to the residence and "show her."

The police forwarded the file to the sexual offense unit. An officer from that unit requested that Schoenborn be detained pending their investigation and a bail hearing.

Timeline of Significant Events

May–July 2007

May		June		July	
MCFD					
MAY 18 Child protection report received re: domestic violence.	MAY 22 MCFD begins investigation.	MAY 31 MCFD serves mother with notice of a hearing for an application for a supervision order.	JUNE 4 MCFD obtains interim supervision order.	JUNE 20 Child protection investigation closed with a finding children in need of protection.	JUNE 26 Risk Reduction Service Plan completed.
				JUNE 28 MCFD decides not to proceed with supervision order.	JULY 2 Mother recants sexual abuse allegation.
Justice System					
MAY 17 Domestic violence call to police.	MAY 18 Schoenborn arrested in the early morning and released by court in the afternoon, with conditions.	MAY 23 Police officer cancels domestic violence support services for mother. Mother missed scheduled appointment with police.	MAY 24 Mother tells police she wants to drop charges.	JUNE 6 Schoenborn arraignment hearing.	JULY 13 Schoenborn arrested, drunk in public. Breach of Order.
					JULY 20 Charges stayed. Courts grant Section 810 with conditions.
Other					
	MAY 24 Mother referred by MCFD to contracted service agency re: domestic violence supports. Contracted service provider worker not available until end of June.	MAY 31 Mother began application for income assistance.			JULY 17 Mother's income assistance application completed.

August 2007–March 2008

August

September

October

November

December

January

February

March

AUG. 22
MCFD file notes Schoenborn attending family home daily.

AUG. 24
Child protection report received re Schoenborn intoxicated and threatening at family home.

AUG. 25
MCFD updates comprehensive risk assessment to "high risk."

AUG. 31
Schoenborn at family home against MCFD direction. Safety plan options:
1. transition house
2. remove children
Family moves to Interior.

SEPT. 4
"Courtesy Supervision" agreed upon by Interior and Lower Mainland MCFD offices.

NOV. 16
August child protection investigation closed. Finding: no child protection concerns. File to be transferred to Interior (didn't occur).

DEC. 21-24
MCFD receives three reports re: Schoenborn at family home. Police and MCFD visit home twice. MCFD starts child protection investigation. MCFD closed this investigation on May 12, 2008 after the children's deaths.

JAN. 7, 2008
Interior MCFD receives file from Lower Mainland.

NO FURTHER SERVICE UNTIL APRIL

AUG. 23
Police arrest Schoenborn in family home.
Breach of Order.

AUG. 24
Schoenborn released on unsupervised bail with same conditions as Section 810.

NOV. 16
Schoenborn fails to attend court on Aug. 23.
Breach charges warrant issued.

AUG. 31
Contracted service provider calls transition house in Interior – not able to house mother and 3 children.

JAN. 22, 2008
Mother provides income assistance office with eviction notice she received for unpaid rent.

FEB. 28
Mother requests crisis grant – no food. Crisis grant approved.

MARCH 13
2nd crisis grant rec'd – no food.

Continued on next page

Timeline of Significant Events Continued from previous page

First Week of April 2008

MARCH 31

Schoenborn applies for income assistance.

APRIL 1

MCFD child protection report. Schoenborn at school. Second call from community that Schoenborn at family home. Schoenborn attends MCFD office for meeting and is arrested for outstanding warrant.

APRIL 2

Schoenborn in altercation with bus station staff and passenger. Schoenborn appears in court.

APRIL 3

In early hours Schoenborn arrested for drinking in public and released same morning. Schoenborn goes to school three times. Schoenborn aggressive, threatens school staff and student. School calls police. Schoenborn arrested. MCFD meets at school with mother and staff. MCFD directs mother to keep Schoenborn out of home. JJP hearing, Schoenborn released with conditions.

APRIL 4

Schoenborn attends MCFD office, asks for family visits. Team leader says too late in day to deal with request. Schoenborn meets with bail manager, says he is living with common-law wife and children. Bail manager calls MCFD regarding the disclosure. Mother goes to stay at relative's home. Schoenborn home alone with children.

APRIL 5

Mother, Schoenborn and children visit at park. Children return to family home with Schoenborn. Mother goes to relative's home for the night.

APRIL 5/6

Schoenborn kills his children.

APRIL 6

Early afternoon mother finds children.

There is no record of the children's mother being referred to a specialized community-based victim assistance program to assist with safety planning and other practical safety needs of herself and her children.

Bail Order

Schoenborn was released on bail the afternoon of May 18, 2007 (hours after his early-morning arrest) without having been interviewed by police about the escalating incidents of domestic violence.

He was released on the following conditions:

- *Condition 1: Keep the peace and be of good behaviour.*
- *Condition 2: Not to possess any weapons as defined in the Criminal Code of Canada, including knives, except when immediately preparing or consuming food.*
- *Condition 3: Not to have in your possession any alcohol and refrain absolutely from consuming alcohol.*
- *Condition 4: Have no direct or indirect contact with (the mother), Kaitlyne Schoenborn, Max Schoenborn or Cordon Schoenborn.*
- *Condition 5: Not to be within a two (2) block radius of (address removed) in the City of (city removed) in the Province of BC.*
- *Condition 6: Not to possess any firearms, explosive substances or ammunition as defined in the Criminal Code of Canada.*

As there was no requirement to report to a bail supervisor, the release conditions were not monitored.

There is no record of whether or how the conditions of his release were communicated to the children's mother; nor is there a record of anyone assisting her with what to do or who to call if she was to become aware that he breached his release conditions.

On May 18, 2007, a police officer contacted the police department's domestic violence unit to request domestic violence victim services for the mother. When the mother failed to attend a scheduled appointment, the officer told the domestic violence unit on May 23, 2007 to cancel the service.

Domestic Violence Unit

This particular Lower Mainland community has a domestic violence unit, which is a partnership between the local police department and a community-based victim support service. The victim service worker works in partnership with the police officer to support victims of high-risk domestic violence (in this case the children's mother). Only high-risk cases are referred to the domestic violence unit.

MCFD investigation

MCFD began an investigation on May 22, 2007, four days after police called After Hours. The district office received the report after the May long weekend. This was the third investigation undertaken by MCFD.

On the evening of May 22, 2007, an After Hours social worker and a police officer made an unannounced visit to the home. The social worker did not enter the home because she was told by the children's mother that the children were sleeping. The social worker gave the children's mother a business card with the number of the MCFD district office on the back and reminded her to call police if Schoenborn showed up.

The next day, on May 23, 2007, an MCFD intake social worker conducted a home visit. The children's mother explained that she had ended her relationship with Schoenborn after the May 17 incident. She stated that he had increased his use of marijuana and alcohol and that she believed this contributed to his deteriorated mental state. She said he had become uncontrollable, violent and aggressive.

She stated that her husband had never had a psychiatric assessment, although she was encouraging him to do so. She said she had been terrified of Schoenborn during the previous incidents.

The children's mother told the intake social worker that she did not want charges laid; she wanted Schoenborn to get better and she felt that he would not get help if he were facing criminal charges. She also told the worker that the children were not afraid of their father and that he had a good relationship with them.

MCFD safety plan

The MCFD intake social worker developed the following safety plan with the children's mother:

- The children's mother was to protect the children by not allowing the father in the home and not allowing him to speak with the children on the phone.
- She would call the police in the event that Schoenborn appeared at the residence.
- If the father wished to see the children, he could contact the MCFD social worker, who would set up supervised visits at the MCFD office.
- If the father wished to have ongoing contact with the children, he would need to participate in several support services, including parenting, aggression/violence management and alcohol addictions treatment.
- The children's mother would agree to work with a family support worker for continued monitoring and support.
- The After Hours team would conduct random home visits to ensure that the mother was following the safety plan.

It is noted that the third condition in the safety plan was not consistent with the fourth condition in the bail order: "Condition 4: Have no direct or indirect contact with the mother, Kaitlynn Schoenborn, Max Schoenborn or Cordon Schoenborn." It is not clear if the MCFD social worker was aware of the bail order.

Interview with the children

The MCFD intake social worker interviewed the three children. The youngest son, Cordon, who was four, said he had witnessed his father break a window and a popcorn stand during the May 17 incident. Cordon said he was happy at home but was sometimes scared.

Kaitlynn, who was nine, said she had seen her father yelling at her mother and she had seen them argue. She said the children were scared when her father was yelling during the incident on May 17. She also said she did not feel afraid at home. She said she had not seen her father since he was taken away by police.

Max, who was seven, denied having a father. He told the intake social worker that his family was made up of his mother, sister and younger brother. He kept insisting that he did not have a father, and had never met his father.

Finally, when asked to tell the intake social worker good and bad things about his father, Max disclosed that he did not like it when his father was drunk. He stated his father did not yell at him or his siblings. He had not seen his father since May 17, but he had spoken to him on the phone the previous evening.

On May 23, 2007, Schoenborn arrived at the MCFD office unexpectedly, asking to speak with the intake social worker. The intake social worker was unavailable, and Schoenborn refused to wait. He was reportedly aggressive and rude with administrative staff at the office. The intake social worker later called Schoenborn to make arrangements to meet on May 28, 2007.

Mother asks police to lift no-contact conditions

The next day, on May 24, 2007, the children's mother went to the police station. She requested that the no-contact release conditions be lifted. This was an unscheduled visit, and the officer responsible for the case was not available to talk to her. Another officer met with her. The interview took approximately 40 minutes and was videotaped.

The children's mother told police that because Schoenborn was already visiting her and the children every day, she wanted the no-contact conditions dropped. There was no follow-up by police on her disclosure that Schoenborn was violating the bail order on a daily basis.

In spite of the officer's significant efforts to dissuade her, the children's mother was adamant that she did not want Schoenborn to be charged and that she only wanted to help him. She said that having him go to jail would not help him in any way. She felt that the contact prohibitions were too restrictive and were not fair to Schoenborn.

During the same interview, the mother disclosed another domestic violence incident from 2001. The children's mother said that this occurred after Schoenborn was drinking heavily and using increasing amounts of marijuana. She reported that he came home extremely intoxicated and began an unprovoked argument. The argument ended with the children's mother being hit in the face by Schoenborn.

She attended the hospital for a broken nose, telling hospital staff that she had tripped over the family dog. When questioned by police about the incident years later, Schoenborn said it was an accident, and he had meant to hit the wall, not his wife.

The police officer tried to help her understand the seriousness of the assault and the impact it could have on her children. The mother said she did not believe there was any impact on the children. She said that MCFD was causing a negative impact on her children by keeping them away from their father, and that she would not reconcile with Schoenborn until he received help. She believed that leaving the relationship would be the motivation Schoenborn needed to finally get help for his drinking and mental health issues.

She told the officer that she did not fear for her safety. She did not believe he would hurt her again and said that the May 17 incident was isolated and a result of a "drunken rage." She believed that MCFD social workers had unfairly judged Schoenborn, even though they hadn't met him.

The police officer continued to try to help the children's mother understand the cycle of violence she was living in. The officer asked her how she would react if it were her daughter in her situation. The children's mother replied that she would kill anyone who hurt her daughter in the way she was hurt. Yet she continued to insist that charges not be pressed. During the interview with the officer, the children's mother said she believed she was in control of whether charges were pressed. She did not understand that it was up to Crown Counsel, based on information from the police, to determine whether to proceed with criminal charges.

Requesting Changes in Orders

It is common for many abused women to ask that no-contact orders be dropped. Many communities in B.C. have protocols in place where women are referred to community-based victim assistance programs so that the reasons for the request can be explored fully, specialized support provided and safety plans updated.

The police officer reluctantly ended the interview, telling the children's mother that her file would remain open and that she could come back at anytime, at which point the police could provide additional information to Crown Counsel. The officer provided her with a number of resource pamphlets regarding counselling and shelter. The officer informed the children's mother that a counsellor from the domestic violence unit would be contacting

her to follow up with any of her concerns or questions. It does not appear that this ever occurred. As noted previously, it also does not appear that any police action was initiated against Schoenborn for failing to comply with the bail order.

Mother asks MCFD to lift the no-contact requirement

Following her interview with police on May 24, 2007, the children's mother called the MCFD intake social worker, saying the demands of not allowing any form of contact with Schoenborn were unfair and unjust. The MCFD intake social worker told her that Schoenborn posed a risk to the children and that she wanted to meet with him.

Later that day, the MCFD intake social worker made a referral to a family preservation worker at a contracted agency. The referral outlined the services that should be provided to the children's mother. They included support with the separation, domestic violence counselling and supporting her in registering the children in a Children Who Witness Violence program (now commonly referred to as Children Who Witness Abuse).

Family Preservation Worker

This is a family counsellor who provides services to families referred through MCFD. The services are intensive, goal oriented and home based with the intent to prevent out-of-home placement. A family counsellor or family preservation worker provides therapeutic and educational interventions and connects the family to professional and community-based resources (Family Services of Greater Vancouver, 2002-2011).

Children Who Witness Abuse (CWWA)

CWWA is an intervention/prevention program created by the BC/Yukon Society of Transition Houses to address the needs to children and youth aged 3 to 18 who have been exposed to violence at home. The CWWA program provides individual and group interventions aimed at helping youth and children between 3 and 18 years of age to understand and cope with violence against their mother and the effects of this violence on themselves. CWWA counsellors also provide support and information to mothers, non-offending caregivers and individuals who work with schools on prevention activities such as the Violence Is Preventable (VIP) project (BC Society of Transition Houses website, www.bcsth.ca).

In that request, the MCFD intake social worker incorrectly wrote: "An initial no-contact/no-go order has been vacated. MCFD has requested that the mother enforce a no-contact/no-go as part of an immediate safety plan." In fact, these no-contact conditions in the bail order had remained unchanged and would remain in effect until July 20, 2007. On that day (July 20, 2007), Crown Counsel sought a Section 810 recognizance (also known as a peace bond) for one year with conditions, after staying the criminal charges.

Section 810, Criminal Code of Canada

Section 810 of the Criminal Code allows a court to impose a recognizance, frequently referred to as a peace bond, on an individual where grounds exist to believe that person will injure someone or damage their property. Although similar to and often confused with bail conditions, a Section 810 recognizance can be imposed on someone who has not yet committed an offence or been arrested. It is a proactive or preventative measure that is designed to prevent or deter an offence from being committed.

Like a bail hearing, this process is conducted before a judge or justice of the peace, who receives information from both parties. Section 810 recognizances are often sought in domestic violence situations where the evidence supports the existence of a threat but falls short of the requirements for a criminal conviction. If granted by the court, a Section 810 recognizance, like a bail order, may contain a number of conditions imposed on the threatening party, including prohibitions on contacting the other party, possessing weapons or being close to a residence or workplace.

If the party the recognizance is imposed on violates a condition of that order, they can be arrested and a separate criminal charge for breaching that recognizance laid.

While bail conditions remain in place until the conclusion of the criminal trial, Section 810 recognizances have a duration of 12 months.

The MCFD intake social worker recalled that the children's mother had told her the order had been vacated, and she accepted that as correct.

On May 24, 2007, following the mother's call to MCFD, the MCFD intake social worker placed an action alert on the After Hours system. (An action alert is a memo placed on a file that advises After Hours staff to follow up on an item of concern.) The alert noted that the children's mother told the intake social worker she had requested that the police lift the release conditions on the order. It also noted that the intake social worker advised her to comply with MCFD's request not to allow Schoenborn in the home and to call the police if he attended the home.

The alert also indicated that neither the children's mother nor the children could have any verbal contact with the father until the MCFD intake social worker had a chance to meet with him and assess "where he is currently at." The intake social worker advised After Hours to remove the children if either parent (if the father was in the home) was uncooperative or resistant.

The action alert also reported that Schoenborn called the intake social worker on that same day to say his no-go/no-contact order was going to be lifted on May 29. The MCFD intake social worker requested that After Hours social work staff check the status of the order.

On the evening of May 24, 2007, an After Hours social worker and police conducted a home visit. They verified that the original bail order was still on the police system. The children's mother reported that the order would be coming off the system as of May 29, 2007. She told the After Hours team that she had not seen or heard from Schoenborn and had no intention of resuming their relationship. She was unhappy that the children could not see or speak to their father and did not understand why this restriction was in place. She told the After Hours team that Schoenborn "would never harm them."

On May 28, 2007, the children's school called MCFD to report that Schoenborn had come to the school. He was demanding to know if his two older children were in school that day. The caller reported that Schoenborn said he had every right to be at the school and that he refused to leave until he found out whether two of his children were in attendance. He was described as having been very aggressive toward the caller.

Later that day the caller phoned MCFD again to report that the father had returned to the school, this time wanting to see the children. The caller told the MCFD intake worker that the father was co-operative and left upon request. The MCFD intake social worker told the caller that the father had a no-contact order with the children and that the caller should call the police. No call was made to the police, although it was school policy to do so.

Schoenborn meets with MCFD and police

After Schoenborn left the school, he attended a scheduled meeting at the MCFD office, which was attended by at least four staff from police and MCFD. Schoenborn left shortly after it started, saying that he felt overwhelmed by the number of people in attendance and he wanted a lawyer present.

Schoenborn told an RCY investigator that he was expecting to meet with the intake social worker to discuss the situation with his family. He said he was completely unprepared for a meeting with so many people, and this seriously undermined any trust that he might have with MCFD. The meeting notes indicate that Schoenborn was living in his truck at this time.

In response to questions at the meeting about the threats and violent behaviour of May 17, 2007, Schoenborn stated that he was not the person involved; that is, he was physically there but that it was not the real him, that it was someone else taking over his actions.

Before Schoenborn left, he said he wanted to see the children. He agreed to participate in support services that would address his anger and violence, parenting capacity and alcohol/drug use. He did not believe he needed any services related to mental health issues.

On May 28, 2007, the After Hours social worker made an unannounced visit to the home. The After Hours report notes that "a cursory check of the home [was done] but it was dark and crowded and it is quite possible that [the father] was either hiding or had slipped out another door before we were let in the home."

On May 29, 2007, the MCFD intake social worker received a call from a domestic violence counsellor at the contracted agency in relation to the referral of May 24, 2007. The counsellor said that due to her heavy workload and waitlist for services, she could not begin work with the mother before the end of June.

MCFD application for supervision order

On May 31, 2007, MCFD served the children's mother with a notice of a hearing for an application for a supervision order and presented her with a document to sign that would waive the usual 10-day notice period for such a hearing.

Supervision Order

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

Child Protection Responses to Risk

Ministry staff have a number of responses available to them when child protection issues come to their attention. The responses range from a "least intrusive" approach to removal of the child/children from their homes and the custody of parents. The child protection response is dictated by the level of risk that has been identified. If the risk is low, ministry staff can employ a measure that is less intrusive than a court order or removal. The ministry may enter into an agreement which outlines support services the family will be involved in that will help reduce the risk. If the risk is immediate and high, then it may be that ministry staff remove the child/children and apply to the courts for temporary custody.

There are also circumstances where the ministry applies for a supervision order. This response would likely be used in a situation where a parent was cooperating with the ministry and there is an identified level of risk that can be managed through this order. The order will direct the parent to follow a set of activities that would reduce the level of risk to the children. If the parent did not follow the instructions, the supervision order has a stipulation that allows for removal of the child/children as a consequence of not abiding by the supervision order.

The children's mother refused to sign, saying she did not have sufficient time to consult a lawyer. Schoenborn was not served any court documentation; nor was he notified of the proceedings.

Income assistance application

Also on May 31, 2007, the children's mother went to an income assistance office and began an application for income assistance. She did the computerized orientation, which provides prospective clients with information about the income assistance program and is the first step required in the application process. The file noted that she was a single parent and that she had just separated from her abusive husband. She was required to complete daily job search activities.

There is nothing on file to suggest that anyone at the income assistance office contacted the children's mother or MCFD to follow up on her disclosure of abuse.

Interim supervision order

On June 4, 2007, MCFD obtained an interim order for supervision by the Director without removal in order to "supervise the mother's care of children." The court agreed to all the conditions and terms that MCFD requested. The supervision order was obtained by consent, meaning the children's mother agreed with the order and conditions. There is no explanation on the file for why she changed her mind and consented to the order. Conditions of the supervision order were as follows:

1. The mother must continue to reside with the children at their current address.
2. The mother must allow the director to visit and inspect the home, whether scheduled in advance or not.
3. The mother must attend all scheduled appointments with the MCFD social worker.
4. The mother must attend all scheduled appointments with the family preservation worker.
5. The mother must attend all scheduled appointments with the domestic violence worker.
6. The mother must immediately report any breach of the criminal court bail order no-go/no-contact conditions placed on the father to the police or director.
7. The mother must ensure that the father does not enter the home or have contact with the children under any circumstances unless approved in advance by the director.
8. The mother must ensure that the father has access to the children only as and when directed by the director.
9. The director must remove all three children if the mother fails to comply with #2, 6, & 7.

The children's mother was present at court on this day and had obtained legal counsel. Schoenborn was not present.

When an interim supervision order is issued, the law requires a child protection hearing. In this case the child protection hearing was scheduled for July 9, 2007, a little more than one month from when the interim order was issued. This is typical family court process. An interim order is granted and then the family and MCFD go before a judge for a child protection hearing up to six weeks later. This allows the social worker to gather as much information as possible for the investigation.

After Hours alert

An After Hours information alert placed by the social worker on June 5, 2007 reported that the children's mother was unsuccessful in her attempt to have the no-go/no-contact conditions lifted. The alert noted that she was reluctantly agreeing to engage with services. However, she would not cooperate with Crown Counsel on either the sexual assault charge or the charge of uttering threats, as she didn't feel that pursuing these issues as criminal matters would be beneficial. The alert further said: "The Director deems the children to be in need of protection, because the mother is minimizing the significance of violence in the home."

Mother asks Crown to lift no-contact conditions

Arraignment Hearing

An arraignment hearing is the first phase of the criminal case after arrest. The accused usually appears before a judge, and the judge reads the charges to the defendant. The judge will also address the issue of bail if it hasn't been dealt with either through release by police or an order made by a justice of the peace.

On June 6, 2007, the children's mother spoke to Crown Counsel at the arraignment hearing. She said that her relationship with Schoenborn was over. However, she wanted the no-contact/no-go conditions lifted. Crown Counsel did not agree to vary the bail/release conditions.

Home visit

Five days later, on June 11, 2007, the After Hours social worker and uniformed police officers made an unannounced visit to the home, per the supervision order. They searched the home and reported no concerns. The MCFD intake social worker conducted collateral checks with the school and the family

physician and planned to continue unannounced home visits. The school reported no child protection concerns and the family physician reported that the children's mother was an "appropriate mother," but could not provide any examples. MCFD files do not reference any subsequent unannounced visits.

Child protection investigation concluded

On June 20, 2007, MCFD's child protection investigation was closed with the finding that the children were in need of protection, that the parent was unable/unwilling to care for them and that there was a risk of emotional harm.

The response to these findings was to offer support services. The MCFD file was transferred from an intake team to a family services team. The supervision order was still in effect at the time of transfer, with the child protection hearing pending for July 9, 2007.

On June 26, 2007, MCFD completed a risk reduction service plan, identifying the issues of family violence, housing, parenting and stress. There was no mention of Schoenborn's untreated mental illness in the risk reduction plan. The plan contained no expectations of him or services to be provided to him, even though the social worker wrote, as part of the assessment: "Allan is dangerous to himself and to others due to his paranoia and aggression...."

MCFD withdraws protection proceedings

On June 28, 2007, MCFD (the family services team continued to have conduct of the file at this time) withdrew from court proceedings. At the time, MCFD had the interim supervision order that had been granted at the interim child protection hearing. That order was expiring, and the protection hearing was scheduled for July 9, 2007. Rather than applying for the supervision order at the protection hearing, MCFD decided to withdraw all court applications. The MCFD file indicated that they did not want to proceed with the July 9, 2007 child protection hearing for the following reasons:

"The mother states that she has no plans to reconcile with the father and she has demonstrated that she was willing to address the children protection (sic) concerns by signing her risk reduction service plan, thereby agreeing to do the following:

- Connect with family violence counsellor.
- If the father does not participate in service provision, then the mother will not have contact with him when the children are present. The mother will ensure that if the father has access to the children he is not under the influence of drugs or alcohol and is presenting as mentally stable.
- The children will attend the Children Who Witness Violence Program.
- The mother will discuss the affects (sic) of violence on children as well as general parenting issues/information with her family preservation worker."

The risk reduction service plan contradicted the criminal bail release conditions that would remain in effect until July 20, 2007. The release conditions specified a no-contact/no-go with the mother, the children and the residence.

The MCFD family service social worker advised the children's mother that MCFD would seek a new supervision order if Schoenborn was back in the family home.

Mother recants allegation

On July 2, 2007, the children's mother wrote a letter saying that she wanted to withdraw all charges against Schoenborn and that she had fabricated some of the allegations, including the sexual assault allegations. (During the subsequent criminal trial for the murder of his children, Schoenborn did admit to some of the events from May 15, 2007, but said he did not remember if a sexual assault took place that evening.)

In her letter, the children's mother wrote: "The Judge had now put a wall between the father and me and our children, who are very confused about not having ANY contact with there (sic) FATHER. The father has been good and has continued to provide for myself and children by paying our rent, groceries, bills, clothes, toys and a truck for myself. Dispite (sic) his and my situation. In all Honesty, the father has never intentionally hurt me or threaten (sic) to."

As noted previously, the children's mother told this investigation that Schoenborn coerced her into writing this letter, partly because he believed that she was involved with police and MCFD and that they were all out to get him. She felt she had no other choice but to recant in order to ease the pressure she was under from Schoenborn.

On July 10, 2007, the MCFD family services social worker noted that Crown Counsel told her the no-contact condition with the children's mother would be dropped. On July 12, 2007, the same social worker noted that the domestic violence counsellor at a contracted agency the children's mother had been referred to was not taking new clients until September 2007 due to heavy workloads and waitlists.

Schoenborn arrested

On July 13, 2007, police arrested Schoenborn for being intoxicated and in a physical struggle with two taxi drivers. He was charged with breaching the no-alcohol condition of his bail order. The breach was reported to a specialized unit where an MCFD social worker and police officer work together and respond to issues. However, the MCFD files do not note the breach. Schoenborn was released back onto unsupervised bail by the court.

Mother continues efforts to receive income assistance

The children's mother returned to the income assistance office on July 13, 2007, with a job log which the employment and assistance worker noted was "very sparse." The worker advised the children's mother that five job search activities were required per day. The children's mother presented an eviction notice ending tenancy on Aug. 31, 2007. July rent had not been paid. She said that she only had \$20 cash and food to last one week.

On July 17, 2007, the application for income assistance was completed. The file notes: "client is fleeing abusive spouse." It was also noted that her spouse had paid May and June rent but that rent had not been paid for July. Crisis funds were issued to BC Hydro to prevent disconnection of electricity.

On July 18, 2007, a pro-rated support cheque was issued to the mother for \$200. On this same date the file states: "Hold to be released once FMW meeting completed."

A Family Maintenance Worker meeting was required so that the mother could sign over her maintenance rights to the Minister of Employment and Income Assistance, as is required by legislation for all spouses with dependent children seeking assistance (Employment and Income Assistance Regulation, B.C. Reg. 263/2002, s. 20). On July 23, 2007, a family maintenance referral was created.

On July 25, 2007, the file says: "Issued \$300 as not received any payment from ex must see FMW before released."

Criminal charges stayed

On July 10, 2007, Crown Counsel reviewed the sexual assault charge and determined that it was no longer a viable prosecution as it relied solely on the initial statement the children's mother gave, and she had since recanted.

In its place, Crown Counsel sought a peace bond, also known as a recognizance, under Section 810 of the Criminal Code of Canada, for one year with conditions. The proposed conditions to remove the no-contact condition relative to the children and to modify the no-contact condition relative to the children's mother came into effect on July 20, 2007.

After hearing Schoenborn's plea for contact with his family, the Provincial Court granted the order with conditions that included no consumption of alcohol within 12 hours prior to visiting the children's mother and that Schoenborn must immediately leave her presence upon her request. The conditions of the bail order were as follows:

- Condition 1: Keep the peace and be of good behaviour.
- Condition 2: You are not to be found at (address removed) or any other residence of (the mother) if you have consumed alcohol in the immediate preceding 12 hours.
- Condition 3: Not to possess weapons as defined in the Criminal Code.
- Condition 4: You are to immediately leave the presence of (the mother) upon her request or the request of a Peace Officer.

Again there were no reporting requirements.

Mother's ongoing interactions with workers

The children's mother did not attend a scheduled meeting with a family maintenance worker on July 20, 2007. However, they did meet on Aug. 2, 2007, at which time she identified family violence as an issue. An order for family maintenance wasn't sought, mostly because the children's mother was in a domestic violence situation, and seeking maintenance from a violent partner could have further escalated an already high-risk situation.

On Aug. 3, 2007, during a home visit with the mother, the family preservation worker left a handwritten note for Schoenborn outlining services and saying: "Regarding the ministry expectations, they do not agree with you living together until you get involved with a service and speak to a social worker about your plans." The family preservation worker told the social worker that Schoenborn wrote on the letter: "Please do not bother me with your psycho-babble and dribble." There was no documented response to this noted in the MCFD file. The family preservation worker also faxed a copy of the letter to the MCFD social worker on Aug. 22, 2007.

Schoenborn visiting the family

The MCFD social worker noted on Aug. 22, 2007, that the father was going to the home every day to see the children and their mother. Schoenborn was not involved with any support services; nor had he met with any social workers from MCFD to further discuss any protection concerns. The children's mother also advised the MCFD social worker that she was planning to reconcile with him.

On that same day, as per Schoenborn's request, the family preservation worker faxed the father the hand-written note with a list of services and comments outlining ministry expectations.

Just as there was no criminal law consequence to the earlier breach of the bail order, there was no family court intervention or response to the father being in the home contrary to the risk reduction plan. This was despite the MCFD social worker stating only a few weeks earlier that if the father was in the home, MCFD would renew the supervision order. The social worker further noted that she consulted with her team leader on what to do with this information and was told she didn't have to respond immediately to the concerns raised. She was further directed to meet with the children's mother and find out what her new plans were for her safety.

Mother calls the police: Schoenborn charged

On Aug. 23, 2007, the children's mother called the police to report that Schoenborn had been in the home. He had alcohol with him and started to drink. He fell into a jealous rage and an argument started. The children were at home at the time. He then went outside to confront a driver who was speeding on the street. The children's mother locked the doors and phoned the police.

Schoenborn broke into the home, first by trying to break down the doors and then by breaking through plywood that covered the window he had broken in May. He was arrested and charged with breaching the peace bond. When police arrived, the children's mother was found crouched in a fetal position, waiting for them.

New MCFD investigation

The next day, the MCFD social worker opened a new investigation. In response to the increased risk and recent incident, the MCFD social worker, family preservation worker and the children's mother agreed that she would leave with the children and stay with relatives in a nearby community.

As part of the investigation of this incident, the MCFD social worker interviewed the three children together instead of individually, as they were about to leave town with their mother. The older children said their parents were arguing the previous evening. They stated that no one was injured but that they felt scared and that their mom felt scared too. Max and Cordon reported that they were crying because they were so scared.

Schoenborn released on bail

The MCFD social worker learned that Schoenborn was being released with the same conditions as were on the original Section 810 peace bond that he had just breached. These included that he must leave the mother's presence if she requested and that he must not consume alcohol within 12 hours prior to visiting the mother.

Ministry action alert

On the evening of Aug. 24, 2007, the mother and the children left to stay with relatives who lived about a three-hour drive away. That same day an MCFD social worker placed an action alert on the After Hours system related to monitoring their safe arrival. The memo notes:

"When the file was transferred to the family services team, this social worker did not renew the interim supervision order as the mother was participating in service provision and had agreed to ensure the children would not be present if she were to meet with the father. The mother also agreed to ensure that if the father were to take the children for a visit that the mother has devised a safety plan with [her family preservation worker]... The mother has also agreed that if the father appears in (the area) she will not allow him access to the children and will call 911."

There is no explanation for the contradiction between having the children's mother agree that if Schoenborn were to take the children for a visit she would devise a safety plan, and having the mother agree that if the father appeared she would call 911 and not allow him access to the children.

On Aug. 25, 2007, the MCFD social worker updated the risk assessment to "high risk."

Mother returns home against advice

A week later, on Aug. 31, 2007, MCFD received information that the mother and the children had returned to their home in the Lower Mainland. This was after the family preservation worker and the MCFD social worker advised her not to return to the home with the children, due to the child protection concerns about risks of contact with Schoenborn.

As an alternative to having them return home, the family preservation worker offered to pack and move the family belongings. She also suggested that the children's mother leave everything back at the home and start fresh in a community in the Interior, rather than returning to the Lower Mainland and exposing herself and her children to risks.

Family moves to a new community

On Aug. 31, 2007, the two MCFD social workers went to the home with police and found Schoenborn helping the family pack for the move to a community in the Interior. The children's mother told the social workers she did not feel that the father was a threat to his children. Schoenborn said he did not understand why he could not be with his family when he was not intoxicated, adding that the court order conditions were different than conditions given by MCFD.

The MCFD social worker gave the children's mother two options: go to a transition home with the children; or have the children removed to the custody of MCFD. The children's mother eventually left with the children to go to a relative's home about an hour away. This plan was supported by the MCFD social workers and community services manager with whom the social workers consulted in their team leader's absence.

The children's mother told RCY investigators that she did not want to go to a transition house because she wasn't able to take the family dog along and she wasn't willing to give the children's dog up to live in a transition house.

At the subsequent criminal trial for murdering his children, Schoenborn gave evidence that in fact he joined the family and they left together for the Interior. The MCFD social workers approved the move for the mother and children as a safe response to the child protection concerns, not realizing that the father initiated this plan and that he would be with the family.

File documentation did note that MCFD was given information that the family had planned to move in July 2007. At that time, the family preservation worker advised the MCFD social worker that the children's mother was considering moving and that Schoenborn was fully aware of and supportive of the move. Both parents confirmed to RCY investigators that the move was Schoenborn's idea. The children's mother wanted to stay in the Lower Mainland, but Schoenborn felt she should move closer to relatives who could be a support to her.

On the day of the move, the MCFD social worker relayed concerns about this family to the family preservation worker. The MCFD social worker said that she believed the father would kill the children's mother in front of the children. The MCFD social worker said she had also shared this with the children's mother more than once over the previous months. Despite this belief, no protective action was taken.

The family preservation worker put a call into a transition home in the Interior on Aug. 31, 2007. She was told that the transition house couldn't take the mother and three children at that time. In any case, the children's mother would not have gone to the transition house unless they were able to bring the family dog.

A new community

In September 2007 the children and their mother were living in a motel in the Interior. The children's mother told RCY investigators that at this time she believed she was separated from Schoenborn, though there is evidence that shortly afterward, Schoenborn was living on and off with the family.

On Sept. 4, 2007, the Lower Mainland MCFD office referred their file to the office in the Interior for what they called "courtesy services." The Lower Mainland MCFD office would retain responsibility for the file, while the Interior MCFD office would respond to any direction from the Lower Mainland MCFD office. The MCFD social worker emailed an intake social worker at the Interior office. She gave a brief synopsis of the file, advising that the last incident at the end of August was life-threatening and dangerous and that the children's mother continued to minimize the violence and its impact on the children.

On Sept. 10, 2007, the intake social worker at the Interior office requested information about Schoenborn from the local police relating to recent contact with police in the Lower Mainland or in the Interior, and any history of instability. File notes indicate that the intake worker learned from police that Schoenborn had a no-contact order and a no-go order relating to the Interior community MCFD office, with two breaches of his condition of no contact. In fact, there was no such no-go order in place at the time.

In the third week of September 2007 the MCFD intake social worker from the Interior contacted the MCFD social worker in the Lower Mainland to advise that he had visited the mother and children on Sept. 24, 2007 at the motel where they were living and that there were no protection concerns.

On Oct. 22, 2007, the MCFD social worker from the Lower Mainland contacted the Interior intake social worker as she had contact from the mother and had concerns about the mother's continued denial of risk regarding the "extreme domestic violence incidents." The social worker asked the Interior intake social worker what supports could be provided to the mother and her children. There is no evidence of a response to this request.

MCFD investigation closed

The MCFD social worker from the Lower Mainland recorded on the electronic file that the children's mother was now living in the Interior and was being supported by extended family as part of a safety plan. She further noted: "File to be transferred...for further ongoing support to the family."

The intake and investigation were closed Nov. 16, 2007, with a finding of no child protection concerns. The response to the child protection findings was to offer support services.

The social worker from the Lower Mainland office with responsibility for this file then left MCFD. There is no documentation indicating who the new social worker was.

A file transfer did not happen at this time. MCFD staff from the two offices agreed to provide "courtesy services." They agreed that the Lower Mainland office would retain responsibility for conduct of the file, while the Interior office would provide services as per the Lower Mainland's requests. The staff from the two offices never clearly articulated or documented what "courtesy services" would mean and what process they would follow.

There was confusion between the MCFD office staff on what kind of intervention was to be made with the family. It is not clear why the file wasn't transferred rather than set up as this sort of loose agreement to provide undefined courtesy services.

Bench warrant issued

On the same day as the child protection investigation was closed, a bench warrant was issued for Schoenborn after he missed a Nov. 16, 2007 court appearance for the Aug. 23, 2007 breach of his bail order. The August breach related to the report by the children's mother that he was drinking and that he refused to leave the home.

New charge and arrest

On Nov. 22, 2007, in a community in the Lower Mainland, Schoenborn was charged with impaired driving after running into parked cars at a gas station. He was issued a 24-hour driving suspension. He was later issued with a three-month driving prohibition effective Dec. 14, 2007 to March 14, 2008.

The next day, on Nov. 23, 2007, he was arrested for the outstanding bench warrant and placed on supervised bail conditions for both the November 2007 impaired driving and August 2007 breach of recognizance charges. On Nov. 26, 2007, Schoenborn was released and a condition was added to his bail order that required him to report to a bail supervisor.

On Dec. 19, 2007, Schoenborn was stopped by police and found to be driving while prohibited. He was arrested and released without conditions with direction to appear on Feb. 21, 2008.

There was no communication between Corrections staff and the mother to advise her of the contact restrictions and how to enforce them.

New social worker assigned

The children's mother told RCY investigators that she had no understanding what, if any, role MCFD would continue to play in her family's life after the move. As matters unfolded, there was very limited MCFD contact with the children's mother over the next two-month period.

The children's mother and the children moved from the motel to a mobile home in a residential area. There is conflicting information on whether the family moved in November or December of 2007.

On Dec. 21, 2007, the MCFD intake social worker from the Interior office emailed the social worker in the Lower Mainland office stating that he had conducted a home visit but that no one was home. The MCFD intake social worker had spoken with a community member, who reported that Schoenborn had been living in the home on and off since Nov. 29, 2007. The MCFD intake social worker provided the community member with the After Hours number, asking for a call if Schoenborn was seen there again.

On that same day, a new MCFD social worker from the Lower Mainland office emailed the Interior MCFD office. The Lower Mainland office continued to have responsibility for the file. This social worker was new to MCFD, and this family's file was part of her very first caseload. She was looking for an update on the family. She noted that it was her understanding that the children were enrolled in school and doing well. She was gathering information to determine if she could close the file or whether it should be transferred to the Interior office.

The intake social worker from the Interior office replied that he would visit the home and that a recent check of the electronic income assistance file showed that Schoenborn was registered on the children's mother's income assistance (IA) file. (A review of the IA file does not indicate that assistance was issued to Schoenborn and the mother as a family unit at any time during 2007.) The intake social worker from the Interior office followed up with another email at the end of the day raising a number of concerns, including asking: "What will MCFD do to ensure safety?" and advising that a file review found that Schoenborn was very resistant to any MCFD intervention.

The social worker from the Lower Mainland office responded: "Thanks for the info, will consult with TL [team leader], re the q's you've asked and let you know what should take place next." There is no further documented response in MCFD files.

New report to MCFD that Schoenborn was in the home

On Dec. 23, 2007, After Hours received a report from a community member that Schoenborn was staying at the family home.

On the same day, the team leader met with the police. The police confirmed that there was a current peace bond but advised that Schoenborn could reside with the children's mother but could not drink alcohol in her presence and had to leave on her request. This meant that Schoenborn would not be removed or arrested if found in the family home unless he was violating the conditions. The team leader told the police that from MCFD's point of view, Schoenborn was to have no access to the children until he met with a social worker. There was no discussion on how they would proceed given their conflicting perspectives.

The team leader and RCMP went to the home. There were no signs of Schoenborn having been there. The team leader told the children's mother that MCFD's expectations were different from the peace bond and bail conditions and that the father needed to talk to a local social worker before he had access to the children.

Another report of Schoenborn being in the home

On Dec. 24, 2007, another community member called in to report that Schoenborn was in the home. This was the fifth intake, and MCFD commenced an investigation.

An MCFD social worker conducted a home visit. She talked to the children, who reported that they had not seen their father for a few weeks. She believed they had been "coached" into saying this. The children's mother said her understanding was that she and her common-law husband could be together without the children present. In addition, she understood that he could not consume alcohol for 12 hours prior to a visit.

The children's mother told the social worker that her common-law husband had recently had about five visits with the children. The visits took place in the home of one of her relatives. The social worker advised her that if Schoenborn wanted to see his children, he must talk with the social workers first. There was no documentation of checks with those relatives about these reported visits.

The MCFD team leader later advised RCY investigators that Schoenborn would only be able to have supervised visits with the children, and again, only after he talked to the social worker.

On Dec. 24, 2007, another social worker from the Interior office requested Schoenborn's records from police, specifically concerning a no contact/no-go order, as well as information regarding charges and/or convictions. Nothing was found in the files reviewed to indicate that this social worker received a call back or received any information on charges or convictions.

That same day the new MCFD social worker in the Lower Mainland sent a letter to Schoenborn at the family's previous address, inviting him to contact her and outlining some of the MCFD's protection concerns. This letter says: "It is strongly suspected that you are residing with the children's mother and your children. This is in direct violation of the no go/no contact order and it is important that you understand the potential repercussions of this violation." This letter was returned to MCFD as undeliverable.

The children's mother told RCY investigators that Schoenborn was spending his time between the Lower Mainland and the community in the Interior. The mother said that during this time, from September 2007 to March 2008, she definitely believed she was separated from Schoenborn. She lived in fear and, in her words, was "living on glass" because he would show up unexpectedly at the home and pressure her to reconsider their relationship.

At this time, Schoenborn was under active bail supervision in the Lower Mainland for the breach of recognizance and the Nov. 22, 2007 impaired driving charge.

On Dec. 28, 2007, the team leader from the Lower Mainland sent an email to the Interior MCFD team leader. The email advised that it appeared Schoenborn continued to be at the family home without MCFD approval and that the mother continued to minimize the protection issues. The offices eventually agreed that the file needed to be transferred so that the Interior office could take formal responsibility for the file.

2008: Interior

January–March 2008

On Jan. 7, 2008, the Interior MCFD office received the family's file from the Lower Mainland office. This was three months after the MCFD office staff in the two regions had made a decision to transfer the file. A file transfer recording and comprehensive risk assessment were also sent via email. The email sent said that the children were considered at "medium" risk. However, the completed risk assessment on the file transferred rated the children at "high" risk. There was no explanation for this discrepancy.

Over the next few weeks, the MCFD intake social worker met with community members who reported that the children's mother had a "boyfriend or husband" living at the home. During one attempted visit to the home, a community member told the social worker that Schoenborn had just left the residence.

MCFD had no contact with the children's mother over the next two months. Case notes indicate that the social worker attempted to call her four times in a two-month period. The notes said that the line was busy or there was no answer. The purpose of those phone calls is not documented in the files.

On Jan. 22, 2008, the children's mother provided the income assistance office with an eviction notice she had received for unpaid rent. She stated that she had expected child support but did not receive it. She was issued a cheque for \$700, which is the maximum shelter allowance. The full amount of the rent was \$800.

On Feb. 28, 2008, the children's mother reported to the worker that she had no food and no other resources. She said she ran out of money that month due to having to pay rent that was past due. She was issued an \$80 crisis grant for food.

Ongoing criminal proceedings

On Jan. 28, 2008, Schoenborn received a fine of \$900 for the impaired driving charge.

On Feb. 21, 2008, a bench warrant was issued for a failure to appear on the Dec. 19 "driving while prohibited" charge.

On Feb. 26, 2008, Schoenborn was again before the courts in the Lower Mainland on two counts of breaching his bail order. He received a \$200 fine for one count, while the second was stayed by the Crown so it did not proceed. At the time of his sentencing, the court was not aware of the active Feb. 21, 2008 bench warrant. It remained outstanding.

Crisis grant for food

On March 13, 2008, the children's mother received another crisis grant for food. The worker reviewed the crisis grant policy with her and advised that food was not an unexpected expenditure. The worker also reviewed the history of crisis grants over the previous two years and advised that she would now be subject to a process where part of her cheque would be held until mid-month. She was also told that if she requested crisis grants in the future, she may not be approved, or her cheque might be held and given out in even smaller portions throughout the month. She was eventually given an \$80 crisis grant for food.

On March 31, 2008, Schoenborn went to the same income assistance office. Initial application forms were completed, and he was issued two vouchers for food/sundries.

April 2008

April 1, 2008

Report from the school

On April 1, 2008, MCFD received a call from the children's school that Schoenborn was at the school. Staff reported that he was concerned about his children's well-being and performance at school. Another staff person reported that Schoenborn was worried that the mother would flee with the children, so he was there to check that they were present on that day.

While reviewing the call, the MCFD social worker received a second call, this one from a community member reporting that Schoenborn had been seen living at the children's mother's home. The community member had been asked by a social worker to call MCFD if Schoenborn was seen at the home.

MCFD social workers went to the home with the police. They learned en route that there was an outstanding warrant for Schoenborn's arrest. The warrant was for a Dec. 19, 2007, driving while prohibited charge, for which he failed to appear in court on Feb. 21, 2008. When they arrived at the home, no one was there.

They then received a call that Schoenborn was at the MCFD office. According to Schoenborn, he went there earlier and was told to come back. The intake social worker advised police that Schoenborn was at the MCFD office and that they would keep him there until police arrived and could arrest him.

Schoenborn meets with MCFD and police a second time

Later on April 1, 2008, social workers and the police met with Schoenborn at the MCFD office. Schoenborn was at the office to talk about his concerns regarding his children. He stated that he wanted the order dropped, meaning the "order" that restricted access to his children.

The MCFD file notes that Schoenborn explained he was given instructions by the Lower Mainland MCFD office that prevented him from being with his children when their mother was present. He said he could see the children or their mother separately, but he could not see them together.

He told the social workers he had never seen any paperwork regarding this "order" and so had no knowledge of when it expired. He was not sure if this was an MCFD or police order, but he believed it was put in place in May 2006. According to the MCFD files, Schoenborn could not identify any child protection concerns, including family violence. He denied living with the children's mother and their children.

During the meeting, Schoenborn became agitated that the police were there and was concerned about how they knew he would be at the ministry office. After Schoenborn repeatedly asked police how they found out he was there, the meeting was ended and police arrested him for an outstanding warrant for driving while prohibited. This was the second time that Schoenborn went to the MCFD office in an attempt to engage with social workers and the second time that police were present.

Schoenborn told RCY investigators he found the police presence very disturbing and felt that it distracted him from being able to concentrate on his family issues. He said he felt it was more important to have the time to talk with MCFD social workers about his family than to deal with a motor vehicle violation.

Later that same day, on April 1, 2008, the MCFD social worker followed up with Schoenborn at the police station and advised him to meet with her once he was released.

April 2, 2008

Court appearance and release on bail

The next day, on April 2, 2008, Schoenborn appeared in court in a nearby city on the driving while prohibited charge and was released on supervised bail. He attended a brief appointment with a bail supervisor. A number of standard release conditions were put into place, most notably to report to a bail supervisor and thereafter as directed notify the bail supervisor of current address and not change address without written permission.

The bail supervisor did not note any unusual behaviours or anything to indicate Schoenborn may have had mental health issues. He did note that Schoenborn said he was reconciling with his common-law wife and that they were planning a move in the near future. Schoenborn told the bail supervisor that he had recently been living on the streets. He was instructed to report to another bail supervisor by April 7, 2008, in the community where he had been arrested and where the children's mother was living.

On the afternoon of April 2, 2008, Schoenborn went to a bus station and bought a ticket back to the community where his children and their mother were living. He then got into an altercation with another passenger before the bus pulled away. He was removed from the bus and got into a subsequent altercation with bus station staff over a refund for his ticket. (Evidence given during his subsequent murder trial was that he had been drinking alcohol and appeared extremely agitated and threatening.) He eventually got on a bus at around midnight, after drinking a bottle of wine.

April 3, 2008

Schoenborn arrested

In the early hours of April 3, 2008, Schoenborn arrived in the community where his common-law wife and children were living and was quickly arrested for being drunk in public. He had been loitering in the parking lot of the police station. He gave evidence at his subsequent murder trial that he did not go directly to his common-law wife's home because he understood he was ordered not to be in her presence if he had been drinking.

He was held in police cells until the morning and released on April 3, 2008 with a ticket. There is no record of what type of ticket he received. This was his second time in cells in two days. Police officers reported that they did not note any unusual behaviours or any sign of mental illness.

Events at the school after Schoenborn's release

On his way to his common-law wife's home after being released from police cells, Schoenborn passed by his children's school. He stopped at the school, asking to speak to the principal. The principal was unavailable, so he spoke with another staff member. He wanted proof that his children were in attendance. He was not satisfied with the staff responses and demanded to be taken to his daughter's class. The school staff person took Schoenborn to his daughter's class. His daughter came out and said hello to Schoenborn. Schoenborn said he felt assured she was okay and left the school.

Evidence presented at his later murder trial suggested that a school staff member found him to be more anxious and dishevelled than when he had been there two days earlier and that he was over-reacting and did not make sense. The staff member thought he was "falling apart."

At around noon that same day (April 3, 2008), Schoenborn was on his way downtown. He again passed the children's school. His evidence at trial was that he could not see his daughter Kaitlynne on the school grounds, and he panicked. He was frightened for her safety. He believed that she had been taken away and was being molested and groomed for prostitution.

He entered the school property and eventually found his daughter, who told him she had been there all along. He then left but could not accept her version of the events. He was more convinced now that she had been taken away.

He returned to the school for the third time that day and found Kaitlynne crying. He thought she was being bullied by another student. He made aggressive and berating comments first to this student and then to the playground supervisor. School staff were called and Schoenborn was asked to come into the office. Schoenborn demanded answers from the staff person. When she did not provide the answers to Schoenborn's satisfaction, he made further threats to her.

Schoenborn then wanted to make a police report about his daughter being off the school grounds. The staff person encouraged him to call the police if he wanted. He called police, demanding an explanation of why his child had been off the school grounds and expressing concerns about her safety that he felt were not being addressed by the school. Reports are that Schoenborn was extremely distraught and irrational.

The intake clerk at the police department had difficulty understanding Schoenborn's concerns and on the second call decided to get help from an officer. The officer reported that Schoenborn was upset but that he was able to calm him down.

The school staff also called the police, as they felt threatened. A staff member later told RCY investigators that she was more fearful on this day, with Schoenborn, than at any other time in her career.

The children's mother told RCY investigators that during the first week of April 2008 she experienced a terrifying incident of domestic violence that she did not report to police. She said Schoenborn grabbed her by her neck and threw her up against the wall. He was yelling at her to take something back and threatened to hurt her if she didn't. She said she was more terrified than usual. She said the look in his eyes that night was different, as if it wasn't him.

Schoenborn has a different recollection of this event, and told RCY investigators that he recalls only punching a hole in the wall during an argument in early April 2008.

New arrest for uttering threats

As a result of the incident at the school, Schoenborn was arrested for uttering threats and was taken into police custody the same day (April 3, 2008). He tried to bolt from police custody and had to be restrained. The officers later reported to RCY investigators that they did not see this as unusual behaviour and did not view Schoenborn as aggressive or agitated. The officer believed he was scared and that was why he bolted, but he was otherwise seen to be coherent and cooperative.

A few hours later, the MCFD intake social worker listened to a voicemail message from the children's school that Schoenborn was on school premises. There was a two-hour delay between when the message came in and when the social worker heard it on voice mail. The intake social worker went to the school immediately upon hearing the voice mail. While the worker was leaving the office, he saw the children's mother in the MCFD waiting room.

Interactions between the children's mother and MCFD

She said she wanted to talk with the social worker about "cancelling the order." The intake social worker advised her to contact another social worker, who was the case manager of her file.

The children's mother told RCY investigators that the intake social worker was on his way out to an incident at the school. The intake social worker said that he wasn't sure if the incident involved her kids or not, but not to worry. She said she was worried about what would happen, and she immediately left with Cordon and walked to the school as fast as she could.

A school staff person met with the children's mother and an MCFD social worker. The school staff person explained to the mother that Schoenborn had been at the school and had threatened a student and school staff member.

The children's mother told the school staff person and MCFD social worker that Schoenborn had been at her house earlier that day because the children were at school and there was nothing prohibiting him from being there while the children were not there. She agreed to call the police if Schoenborn showed up at her house while the children were at home. The MCFD intake worker told the children's mother that he was trusting she would do what was needed to keep the children safe, or more intrusive steps would be taken. She understood and told the MCFD intake social worker: "I've heard that threat many times before."

The MCFD intake social worker believed that the police advised they would try and hold Schoenborn over the weekend. The police do not recall saying this.

Later, on the acting team leader's instruction, two MCFD social workers went to inform the children's mother that the children would be removed if Schoenborn had contact

with them. The intake social worker told her that Schoenborn must have a meeting with his social worker prior to any contact with the children. The file notes that the mother assured the MCFD social workers that "she would protect" and call police and After Hours if Schoenborn turned up.

MCFD unsuccessful in seeking interview with Schoenborn in police cells

Later that same day, April 3, 2008, the MCFD intake social worker called police to request a meeting with Schoenborn in police cells. The purpose was to discuss with Schoenborn the seriousness of the situation and to let him know they were considering removing the children if he had contact with them.

How the police responded is unclear. Two conflicting recollections were reported by MCFD: that the police refused to allow MCFD access because they "did not want to be seen as a party to a threat of removing children" and that police reported Schoenborn was agitated at the time, and they didn't want that to escalate by virtue of MCFD's presence at the cells.

Police told RCY investigators they did not recall the phone call or request from MCFD. They stated that Schoenborn did not present as agitated. The MCFD intake social worker said that the police advised they would notify MCFD in advance of Schoenborn's release. The police told this investigation they could not recall that conversation.

Schoenborn released following tele-bail hearing

On the evening of April 3, 2008, police contacted a school staff person to say Schoenborn was still in custody. With no notice from police to MCFD, the children's mother, the school or the family of the child he threatened at the school, Schoenborn was released the same day he was arrested for uttering threats.

The next day, the school staff person attended the police station in the morning and was planning on serving Schoenborn with a letter advising he was no longer allowed on the school grounds. This was a letter pursuant to Section 177 of the *School Act*. It directed Schoenborn not to disturb school proceedings or be on the school premises. The school staff person learned Schoenborn had been released. The letter was never delivered.

Tele-bail

In B.C., if someone is arrested on a weekend, when the courts are closed, it may be impossible to bring them before a local judge within the 24-hour time limit imposed by the Criminal Code. In these circumstances the bail release hearing is conducted by telephone with a judicial justice of the peace (JJP) working at the B.C. Justice Centre in Burnaby. This process is referred to as tele-bail. In these proceedings, the police act as prosecutor and present the evidence. The accused does not leave the police station. This JJP has the same power to order an accused released or detained and to impose conditions on any release.

The release on April 3, 2008, followed a tele-bail application involving Schoenborn, a judicial justice of the peace (JJP) and the police officer. The officer recommended that Schoenborn be detained over the weekend until Monday, April 7, 2008.

Schoenborn's criminal history, including failure to appear and resisting arrest, was reviewed by the police officer. The previous domestic violence incidents were not referred to during this hearing. The officer did not believe Schoenborn would appear for a later court date if released. The officer noted that it was Schoenborn's third arrest that week. In addition, the officer understood that Schoenborn had no fixed address, although Schoenborn gave the children's mother's home address as his own. Schoenborn said that he had been living there the last three days.

The JJP asked if there was any friction between Schoenborn and the mother. Schoenborn answered "no" to this question. The JJP thought it was the police officer who answered "no." This is an inherent problem with tele-bail, which places a special responsibility on all parties to ensure there is clarity about who said what.

When the Representative's investigation tried to establish what happened, police reported that they did not recall the JJP asking Schoenborn about friction in the relationship and could not speak to who said what or when and whether or not the criminal record check and/or the Canadian Police Information Centre (CPIC) was forwarded to the JJP for review. The transcript shows that early in the tele-bail call, the officer did mention that there was an application for a Section 810 peace bond, which was incorrect. The peace bond was in fact open and active. This is not mentioned again by the JJP or the officer. The officer did not advise the JJP about the child protection concerns MCFD had regarding Schoenborn being in the family home.

Bail was set at \$500, with a \$100 deposit required prior to release. The \$100 deposit was paid by one of Schoenborn's relatives. Conditions included a no-go to the school and no contact with the young student who was threatened or with the school staff person. According to court transcripts, at release the JJP told Schoenborn: "You've got a break on this."

April 4, 2008

Bail appointment with local manager

On Friday, April 4, 2008, Schoenborn attended a bail appointment with an experienced local manager covering for the bail supervisor. They discussed his conditions of release pertaining to the charges of uttering threats at the school.

Schoenborn told the local manager that he was living with his common-law wife and his children. The local manager was not aware of any court orders that prevented Schoenborn from having access to his family. However, Schoenborn advised the local manager that there was an order in place that prohibited him and the mother from being with the children at the same time.

The local manager found this unusual, so he placed a call to MCFD to report that Schoenborn was using the children's mother's address as his permanent residence. The local manager advised Schoenborn that he would need to call MCFD. The local manager thought Schoenborn presented well, was articulate and fully understood the conditions of release. The interview was relatively short, and a longer intake was planned with another bail supervisor, his caseworker, for the following Monday.

Schoenborn speaks with MCFD team leader

Consistent with the local manager's advice, Schoenborn went to the MCFD office on April 4, 2008 and spoke with the team leader in his social worker's absence. He stated that he wanted to reunite with his family and asked what he needed to do in order for this to happen. The team leader outlined MCFD's concerns about the children's safety and their expectations.

The file indicates the team leader told Schoenborn that supervised visits could be arranged after he met with his social worker the following Monday, April 7, 2008. Schoenborn said he could not commit to this appointment, but he reportedly agreed to call and make an appointment. The team leader told Schoenborn that it was 2 p.m. on a Friday, too late in the day to further plan or to arrange visits.

April 5 and 6, 2008

On April 5 and 6, 2008, the weekend the children were killed, Schoenborn was their primary caregiver. He was staying with the children in their home, while the children's mother stayed at a relative's apartment in the same community. The children's mother had begun staying with the relative on April 4, 2008. Evidence at the trial was that this arrangement had been imposed by MCFD. The children's mother and Schoenborn both believed MCFD had an order prohibiting them from being together with the children at the same time. They understood this was an effort to protect the children from being exposed to their constant arguing.

The children's mother was getting worn out and made some efforts to get relief from her situation. A few days earlier she had visited a general practitioner and was prescribed anti-anxiety medication. She also said that she sought counselling from a "therapist." The mother told RCY investigators that she felt very discouraged after leaving the therapist's office. She reported that she was told that her survival skills would have kicked in by now or she would have left the father, and she was obviously getting something out of their relationship.

File information suggested she was only allowing Schoenborn to stay in the family home over the weekend while he waited for money from income assistance.

On the morning of April 5, 2008, Schoenborn took Kaitlynne for hot chocolate while the mother went to a park with the boys. After Schoenborn returned Kaitlynne to the mother at the park, the mother spent the afternoon out with the three children, then took them home to spend the evening with Schoenborn. The mother left to stay overnight with a relative.

She reported that Schoenborn called her numerous times that evening. The first call was after one of the daughter's friends had called. Schoenborn did not allow his daughter to talk to her friend, then called the mother and demanded to know who the girl was that had called his daughter.

Court transcripts from the murder trial revealed that the last call the children's mother received from Schoenborn was close to midnight. As in previous calls that evening, Schoenborn repeatedly begged her to come home and reconsider their separation. She responded that she was tired of constant fighting, and it wasn't good for the children. She remained steadfast in her decision to stay separated.

After putting the children to bed, Schoenborn killed them. Schoenborn testified that he had become suspicious that the children were being groomed for prostitution. He concluded that no one could protect the children from these dangers. He decided not to run from this anymore, saying that he needed to "put them where they are safe."

According to the police report, on the afternoon of April 6, 2008, after unsuccessfully trying to contact Schoenborn for most of the morning, the children's mother walked 20 minutes to her home. As she walked up to the door, she noted nothing out of place. She could see Max and Cordon lying on the couch, wrapped in a blanket.

She realized something was wrong when she saw her boys' eyes slightly open and their bodies looking very stiff. As she drew nearer, she noted their skin to be very purple and cold to the touch. At this time, she realized they were dead. The boys had been suffocated.

She ran through the home looking for Kaitlyne and found her wrapped in a blanket in her bed. She saw that her face had been cut.

She saw the words "forever young" smeared on the kitchen wall, written in soy sauce.

A warrant was issued for Schoenborn's arrest. He was found about one week later, in the bush on the outskirts of the community. Schoenborn was charged with three counts of first degree murder and pled not criminally responsible due to mental disorder.

On Feb. 22, 2010, the B.C. Supreme Court reached a verdict that Schoenborn killed his children but was not criminally responsible on account of mental disorder. The British Columbia Review Board assumed jurisdiction of Schoenborn's case.

A hearing was held on April 6, 2010. The board decided that Schoenborn would be confined to the Forensic Psychiatric Centre in Port Coquitlam and be prohibited from any contact with his wife. At the time of this report, he remains confined in the Forensic Psychiatric Centre.



MCFD Internal Comprehensive Case Review

MCFD completed an internal comprehensive case review in January 2012 of its services to the family.

The purpose of the MCFD review was to examine the ministry's involvement with this family and to provide an opportunity to identify:

- strengths in practice
- level of compliance with standards/policy/legislation
- patterns of interactions with a systemic context.

Comprehensive Case Review

These internal reviews include both a review of file information and interviews with relevant individuals. Terms of reference are established to define the scope of the review. Facts are established and verified. The information is analyzed and findings are made. Recommendations are developed and tracked for implementation.

Additionally, the review's purpose is to "inform individual professional practice improvement and identify systems which enhance or impede progress toward positive outcomes for children and families."

From 2006 to early 2011 MCFD was driven by a "transformation" agenda. This project has been commented on extensively in the Representative's reviews of implementation of the recommendations of the Hughes Review. In her 2010 report, the Representative noted that the "transformation" agenda appeared to have a weak foundation and that MCFD staff, service providers and related professionals had repeatedly conveyed that there was a considerable degree of confusion and frustration around "transformation."

The "transformation" was characterized by a significant transfer of authority to regional staff along with a reduction of oversight and quality assurance functions in the ministry's headquarters, due to the removal of the position of Provincial Director of Child Welfare. At the same time, MCFD staff was directed by the ministry's senior leadership to follow a set of principles regarding practice that were poorly defined. These principles, it was suggested, formed the basis of the ministry's approach to child welfare and should be applied even in the face of a lack of clarifying policy and procedures. The principles and related approaches were described in the MCFD *Strong, Safe and Supported* pamphlet.

The confusion and difficulty that front-line workers faced was well illustrated when the Deputy Minister at the time, while reviewing information regarding the deaths of Kaitlynn, Max and Cordon, wrote on the briefing material: "I would like to understand (a) Why, if

RCMP involved 3 times in 3 days this does not warrant serious intervention? Yet we remove a child on grounds of neglect?? (sic)." The Deputy's comments about the conduct of the case were about actions that were led by the set of poorly defined "transformation" principles regarding practice. Despite this stated concern about the conduct of the case, the ministry's subsequent review of the case failed to take into account the confusion the *Strong, Safe and Supported* approach caused for staff. The ministry's review focused primarily on the principles articulated in the *Strong, Safe and Supported* materials, rather than conducting a rigorous and insightful examination of the details of the practice, which would have enabled organizational learning.

The review identifies a number of the issues that the Representative has identified in this investigation, including the inadequate case file transfer process, the misunderstanding of the real level of risk to children living with domestic violence and a lack of understanding of domestic violence in planning for this family.

The ministry review identifies four significant practice challenges. The practice challenges include staffing challenges in each region, the parents deliberately misleading staff, government system intercommunication and the repeated underestimation of risk that the children faced. The Representative does not believe that staffing issues and the parents' responses to staff can be considered practice challenges. They are more accurately described as contextual circumstances.

MCFD appears to be placing some blame on the family for "deliberately misleading staff." While this obviously poses difficulty for social workers, it would seem that child protection workers would have an understanding of why victims, in particular women involved in domestic violence circumstances may respond negatively to child protection authorities. There was clear evidence in the MCFD files that the mother was reluctant or unable to fully cooperate with MCFD safety plans time and time again. Child protection workers could have used this information in assessing the mother's ability to protect and the father's ability to engage.

The most significant practice problems, in the Representative's view, were the:

- consistent underestimation of the real risk of lethality to the children
- inadequate case file transfer process, and
- expectation on the children's mother to protect.

This expectation existed with no assessments of the mother's ability or capacity to do so, or of the dynamics of how both child protection and criminal justice pushed her away from supports into withdrawal from contact. In addition, workers failed to address the father's significant and obvious mental health issues.

The practice strengths that were identified as part of the ministry's review were inconsistent with the findings in the Representative's investigation. Although it is important to acknowledge good practice, it is not helpful to staff to inaccurately identify good practice when in reality it fell below an expected standard. An accurate assessment of both strong and inadequate practice will help social workers in making the necessary changes in their practice.

The regions did not develop any recommendations. Instead they created organizational goals. It is unclear if the current goals and strategies will result in significant practice changes for child protection staff.

The Provincial Director did make two recommendations as part of this review. The Representative supports the Provincial Director's recommendations and is hopeful that the commitment to fully incorporate current domestic violence guidelines into MCFD policy and standards and to offer domestic violence training to all child protection staff is realized.

Overall, it is the Representative's hope that the ministry staff involved in this case, and all ministry staff, are able to learn from this terrible tragedy and are better prepared to respond appropriately and effectively to families involved in domestic violence and experiencing parental mental health issues. It is her hope that the recommendations and identified organizational goals will support a comprehensive change in practice for staff working with children and families involved with complex issues such as domestic violence, mental health and addictions.



Analysis and Recommendations

Overall Finding

The deaths of these children were preventable.

These children were extremely vulnerable to violence and harm due to the domestic violence in their home, and their father's untreated mental illness. Countless opportunities to ensure that the children and their mother were safe were missed because of a profound lack of coordination among the child-serving, mental health and criminal justice systems over many years, compounded by glaring failures in child protection practice, and an inability to recognize and assess the extent of the father's mental illness.

These three children died at the hands of their father. The child-serving, mental health and criminal justice systems failed to protect them from known risk of harm. In the one week leading up to the children's deaths, no fewer than 14 professionals were involved with this family. However, appropriate actions were not taken. The deaths of these children were tragic and could have been prevented. Coming to grips with the finding of this investigation requires that we delve into the decisions that were made – and those that were not made – by officials in the systems.

By their very nature, complex cases (which in this particular situation included untreated parental mental illness, domestic violence and substance abuse) require a high degree of collaboration amongst different service providers working in multiple systems. That did not happen in this case. This family required a coordinated approach that allowed for professionals to be able to share information and plan together to address risk assessment findings and risk management requirements.

The children in this family were innocent, silent witnesses to terrible acts of violence directed by their father at their mother, as well as irrational and paranoid behaviour by their father. One can only imagine how concerned they must have been for their mother and how scared they must have felt for themselves.

If a parent has a mental illness, it can often be effectively treated and the needs of their children and family addressed through personal supports and services. When a parent's mental illness goes unrecognized and untreated and is not accepted by the individual, vulnerability increases for the family.² In this case the father's mental illness went untreated, and it was never adequately considered as a risk factor in planning for the

² Victorian Government Department of Human Services, 2007: *Families where a parent has a mental illness: A service development strategy*. Melbourne, Victoria, Australia.

safety of the children. Social workers struggled to recognize and respond appropriately to the needs of the family and were not aware of or responsive to the risks for Kaitlynn, Max, Cordon and their mother.

Adding complexity to this case, the mother and children were victims of domestic violence. Like most dependent women subjected to ongoing domestic violence, the mother of these children was unable to extricate herself from her situation or to act decisively to protect her children on her own. She faced the dilemma of balancing the safety of her children and herself with the belief that the children deserved an ongoing relationship with their father. She didn't understand the level of risk of harm to herself or her children when she resided with her common-law husband. Nor did she understand that once she separated from him, the risk of harm to herself and her children would increase dramatically.

When a mother is trapped in a domestic violence relationship, she cannot predict the risk of harm to her family and protect the children on her own without adequate and wide-ranging supports from many different service systems. Therefore, it is essential that those services play an active role of aggressive outreach in protecting the children and supporting the mother.

There was so much pressure put on the children's mother by the child protection system to protect her children from their father, but little support to help her do that or help to understand the dynamics of her situation. Social workers did not have the required level of understanding of patterns and dynamics of domestic violence to provide that help. They failed to adequately assess her capacity to parent. Nor were they aware of the complications posed by Schoenborn's untreated mental illness, since they failed to assess his mental health and the risk this posed to the children and their mother.

Although a number of individuals did their best to intervene and offer services, particularly in the summer of 2007, there were no effective interventions or services put in place to support the mother. She was terrified of losing her children and yet she was left so alone in managing her family's circumstances. She lived in daily fear of her common-law husband's violent episodes and in fear of her children being removed by child protection authorities. The mother believed she was left alone to try to manage his behaviours, as no one really helped her with all she had before her.

In this case, the system did not recognize the extreme pressure the children's mother was dealing with, and service providers did not develop an understanding of the extreme risk to the children and their mother or the level of stress she was facing. The responses of the various systems were too passive; they did not match the severity of the situation.

Child Protection Practice

Child Protection Investigations

Finding: *Child protection investigations did not meet standards and contributed to a failure to protect these vulnerable children and their mother. Ministry social workers did not apply a domestic violence lens or use their own domestic violence guidelines during this investigation.*

When a decision is made to conduct an investigation, Child and Family Service (CFS) Standard 16: Conducting a Child Protection Investigation outlines the steps that a social worker must conduct to complete an investigation. The standard states:

After a thorough assessment of the information in a child protection report, if a decision is made to investigate, begin immediately if:

- the child's safety or health may be in immediate danger, or
- the child is vulnerable to serious harm because of age or developmental level.

In all other circumstances, when a decision is made to investigate, begin a thorough investigation appropriate to the report within five calendar days.

Each investigation includes, at minimum:

- seeing the child and all other vulnerable children in the home
- interviewing the child and all other vulnerable children in the home, where developmentally appropriate and with supports if necessary
- directly observing the child's living situation
- seeing and interviewing the parent
- reviewing all relevant and necessary information related to the report, including existing case records and files, and
- obtaining information from people who may have relevant knowledge of the family or child.

The investigation is to be completed within 30 calendar days of beginning the investigation.

The May 2007 investigation identified and responded to most of the risks presented: it found the children in need of protection. Steps were then taken that resulted in the appropriate court intervention in the form of a supervision order. The supervision order clearly identified steps for the children's mother to take.

Although the investigation was relatively consistent with standards and supported an appropriate course of action, it would have been better had the father been involved. During the investigation the mother raised serious concerns about Schoenborn's deteriorating mental health, yet it was never considered in the safety plan and

assessment. All too often fathers are invisible in the child protection system, and the focus is on the mother to manage difficult circumstances to protect her children.

An important task of the child protection system is to engage the father to help hold him accountable and offer opportunities to change. An optimal risk reduction plan and/or court order would have been informed by what the father (who was the primary risk) had to say and an analysis of how he might respond to different conditions. In this case, there is no evidence that Schoenborn even had notice of the application for a supervision order, let alone that he was engaged in attempting to ensure its success.

The mother has to weigh different strategies to keep herself and her children safe. In this decision-making, she has to consider the effectiveness of police, child protection, mental health and other professionals in the community to provide protection compared to the ongoing harassment or promises from the father.

The August 2007 and December 2007 ministry investigations were poorly conducted and resulted in missed opportunities for safety planning that could have protected the children and supported their mother. During the August 2007 investigation there were times when the children's mother met with the father against ministry direction. Although MCFD had concluded and advised the children's mother that the children would be removed if Schoenborn had contact, the ministry failed to follow through on its conclusions and on its statements to the mother, to whom such statements would become less and less credible over time.

When MCFD social workers met with the children's mother in front of her home on a Friday afternoon, their plan was to remove the children or have the mother go to a transition home. These plans were in response to the increased risk presented by Schoenborn's presence in the family home. Instead, the mother convinced the social workers, in Schoenborn's presence, that a move to a new community would protect the children. The social workers consulted with a community services manager, in the absence of their team leader, who approved this new plan.

That plan proved to be flawed because it was Schoenborn who coordinated it, and the children's mother's primary financial support was Schoenborn.

In this regard, it does not appear that a proper assessment of the family or an assessment of the plan developed by the family was completed. The social workers took the word of the children's mother "on site," even though they knew that same day she was with the father against the instruction/direction of the social workers. It is not clear why the social workers believed that she would be able to keep the father away when the evidence was so clear that she had been unable to do so over the years. She did not have the capacity to control a dominating partner with a serious untreated mental illness, yet she was held accountable for MCFD's plans.

At the time, social workers were not aware that the parents had been planning the move to a new community together for months. Even if that hadn't been the case, the safety plan was flawed. A move to another community really changes nothing in relationship dynamics where domestic violence is concerned. Schoenborn was mobile. His commitment to being involved with the children's mother and the children was obvious. A proper assessment would have identified the serious likelihood that this move was probably an attempt to move away from MCFD intervention or involvement.

When an at-risk family moves, the ministry must consider how the move may elevate the risk due to interrupted contact, new workers taking over the case and lack of continuity. In some ways, the family was successful. From September 2007 until April 2008, MCFD intervention and contact were passive at best, although the children's mother told RCY investigators that the problems between herself and Schoenborn were ongoing throughout this period.

Social workers believed the children's mother would be away from the father and be close to family who could support her. There didn't appear to be any ministry-led full or thorough assessments or even discussions with the extended family on their roles in safety planning, whether they were even aware there was a plan in place, or what was going to be required to stop a cycle of upheaval and conflict.

Social workers viewed the move itself as the safety plan. This is seen in their paperwork and was stated in their comments to RCY investigators. Yet a move to another part of the province was never suggested by social workers during their involvement with this family during the initial May 2007 domestic violence incidents. If it was a plausible and safe solution to reducing the risk to this vulnerable family, it is reasonable to expect it would have been considered in 2007.

Following the move, the level of risk to Kaitlyne, Max and Cordon continued to rise. Little or no effort was made by MCFD in the Interior to connect the children's mother to support services in her new community. The children's mother did not participate in any services that could have helped reduce the risk to her children or herself. This approach was inconsistent with earlier decisions to have the children's mother meet with a family preservation worker, have the children participate in Children Who Witness Violence programs or have the mother meet individually with a domestic violence counsellor.

The intent of the ministry's CFS Standard 18: Developing and Implementing a Plan to Keep a Child Safe is to reinforce "the importance of involving family and community in developing a plan to build family and community capacity to keep a child safe." While this standard recognizes that it is indeed appropriate in some cases for a social worker to support a family's plan to move to a new community, that conclusion can only be reached after the social worker has assessed the strength of the family using "standardized,

culturally appropriate assessment tools." The ministry uses the comprehensive risk assessment tool and risk reduction service plan as the accepted assessment tool.

Standard 18 says: "The plan is based on an assessment of identified strengths and risks and strives to engage the family in a trusting, cooperative working relationship." Social workers clearly did not meet CFS Standard 18 during this investigation. There was no evidence that the family received ongoing support to build the necessary capacity to ensure the safety plan was adequate. The children's mother says that she did not trust MCFD social workers. It doesn't appear that they worked with her to build trust and rapport. Instead, there were constant threats to remove her children if she didn't "protect."

There were times during MCFD's involvement with the family when concerns about Schoenborn's mental health were identified but not recognized as a risk factor and addressed in safety planning. As early as 1999 a social worker noted that there would be child protection concerns if Schoenborn had access to his daughter without mental health assessment and treatment plans. Yet there was no follow-up to ensure this occurred. Again, in the May 2007 safety plan, there was no mention of a mental health assessment when the mother had raised the father's deteriorating mental health with a social worker.

In addition, in June 2007 the intake social worker identified Schoenborn's mental health as a risk to the family and others, yet again there was no follow-up. These were missed opportunities by child protection authorities to adequately assess the risk of harm Schoenborn's untreated mental illness presented to his children and their mother.

Schoenborn said that he lost any trust with MCFD after police were present during two interviews, one where he was arrested on a traffic violation. A plan with an assessment of identified strengths and risks would have also been an opportunity for social workers to better understand the father's mental health. A plan could have included a requirement for the father to undertake a psychiatric assessment and subsequent treatment. Good practice would have also seen consultation with mental health professionals to better understand the risk the father's mental health posed to the children.

In having Schoenborn participate in services or a psychiatric assessment, social workers would have been holding him accountable for his violent actions and his mental health issues. Instead, accountability was left solely on the shoulders of the children's mother.

If Schoenborn chose not to engage in services or a psychiatric assessment, an outcome which was entirely possible, then a protective intervention order under the *CFCS Act* could have been sought by social workers. "Obtaining an order of protection removes the batterer from the home and allows the children to remain in familiar surroundings with their mother – a situation where hopefully they can begin to heal from the trauma caused by the batterer" (Coops, 2009). It remains unclear why a protective intervention order under the *CFCS Act* was never considered in this case.

Finally, Standard 18 requires that the social worker "ensure that the plan outlines what steps are being taken to address the child's safety and well-being." There is no documented evidence that this occurred. It doesn't appear that the standard or policy was considered when the social workers agreed to the safety plan put forth by the family. Kaitlyne, Max and Cordon's safety did not seem to be considered.

The December 2007 investigation was also insufficient and did not meet ministry standards. This was the fifth intake and investigation and resulted from information that the father was in the home, against ministry direction.

The immediate safety assessment found that the children were not safe. Months later, after the children died, another staff person changed the original decision in the electronic file to a finding that the children were safe.

Changing records in this manner is unacceptable. When making a change to an immediate safety assessment, how could one not consider the original decision? There is no justification for this type of practice.

Immediate Safety Assessment

An immediate safety assessment (ISA) occurs after the social worker assesses the intake report. It's recorded on the ministry's Management Information System (MIS). Social workers fill out a number of questions addressing safety on the ISA and then answer yes or no to the question: Are the children safe?

CFS Standard 16: Conducting a Child Protection Investigation requires that once a decision to investigate is made, a thorough investigation must take place. This includes reviewing all relevant case information. Sound collateral information that Schoenborn was living with the family was called in to the ministry by more than one person in the month of December 2007. The ministry's investigation found "no evidence of the father found in the home." It is not clear why credible information from multiple sources in the community was not given more weight.

Social workers believed that the children had been coached into saying they had no contact with their father. That information, coupled with strong collateral information, should have warranted putting in place a supervision order or even removing the children temporarily once an entrenched process of retreating from support was established. Again this investigation did not meet standards.

Child protection practice audits of the Interior office were done in 2005 and 2007, as well as an audit of an individual caseload in 2008. These audits raised concerns with respect to some key child protection practice areas, like reassessing a plan to keep a child safe, seeing and interviewing a child and developing a plan to keep a child safe. The findings in the child protection practice audit are consistent with the practice issues identified in this investigation.

Finding: *The framework provided by existing child protection legislation is deficient with respect to guiding assessment and response to families experiencing domestic violence.*

In British Columbia, the *CFCS Act* provides the legal authority to provide child protection services. The ministry's Child and Family Development Service Standards provide the guidance for delivery of child protection and guardianship services. The *CFCS Act* and the standards do not speak to working with families, especially children, experiencing domestic violence.

Many jurisdictions have mandated the reporting of children exposed to domestic violence, because exposure to domestic violence can have an impact on children's social, emotional and cognitive functioning (Graham-Berman & Edleson, 2001; Jaffe, Wolfe & Wilson, 1990 as cited in Jaffe, Crooks & Wolfe, 2003). In B.C., exposure to domestic violence is not in itself recognized as a reason for a child to be found in need of protection under the *CFCS Act*, although it is clear that exposure to domestic violence is a type of child maltreatment. This means that there is discretion regarding whether or not to report that a child may be in need of protection due to exposure to domestic violence.

When domestic violence reports are received, they are assessed in reference to *CFCS Act* section 13(1)(d), which refers to emotional harm, and sections 13(1)(a),(c) and (h), which refer to physical harm and the parents' ability to care for the child.

Sections 13(1)(e) and 13(2) of the *CFCS Act* state that children must show specific behavioural effects in order for them to be subject to protective action by the ministry as a result of emotional harm. The Act states that "a child is emotionally harmed if the child demonstrates severe

- (a) anxiety,
- (b) depression,
- (c) withdrawal, or
- (d) self-destructive or aggressive behaviour."

This is problematic because not all children act out their emotions in these ways.

The Representative is not suggesting that all children exposed to domestic violence should be removed from their homes. Protective action is not limited to removal, and in some cases, removal is in fact necessary. The *CFCS Act* needs to clearly give social workers the tools to fully, sensitively and appropriately exercise their judgments about what protective action is appropriate in domestic violence cases.

In other jurisdictions, child protection legislation explicitly states that exposure to domestic violence constitutes emotional harm. For example, Alberta's *Child, Youth and Family Enhancement Act* cites "exposure to domestic violence or severe domestic disharmony" as an example of a child being emotionally injured. The new British Columbia

Family Law Act (FL Act) recognizes family violence as a factor that must be taken into account in determining the best interests of children.

In May 2007, social workers were tasked with trying to interpret Section 13 of the *CFCS Act* and whether the children's exposure to the domestic violence meant they were in need of protection. The narrow confines of the legislation make it difficult for social workers to assess whether the exposure constitutes a finding of protection. Social workers told RCY investigators that it is almost impossible to consider emotional harm on its own in a domestic violence situation because of the test that the *CFCS Act* requires with a finding of emotional harm.

If the *CFCS Act* and MCFD practice standards actually contained specific references to domestic violence, this likely would have helped ministry workers provide supports that might have helped keep Kaitlynn, Max, Cordon and their mother safe.

Safety Planning

Finding: *Safety planning did not occur as it should have. This contributed to a failure to protect these vulnerable children and their mother.*

Safety planning is critical in domestic violence cases. The purpose of a safety plan is to work with the mother to help her gain required supports and to identify how she can keep herself and her children safe from further acts of violence (Jaffe, Baker & Cunningham, 2004). The safety plan considers the risk factors and levels of danger to herself and her children and identifies strategies to mitigate these risks. Effective safety plans involve collaboration between the mother and service providers to ensure a coordinated response to the risk of harm.

The MCFD document entitled *Best Practice Approaches: Child Protection and Violence Against Women* (2004) provides information and guidelines to MCFD staff working with families involved in domestic violence situations. This document has an appendix detailing the components of a safety plan and also contains the Spousal Assault Risk Assessment (SARA) checklist. Unfortunately, there are no ministry standards on responding to domestic violence situations or developing safety plans.

Since there are no MCFD standards pertaining to domestic violence or policies for social workers to follow, it would seem that the *Best Practice Approaches* document would have been utilized by

Best Practice Approaches: Child Protection and Violence Against Women

Social workers have the option of using these guidelines and are not mandated to adhere to or follow them in the same way they are mandated to follow practice standards. It is not possible to evaluate the effectiveness of these guidelines because social workers are not bound by or held accountable to their practice with families and domestic violence.

all of the social workers involved. While that document is somewhat vague, it does offer guidance to social workers in this difficult area.

The general approach that social workers took after the May 2007 investigation was in direct contradiction to the guidelines in this document. Most of the social workers interviewed in the course of the RCY investigation were not aware of or did not utilize their internal guidelines for working with families in domestic violence situations.

In May 2007, the intake social worker was one of few workers who utilized the *Best Practice Approaches* document. It is noted, however, that the guideline suggests that in their interventions, workers consider how to hold the abuser accountable for his violence. In this regard, the worker could have moved to hold Schoenborn accountable by applying for a protective intervention order under Section 28 of the *CFCS Act*. It doesn't appear that a protective intervention order was even considered by the social worker or team leader. Applying for a protective intervention order would have been considered best practice and would have supported safety planning for the mother and her children according to the ministry guidelines.

In July 2007, MCFD staff made a decision to not proceed with a protection hearing to obtain a final supervision order. The explanation for not proceeding is not consistent with the ministry's guidelines in working with women exposed to domestic violence. The document outlines a number of options to keep the children safe. A few are listed here:

- providing support services that will keep the mother safe so that she can care for her children. These can include children who witness abuse programs, counselling programs for the violent partner, and anti-violence woman's organizations
- having the children reside with their mother and obtaining a protective intervention order against the abuser pursuant to *CFCSA* Section 28
- having the children reside with their mother under an order of supervision pursuant to Section 29.1(1) (a) and (b).

A risk reduction service plan documents services in which the mother must participate, in order to reduce the identified risks. The plan has timelines and identifies outcomes. The risk reduction service plan in this case was as follows:

The mother states that she has no plans to reconcile with the father, and she has demonstrated that she was willing to address the children protection concerns by signing her risk reduction service plan, thereby agreeing to do the following:

- connect with family violence counsellor
- if the father does not participate in service provision, then the mother will not have contact with him when the children are present. The mother will ensure that if the father has access to the children he is not under the influence of drugs or alcohol and is presenting as mentally stable

- the children will attend the Children Who Witness Violence Program (now commonly referred to as Children Who Witness Abuse)
- the mother will discuss the effects of violence on children as well as general parenting issues/information with her family preservation worker.

The question of whether this was an adequate safety plan depended on three factors. The first was whether the plan's terms were adequate. The second was whether the ministry should have confidence that the children's mother could actually carry it out. The third was the ministry's willingness to take other steps if experience demonstrated that the plan's objectives were not being met after it was signed.

With respect to the plan itself, two points are noteworthy.

First, it has already been pointed out that the second point in the plan was in direct contradiction to the bail order (which would remain in effect until July 20, 2007), specifying a no-contact/no-go with the children's mother, the children and their residence.

It states "if the father does not participate in service provision," but nothing in the plan identifies what efforts would be made to engage the father in services.³ As mentioned previously in this report, although he was the primary risk, Schoenborn was not assessed, nor was he engaged in or offered help to address and reduce the risk posed to his family. At no time was he given a copy of the ministry protection order or given a clear and consistent explanation of his contact restrictions.

With respect to the children's mother's ability to carry out the plan, there was no considered assessment of her capacity to do so. There was not proper recognition that the children's mother was already burdened by a number of responsibilities and stressors, including having to monitor Schoenborn's mental state and propensity for violence while having little sleep and few outside supports. Her agreement to sign the plan needed to be weighed against the questions of whether it was fair to place the responsibility on her to protect the children from Schoenborn and how much insight she was capable of having into her circumstances, and in light of whether she would have signed anything to avoid the prospect of having her children removed.

At the time this plan was signed, the children's mother was sinking into profound depression, despair and anxiety. She was not given concrete suggestions or strategies on how to protect her children or how to keep Schoenborn away from the home, except to call police should he show up. Workers repeatedly told RCY investigators that they had no training in working with families experiencing domestic violence, and this is evidenced in the poor practice and approach they took with the children's mother.

3 As pointed out previously, Schoenborn needed to at least be offered services and supports that would improve his social and emotional functioning, in the effort to reduce the level of threat to the children's mother and the children. It would seem prudent to engage the father, who in this case was the offender, in a risk reduction safety plan. There is much research that indicates workers must hold the father accountable for this violence. Rather, social workers held the children's mother accountable by requiring her to participate in a risk reduction plan that did not involve the father.

The Representative recognizes that this is a difficult area. On one hand, social workers need to support a victim of domestic violence. On the other hand, they need to be honest with a parent about the consequences if they fail to protect their children. Social work practice requires a deft touch to address these tensions.

The *Best Practice Approaches* document points out it is not helpful for social workers to make statements to a woman in an abusive relationship that cause her to be fearful and shut down, as most of these women do feel a responsibility to protect their children and often feel blamed by professionals.

The document states that "use of coercion, threats, negative consequences, child removal, and exclusion from support or other strategies that employ authority can compound a mother's experiences of abuse and be experienced as re-victimizing for her.... A statement while not intended to imply blame will likely cause the woman to become defensive or fearful and could compromise your relationship and her safety." This is exactly what happened.

The children's mother told RCY investigators that the approach the social workers took was one of judgment and threats. She could not trust the social workers involved, and did not develop a working relationship with them. It is possible the children's mother would have had this subjective feeling no matter what social workers did in this case. However, this can't be known because there is no evidence that the "support" part of the equation was meaningfully communicated to the children's mother.

With respect to whether the plan's objectives were in fact being met after it was signed, social workers did not adequately follow through or monitor it. One immediate problem with the plan was that it was based on the children having access to services that did not exist for them in any timely way. As noted above, the children were expected to participate in a Children Who Witness Violence program. That program had a waitlist, and the risk reduction service plan did not follow the family to the new community. These services were never followed up on, and as a result, the children did not receive help to deal with the violence they had witnessed.

There is no doubt that Kaitlynn, Max and Cordon were traumatized during their young lives. The children never had the benefit of counselling, support programs or domestic violence supports. Thus, the lack of services affected a key component of the safety plan.

Another problem was that just one month following the June 2007 risk reduction plan, the father did have contact with the children when he was not mentally stable, and not alcohol and drug free, and yet the ministry took no protective action.

A documented safety plan that clearly laid the responsibility for protecting the children with the ministry could have relieved the children's mother of the difficult or even impossible job of keeping Schoenborn away from the children. It would have provided her with a tool to support her attempts to keep him away from the home.

The ministry's *Best Practice Approaches* document was updated in 2010. The Representative remains concerned that the updated guidelines are still not sufficient to adequately protect vulnerable children and their mothers living with domestic violence.

In this case, the onus was on the victim to seek professional help. This does not acknowledge, as demonstrated in this case, that victims may be reluctant or unable to obtain help. The guidelines in the *Best Practice Approaches* document are inadequate because they make no reference to legislation and/or standards.

Case Transfer Process

Finding: *When this family moved, the case transfer process between the offices/regions did not meet the prescribed MCFD standard or follow the MCFD Inter-Regional Protocol for transfer of authority between Directors. The resulting lack of timeliness and of continuity contributed to a failure to protect these vulnerable children and their mother.*

When transferring responsibility for a case, CFS Standard 23: Transferring or Ending Services outlines steps for social workers to follow. The standard states:

When transferring responsibility for providing a child and family with services, or ending services, involve the child and family in planning for the change and inform them of the change.

In addition, if responsibility for providing services is being transferred to another person, service area or delegated agency:

Inform the child and family about how to contact the person who will be responsible for providing the services

Review the service plan to ensure continuity of services required for keeping the child safe

Inform other involved extended family members, persons or agencies, and

Follow all existing protocols and case transfer procedures.

As well, the intent of this standard states that:

This standard is to ensure that a child and family are fully involved in the decision to transfer or end services provided by the director. Furthermore, those who have ongoing roles and responsibilities in providing the child and family with services receive all relevant information about the change to or conclusion of the service plan.

The *Inter-Regional Protocol Transfer of Authority between Directors* (Feb 2005) is a reference guide that is intended to clarify the roles and responsibilities of the directors when families move from one region to another, and describes the processes for transferring responsibility under the *CFCSA* between regions and directors (MCFD, 2005).

The protocol outlines roles and responsibilities for social workers, team leaders and directors when a file is transferred between regions. This transfer protocol states that the purpose or objective of the guide is to:

- promote best practices to ensure all decisions promote the safety and well-being of children and families
- support collaborative and co-operative relationships among regions
- support the seamless transfer of services between regions
- provide for the timely flow of information and documentation
- establish procedures for resolving conflicts.

In this case, the standard was not met and the protocol was not utilized by social workers or team leaders at the end of August 2007, when the family first moved to the Interior. This was a period of high risk. Schoenborn had recently breached the no-contact order, and the children's mother was continuing to minimize the risk. The social workers in the Lower Mainland correctly assessed the family to be at "high risk." However, the subsequent transfer process and passive monitoring was inconsistent with that high-risk assessment.

There is correspondence on the file about transferring authority for the case between MCFD regions, noting safety concerns. It appears that they are the same safety concerns that were present in September 2007. There is no indication why the transfer did not happen in September 2007, as suggested by the MCFD team in the Lower Mainland.

The social worker in the Lower Mainland expressed the belief that Schoenborn would kill the mother in the presence of the children. That being the case, a heightened response and transfer process that followed the stated policy was warranted.

The ministry inter-regional protocol (file transfer process) dictates a 30-day timeline for a transfer. A number of the social workers from both communities believed they were following a case transfer process in which a case cannot be transferred to a new community/office until the family resides in that community for three months. The case transfer process that the workers followed was identified as "courtesy service, courtesy supervision and courtesy home visits."

Courtesy supervision and courtesy services are mentioned in the protocol with respect to children in care and children subject to a supervision order. These children were not the subject of a supervision order, nor were they children in care; therefore, courtesy services or courtesy supervision would not have applied in this case. There is no definition for what courtesy supervision is or what a courtesy service entails.

The protocol states that reciprocal services can be used for a maximum of 30 days, not 90 days. Obviously there was practice in these two regions that was not consistent with any policy. In this case, following the stated policy may have helped protect the children,

because workers in the receiving community would have had to recognize the need to be fully briefed on the file and then take full responsibility for the child protection issues the file raised, including the opportunity to further engage the mother and support the children in a chaotic, confusing and dangerous time in their lives.

A transfer recording did not follow the children's mother to the Interior, another requirement of the inter-regional protocol. A transfer recording is a required part of the file transfer process. Completed by the social worker from the originating office, it is a summary of the current and past child protection issues, services and supports that the family has engaged in. It also includes an updated assessment of risk.

A transfer recording did not happen until January 2008, almost five months after the family moved. A transfer recording would have alerted the social workers in the Interior to the level of risks the children faced and the history of the ministry's involvement with the family. It could have identified any interventions that had worked, and a summary of the services/interventions that didn't work.

The social workers failed to meet CFS Standard 23, which requires that a social worker review the service plan to ensure continuity of services required to keep the child safe and follow all existing protocols and case transfer procedures. In fact, there was no review of any existing service plan and the case transfer procedures were not followed, which compromised the safety of the children.

A recording outlining the dynamics of the parents' relationship and how domestic violence and untreated parental mental health impacted this family and the mother's response would have further assisted social workers in working with this mother. Of most concern was the missed opportunity for sharing information on the children. What had they witnessed in their short lives?

After the transfer eventually occurred in January 2008, practice was faulty. A social worker in the Lower Mainland office, the third social worker that worked on the family file, completed the required risk assessment. She had never met the family, and had few conversations with the Interior office social workers, who knew the family best at that time.

The process of completing the risk assessment appeared to have been done as an administrative task rather than as real assessment of the family risk. In the end, a rating of high risk was appropriate; however, a more thorough assessment with family, plus service provider input, would have resulted in a fuller and more useful risk assessment document.

The risk assessment that the Lower Mainland social worker completed resulted in assessing the current risk to the family as "high." She believed the family was at higher risk due to the recent reports that the father had been in the home despite MCFD direction that he was not to have access to the children.

This part of her assessment was appropriate; however, the Interior team leader did not have time to thoroughly review the assessment completed by the Lower Mainland social worker and believed that the risk was "medium." She came to that conclusion after the intake social worker from the Interior emailed her with a note saying that the file had been transferred and incorrectly advised that the current risk assessment found a "medium" level of risk. She then quickly scanned the risk assessment document, and took the previous dated medium risk assessment as the current assessment.

Perhaps if the team leader believed that the family was in a high risk period, the team would have actively responded and conducted another assessment of current risk. Instead, there was a passive response of monitoring.

A strong supervisory presence would have likely prevented most of the issues that resulted due to the faulty file transfer process that took place.

The inter-regional protocol requires that case transfers are handled by team leaders. In this case, the "courtesy services" agreement appeared to be agreed upon between the involved social workers. At some point, the Interior team leader did become aware that this agreement was in place; however, the team leader did not question why the social workers were not following the policy.

RCY investigators involved in this case were told that case transfers have been a practice issue in the Lower Mainland region. This explains why the process is supposed to be managed by team leaders. There is an expectation that team leaders are to be aware of the process and able to direct and support their team in ensuring a smooth process where the family is not impacted and children's safety not compromised.

The delayed, inadequate case transfer process, coupled with poor supervision, put these children at greater risk. Once again, MCFD failed to protect these children.

Case Management

***Finding:** Case management did not meet reasonable expectations.*

Beyond the factors already noted, a number of additional factors contributed to ineffective case management of this file.

First, there were inexperienced workers in both communities who were not trained to work with high-risk families with multiple, complex needs. An office with new workers is often the reality in the field. New workers must be able to rely on strong clinical supervision and case practice consultation from experienced supervisors/team leaders.

Most of the social workers involved in working with this family lacked an understanding of the nature and extent of the father's mental illness, and that they needed to consult with a mental health professional and engage adult mental health services. Throughout

MCFD's involvement with the family, concerns about the father's mental health were raised but not recognized by social workers in assessing the risk of harm to the children.

Many of the social workers lacked comprehensive domestic violence training and were unable to articulate how the cycles of domestic violence should be considered in planning. The inexperienced social workers believed that there was lower physical risk to the children than to their mother because there was no record of Schoenborn having directed physical violence or threats toward them and because the children's mother described him as a "good father" who loved his children. Also lacking was training to assess and engage the father in a process that would address his risk issues and include him in the protection process.

This finding of social workers being mistaken about the children's level of risk is consistent with the lessons learned from Domestic Violence Death Review Committees. Jaffe & Juodis (2006, p.14) found that the "danger to children in potentially lethal domestic violence cases may be mistakenly overlooked because the cases do not fit the traditional view of child abuse (because mothers are the primary targets)."

They also found that "domestic violence perpetrators may be lethally dangerous to children even when lacking a history of direct child maltreatment or prior involvement with police" (Jaffe & Juodis, 2006, p.15).

Another threat to good case management was the numerous changes in social workers, some as a result of the family's move to the Interior. Since social workers changed a number of times, a lack of case planning continuity resulted. There were nine social workers and four team leaders involved with this family over a one-year period. Both communities saw a relatively high turnover of staff. Many of the social workers were new to the field, often still in their training periods, while working with this family.

The office in the Interior was also experiencing higher than normal caseloads. RCY investigators were told of one worker having 60 files during this timeframe and that it is impossible to actively manage these cases, many of which were considered high risk. RCY investigators were told that it is not uncommon for mistakes to be made, such as misidentifying the assessed level of risk to a particular family, when one is juggling 60 files.

There were no measures in place to mitigate these serious threats to good case management.

The office in the community in the Interior is relatively small. In small offices, staff are often required to cover off for each other when workers are away from the office. In this case, the social workers passed the responsibility for case management amongst themselves with little or no communication with the family. This proved very confusing for the family. The children's mother says she did not feel connected to any of the MCFD workers. She did not feel supported by them. Instead, she felt under attack and was constantly threatened that her children would be removed.

The children's mother also expressed other concerns about the involvement of MCFD social workers. She told RCY investigators that she doesn't feel that they communicated effectively with her. She was never really sure who was assigned as her case manager. She needed someone to help her through many areas of her life. To adequately protect her children she needed help with housing and food and with understanding domestic violence and mental illness. An MCFD social worker should have actively managed these needs with the support of community professionals.

When the ministry became involved with Schoenborn in May 2007, as a result of the alleged sexual assault and threats, social workers did not engage with him. He did not receive notice of the court hearing that found his children in need of protection, which would also have listed the reasons why a supervision order was entered into. He did not participate in the risk assessment, nor was he a significant part of the risk reduction service plan.

On more than one occasion when Schoenborn came into the office looking for help, he was told to come back another time.

The most effective case management model for child protection workers includes referral and collaboration with community services, including domestic violence agencies (Hardcastle, Wenocur & Powers, 1997). In this case, there was an initial attempt (May 2007) by MCFD social workers to engage with community services that would support the mother. However, those services and supports never were fully realized.

Of further concern was the reticence of a team leader to make case decisions on the Friday afternoon before the tragic events of that weekend.

As noted in the chronology, on Friday, April 4, 2008, Schoenborn went to the MCFD office and spoke with the team leader in his social worker's absence. He stated that he wanted to re-unite with his family and asked what he needed to do in order for this to happen. The team leader outlined MCFD's concerns about the children's safety and their expectations.

The file indicates that the team leader told Schoenborn that supervised visits could be arranged after he met with his social worker the following Monday, April 7, 2008. Schoenborn said he could not commit to this appointment, but he reportedly agreed to call and make an appointment. The team leader told Schoenborn that it was too late in the day to further plan or to arrange visits. It was 2 p.m. on a Friday afternoon.

It is unclear why a further plan or supervised visits could not be arranged on that Friday afternoon. This team leader knew the family and the issues very well. The father's reluctance or resistance to working with the ministry was clearly documented. For that reason, when he did show up and appeared willing to engage on that Friday afternoon, the opportunity should have been taken.

The record shows that shortly after the team leader had concluded his meeting with Schoenborn, the corrections manager called MCFD alerting them to the fact that the father had said the family home was his permanent residence. This ought to have raised a red flag with regard to possible protective action. Rather than visiting the home, the social worker made two attempts to call the mother, which were unanswered. When the social worker advised the team leader that she wasn't able to contact the mother, the team leader asked the social worker if the children's mother clearly understood the direction of the previous day by MCFD to keep the father away.

Why wasn't this decision considered in the context of domestic violence, and the unusual, volatile behaviours Schoenborn was exhibiting that week? That Friday afternoon could have been used to arrange supervised access for the father, or to develop a safety plan in an escalating period of risk. This was vital information that should have been acted upon immediately, especially since the weekend started the next day which meant there would be no MCFD intervention for another two days. At the very least, arrangements should have been made that After Hours social workers connect with the family over the weekend.

Schoenborn was open and honest in expressing his desire to see his children that weekend. He also told the worker that he had nowhere to go and would have to sleep outside. An assessment of risk could have alerted the worker to the possibility that Schoenborn would return home. Again, opportunities to engage with and understand the father were missed. As a result, the father spent the entire weekend with the children.

The Representative is very concerned about the attitude some workers seem to have taken. During this investigation, there were several statements made by social workers who were in the Interior office at the time, such as, "Well, it wasn't my case," or "If it was my case, I would have done this." In one instance a worker expressed a belief that the children should have been removed and placed in an undisclosed location. Another worker believed that a court intervention was a necessary response and said a supervision order to protect the children should have been put into place. Instead of taking these concrete actions at the time, which they believed should have been taken, they provided only problematic "courtesy services" which did not properly protect this family.

In child protection, it is simply not adequate professional practice to absolve oneself from case decision-making or safety planning because "it's not my case." A child's safety is paramount in all decision-making, and it shouldn't matter which worker has responsibility. All social workers need to work together to protect children and keep them safe. It is a child's right to be safe.

The Representative believes that Kaitlyne, Max and Cordon's right to safety was compromised by a lack of collaborative, professional child protection practice. MCFD failed to appropriately meet its mandate to protect children.

The lack of quality supervision in the area of case management is also of significant concern to the Representative. The intent of MCFD Quality Assurance Standard 4: Supervisory Consultation and Approval is to ensure that supervisory consultation and approval is "obtained in all significant circumstances and at all decision points relating to service delivery."

Supervisory consultation in significant case decisions was not reflected in the physical files or through interviews with MCFD staff. The complexities of this case required strong supervisory consultation, and that was observed in only one episode.

It is noteworthy that supervisory consultation was reflected in the May 2007 MCFD investigation, and in that instance, the response to the risk that was present was appropriate. Social workers successfully applied for a court order that required the mother to follow a set of activities intended to reduce the risk to the family. Social workers appropriately utilized After Hours staff in requesting unannounced home visits, in addition to leaving instructions to After Hours staff should a child protection call come in outside of regular office hours.

Mental Health Services

***Finding:** On the few occasions that Schoenborn was involved with mental health services, the system appeared blind to the risk to these children, and lack of follow-up contributed to a failure to protect these vulnerable children and their mother.*

A parent's mental illness, if left untreated, will have obvious impacts for any child, especially when their parent's behaviour raises child protection issues. During periods of active illness, a parent may be more vulnerable in their capacity to maintain a protective relationship with their children. They may be emotionally unavailable and not able to respond to their children's developmental, social, emotional and physical needs.⁴

In the criminal trial, the court described the medical evidence this way: "The medical evidence in this case is clear that Mr. Schoenborn at present suffers from a severe or major mental disorder. Dr. O'Shaughnessy, called by the defence, says that he has a psychotic illness, either delusional disorder or possibly schizophrenia. Dr. Lohrasbe, called by the Crown, agrees that at present Mr. Schoenborn suffers a psychotic illness that may be a delusional disorder or schizophrenia."

About 20 per cent of Canadians will experience a mental illness in their lifetime. Yet, two out of three people with a diagnosable disorder in Canada do not seek or get care (Canadian Mental Health Association, 2011: *Fast Facts: Mental Health/Mental Illness*).

⁴ Victorian Government Department of Human Services, 2007: *Families where a parent has a mental illness: A service development strategy*. Melbourne, Victoria, Australia.

The Canadian Mental Health Commission described mental health services in Canada as a "fragmented patchwork of programs and services facing a constant struggle to meet ongoing demands of the population."⁵

In B.C., a person can ask for psychiatric help and be admitted to a hospital voluntarily to receive psychiatric treatment. A person can also be forced to stay in hospital. This is referred to as an "involuntarily" admission. In B.C., involuntary treatment occurs within the framework of the *Mental Health Act*. The most common method of involuntary admission is called "certification."

The *Guide to the Mental Health Act*, published by the Ministry of Health, describes the involuntary admission process:

One Medical Certificate (Form 4) is required to provide legal authority for an involuntary admission for a 48-hour period. A Medical Certificate is completed by a physician who examines a person and finds that the person meets the involuntary admission criteria of the *Mental Health Act* (Section 22(3)).

The completed Medical Certificate provides authority for anyone, including ambulance personnel, police or, if the physician believes it is safe, relatives or others, to take the person to a designated facility (Appendix 1). With the approval of the director or designate, the person may be admitted for up to 48 hours.

A second Medical Certificate by a different physician must be completed within 48 hours of admission; otherwise the patient must be discharged or admitted as a voluntary patient. Once the second Medical Certificate is completed the person may be admitted as an involuntary patient for up to one month from the day of initial admission. The second certificate should be completed as soon as possible, taking into account the necessity for a thorough examination, which may include receiving information from other sources. The patient must be informed that the second Medical Certificate has been completed.

To extend involuntary hospitalization beyond the first month, a physician must examine the person and complete a Renewal Certificate (Form 6) before each certificate period expires. A copy of Form 6 is in Appendix 16. Also see Appendix 4, section 1.2. The patient must again be told the rights information given upon admission (see section 7.1 Rights Information).

The guide describes the criteria for involuntary admission as follows:

In order for a physician to fill out a Medical Certificate, the physician must have examined the patient and be of the opinion the patient meets ALL four of the criteria.

⁵ Canadian Mental Health Commission of Canada, November 2009: *Toward recovery and well-being: A framework for a mental health strategy for Canada*.

The opinion must be based upon information from the examination and preferably includes information received from family members, health care providers or others involved with the person. The criteria are that the patient:

- is suffering from a mental disorder that seriously impairs the person's ability to react appropriately to his or her environment or to associate with others
- requires psychiatric treatment in or through a designated facility
- requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others, and
- is not suitable as a voluntary patient.

The words "in or through" a designated facility mean that a patient initially requires inpatient treatment as an involuntary patient but may subsequently be placed on leave and continue to receive psychiatric treatment in the community. The patient's care, supervision and control may be retained by the designated facility or delegated to an authorized physician in the community.

Schoenborn was hospitalized twice. He voluntarily admitted himself in 1987 and the 1999 admission was involuntary. They were for brief periods. In the latter admission, he was discharged from hospital with no follow-up because of a decision that he did not meet the involuntary admission criteria.

The children's mother told RCY investigators that she felt helpless dealing with Schoenborn's mental illness. She understood that he did have mental illness and that he needed help in managing his mental health throughout the years. However, he was only involuntarily committed once, and in her opinion it wasn't long enough for him to stabilize and get better. She says that she felt frustrated and didn't know where to turn.

The mother said that Schoenborn didn't want help and so there wasn't a way to get him the help he needed. She believes that more needs to be done to support families who are dealing with a family member with a mental health diagnosis.

At the May 28, 2007, meeting that Schoenborn attended with MCFD staff, in response to questions about his threats and violent behaviour on May 17, he stated he was not the person involved. He said that he was physically there but it was not the real him and that it was someone else taking his actions. At this meeting, he advised that he felt overwhelmed by the number of people attending and wanted a lawyer present. Nonetheless, he agreed to undertake counselling for his anger and aggression, parenting and substance abuse.

This meeting was just one of a number of times throughout the course of MCFD's involvement with him where he presented with concerning behaviours. Those situations should have alerted the workers to the significant need for a mental health assessment.

Social workers could have consulted with mental health professionals to better understand his mental health and the risk he posed to his family. A supervision order could have required the father to undergo a psychiatric assessment and treatment plan as a condition of access to the children.

The Representative acknowledges that these steps are not easy ones to take. Schoenborn did not want to engage with the mental health system. This response is common among persons suffering from the type of mental illness he had. Being detained in hospital on an involuntary basis means a loss of control over life and livelihood, and psychoactive medication often has significant and unpleasant side effects. His substance abuse, which may have been an attempt at self-medication, also went untreated.

Difficult as these issues are, they must be confronted in cases where children require and deserve protection and support. In fact, such services may be the key factor in social workers determining if children can safely remain with their parents. An opportunity was missed on May 28, 2007 when Schoenborn agreed to attend addictions counselling but declined mental health intervention.

Research shows that parental mental illness can have a big impact on children in middle childhood. For example, Kaitlynn, Max and Cordon may have been reluctant to bring friends home because of the shame and guilt that is sometimes present for children dealing with parental mental illness. They may have become so accustomed to the violence, anger and hostility that they learned to live in two worlds with two sets of rules (inside versus outside home). They may have experienced anxiety and developed depressive qualities. We will never fully realize the impact of their father's untreated mental illness on their development because neither the children nor their father received the necessary mental health supports.

The various systems involved with the family were not aware of the severity of Schoenborn's mental illness and substance abuse because he was never interviewed from these perspectives by police, corrections or child protection. Also, there was very little collaboration or information sharing among these systems.

The failure of authorities to proactively encourage Schoenborn to engage with mental health services contributed to his continued abuse and violence towards the children's mother and others in the community. His children were repeatedly exposed to violence. He was a threat to public safety given his criminal history of assaults and impaired driving.

In addition to the lack of an aggressive outreach or after-care response to following up and monitoring how Schoenborn was doing, there was another troublesome issue. There was no follow-up or monitoring about how the children and their mother were doing. Clearly, the children as well as their mother had been repeatedly exposed to traumatic events in their home. An effective mental health system must, in the name of meeting

the needs of children, as well as adult victims of violence, help them to understand, cope and recover from the effects of the trauma they have experienced. At very least, ongoing monitoring and outreach is important if immediate safety needs of the children are to be met. Without that, there is no way of knowing how things are going, or whether intervention is needed to keep the children and their mother safe.

In November 2010, B.C.'s Ten-Year Mental Health Plan was introduced by the provincial government. The Representative has reviewed this plan. It involves multiple service delivery systems, including health, education, income assistance, housing and criminal justice. The plan outlines goals for B.C. in the area of mental health and addictions.

The plan describes many outcome measures and lists actions that are intended to improve services for people suffering from mental health and addictions issues, but does not describe the specific process for implementation, where the funds will come from or how they will be allocated to support these goals.

Income Assistance Practice

***Finding:** The services the children's mother received were marked by a lack of continuity, a lack of critical support for clients dealing with domestic violence, and a lack of coordination between MCFD and the income assistance program.*

When the children's mother did try to separate from Schoenborn, she was met with obstacles in acquiring income assistance. She was completely financially dependent on Schoenborn for the whole time they had been together. Breaking the cycle of violence meant that the children's mother needed to have financial independence from Schoenborn. Rather than assist with, support or facilitate this process, income assistance was at best inconsistent, and at worst, a hindrance to her attempts to gain independence from her spouse.

She did not receive assistance until six weeks after her initial application. Though income assistance workers were aware she was attempting to flee domestic violence, her request for income assistance was met with a requirement to complete job search activities and an employment plan before assistance would be granted.

Problems in applying income assistance rules and policies that are meant to assist vulnerable individuals were also highlighted by the Representative in a 2009 report. In *Housing, Help and Hope: A Better Path for Struggling Families*, the issue at hand was different – a young mother was seeking assistance so that she could provide a safe home for a child who was removed from her care. However, the net result was the same. A system meant to support and help instead put barriers in place, despite having specific policies in place to avoid that outcome.

The children's mother was required to complete job search activities, such as distributing resumes, with no consideration of her day-to-day circumstances as the sole caregiver for three young children. She was required to meet with a family maintenance worker before the full amount of her assistance would be granted. This meeting was to enrol her in a program requiring Schoenborn to make regular child support payments. Such applications can have an aggravating effect on already volatile situations involving domestic violence.

Family Maintenance Enforcement Program

This program is included in the most recent Violence against Women in Relationships (VAWIR 2010) revision. Their policies show sensitivity when addressing concerns about violence in the maintenance enforcement process. Specific training is provided to workers in assessing domestic violence. They do not facilitate contact between parties outside of formal court requirements to attend court.

When the mother met with the family maintenance worker on Aug. 2, 2007, she identified family violence as an issue. The maintenance worker recognized the risk and monitored the circumstances monthly. File notes indicate that there was no contact information for Schoenborn, that contact was never established and that an order for family maintenance was never obtained.

In past years, the Ministry of Social Development (known as the Ministry of Employment and Income Assistance at the time) has changed its service delivery model. Clients on income assistance are no longer assigned a single worker; they are asked to address their needs with whomever they make contact with when contacting an office. This inevitably means that context is easily lost, and underlying issues are de-emphasized.

Criminal Justice System

***Finding:** The policies and practices of the criminal justice system were inadequate in protecting the children and their mother from the continued influence and violent behaviour of the father, and they require improvement and immediate attention.*

The successful prosecution of domestic violence charges can be complicated by issues of financial and emotional dependence, physical intimidation, delays inherent in the criminal justice system, and persistent misunderstandings about the role of the victim in the prosecution. A woman's reluctance or fear of proceeding through the criminal justice system is often cited as the most persistent challenge in cases involving domestic violence.

Experienced investigators and prosecutors recognize that many victims of domestic violence will return to or remain with their abusers, and that the continuing influence of the abuser often leads victims to recant their initial statements to police or to take steps

to minimize what has occurred. Reliance solely on the statement of the victim places any prosecution in potential jeopardy, and makes the gathering of independent evidence, including physical evidence like photographs of injuries and other witness statements, even more critical.

This dynamic is recognized in the Provincial Crown Counsel Prosecution policy, which clearly identifies that the decision about whether or not to proceed with a domestic violence prosecution rests with Crown Counsel, and not the victim.

In this case, during the May 2007 investigation, police were solely reliant on the mother's initial statement in recommending that Schoenborn be charged with sexual assault and uttering threats. When she later retracted her statement, the prosecution collapsed. Because of the passage of time between when she alleged the offences occurred and when police learned of them, it is possible that physical evidence may not have been available. However, no statements were taken from the children, and Schoenborn was never interviewed at all.

Criminal Offence Arrest and Release Procedures

When someone is arrested in Canada for committing a criminal offence, the general rule is that they must be released as soon as possible, either by the police or a justice of the peace (JP) or judge. Many persons arrested for relatively minor offences are released by police either at the place where they were arrested or from the police station. Police can issue the offender with an appearance notice or a promise to appear, documents that compel the person to attend court on a certain date.

If police choose not to release an accused person, they are required to bring that person before a judge or JP within 24 hours of their arrest. The judge or JP will then consider whether or not it is appropriate to release the accused. This is often referred to as a bail hearing or as a pre-trial release hearing. The burden generally falls on the Crown to demonstrate that there are sufficient grounds to justify holding someone in custody until their trial.

Policy requires police to refer a victim of domestic abuse "as soon as possible to the appropriate Victim Service Program." The policy further states that, "Early intervention by victim services enhances the victim's safety and increases the likelihood of the victim/survivor's co-operation with the criminal justice system" (Ministry of Public Safety and Solicitor General (2007). *Referral policy for victims of power-based crimes: Family violence, sexual assault and criminal harassment*).

In this case, the children's mother was not referred to community-based victim services because the community she lived in had a Domestic Violence Unit. These specialized units

are based on a coordinated model of specially trained police working in partnership with specially trained victim service workers from a community-based agency, operating out of the police station.

Yet again, there was a missed opportunity to provide the children's mother with support and advocacy. The request for support was withdrawn only five days after the mother failed to attend one of the scheduled appointments with police. The support and advocacy she could have received from the specialized service worker might have helped the mother fully understand the dynamics of domestic violence and how the exposure to violence was negatively affecting her children. She may have been better able to protect them with that knowledge and the help of an advocate/support person.

The hasty decision by the police officer to cancel the request for support from the domestic violence unit's victim services worker is a serious concern. This occurred in one of the few domestic violence units in the province, a unit that is supposed to be a model of collaborative practices. This indicates another serious failure in the systems that were supposed to support this mother and her children.

Government has a policy to guide staff in working with women exposed to violence that was developed in partnership with a number of ministries, community partners and professionals. This is the Violence against Women in Relationships (VAWIR) policy. The VAWIR policy that was in place at this time prescribed a *"proactive charge policy based upon the assumption that police will conduct a complete investigation in every case, including those cases that do not immediately appear likely to proceed to prosecution. The officer will pursue the investigation with a view to obtaining sufficient evidence to proceed even without the cooperation of the victim. The evidence could include an admission by the offender, photographs of injuries, medical evidence, physical evidence and a written statement by the victim and any independent witnesses."*

The Representative notes that the latest VAWIR policy (November 2010) is less prescriptive than the previous version, stating: *"When it has been established that an offence has occurred, police should document all evidence and provide Crown Counsel with a complete written record, even when the victim is reluctant to cooperate with the investigation. Police work to build a case that can stand independent of the victim testimony, taking accurate and detailed notes of the incident. Police should provide all tapes."*

The chronology of events shows that opportunities for protective action were missed in the investigation of the incident at the children's school when Schoenborn threatened his daughter's classmate. This behaviour could and should have raised concerns about the safety of his children, and could have been communicated to MCFD. However, police did not interview Schoenborn, the children's mother or the children.

Communication between police and MCFD during the tele-bail hearing arising from the incident at the school was also problematic. Because no Crown prosecutors were available after-hours, the information that would normally have been presented by Crown was instead provided by a police officer.

During this tele-bail hearing, the JJP was not advised that Schoenborn was the subject of a peace bond pursuant to Section 810 of the Criminal Code of Canada, or that he had recently been convicted for breaching the terms of that recognizance.

Breaching a Court Order

In domestic violence cases, a high degree of risk is associated with breaches of court-ordered protective conditions such as no contact. It is important that any reported breach be dealt with as a high-risk situation for victims and others associated with the victim, with an immediate enforcement response required because of significant risk of escalating violence (Critical Components Project Team, Government of B.C., April 2008: *Keeping women safe: Eight critical components of an effective justice response to domestic violence*).

The JJP was also not advised that Schoenborn had not appeared for a number of scheduled court dates, and that five warrants had been issued for his arrest in the preceding five months.

These omissions should not be interpreted as evidence of negligence or carelessness on the part of the police officer, since it is common for police officers to have received little or no training on how to conduct a tele-bail hearing. However, police also did not conduct a risk assessment related to the long history of domestic and sexual violence. These facts, had they been presented, could well have resulted in the JJP making the decision to hold Schoenborn in custody rather than to release him on bail.

Tele-bail is a convenience that allows for a more efficient process; however, there is a loss of quality to the hearing, as evidenced in this case. There was a misunderstanding about who had actually answered a critical question asked by the JJP. During the bail hearing, the JJP asked if there was any friction between the mother and father. The response was "no," and the JJP believed it was the police officer who was speaking. It was disclosed during the subsequent criminal trial for the murders of the children that it was Schoenborn, and not the officer, who had denied the presence of conflict in the family home.

When, as a result of this hearing, Schoenborn was released back into the community that evening, none of the involved parties, including MCFD, the school, the victim of the schoolground threats or the children's mother was notified of Schoenborn's release.

This case does raise the question of whether tele-bail hearings, which are economically efficient, are appropriate for cases involving violence and threats of violence.

Another aspect of the criminal justice system worth noting is the importance of supervision conditions in bail orders. Although some of Schoenborn's bail orders did include a condition for bail supervision, others did not. None of the orders (May 18, 2007, July 20, 2007 and Aug. 24, 2007) related to domestic violence included a condition to report to a bail supervisor until a bench warrant was issued on Nov. 16, 2007 for failing to appear in court.

Without supervision conditions in a bail order, an opportunity for a bail supervisor to engage with a defendant, police, Crown Counsel or MCFD may be lost. In this case, a supervised bail order could have provided opportunities for the bail supervisor to contact the children's mother and to provide support and encouragement in ensuring compliance with the terms of the order, as well as giving her important information about support available from victim services. Contact with MCFD could have provided additional information that would have been central to the decision-making process around child protection.

Bail Supervision

If an accused is ordered by the court to report to a bail supervisor, that accused will be monitored periodically by a probation officer. The frequency with which an accused must report to a bail supervisor will depend on the perceived risk and can range from daily (in the most extreme cases) to monthly. If a bail supervisor or police find an accused failing to comply with his court-imposed release conditions, the accused can be arrested and charged with breaching that condition. This is a separate charge and an accused can be convicted of a breach offence even if they are subsequently found not guilty of the original offence.

In the current VAWIR policy, B.C. Corrections commits "to delivering coordinated and effective responses to domestic violence that reduce reoffending and enhance victim safety." While the policy requires police to request that Crown Counsel seek a condition requiring an accused to report to a bail supervisor in domestic violence situations, this was not policy in 2007.

When Schoenborn was finally placed under active bail supervision in November 2007, this would have been an opportunity for the bail supervisor to contact the mother and provide support and encouragement to ensure compliance with the bail order. This did not happen. In fact, when interviewed for this investigation, Schoenborn had no recollection of this period of active bail supervision.

Schoenborn was under an active Section 810 peace bond at the time he killed the children. Section 810 peace bonds, like bail orders, can include a requirement for reporting to a bail supervisor. Because no such requirement was attached to Schoenborn's Section 810 order, there was no risk or needs assessment conducted by Corrections Branch. A risk assessment such as the Spousal Assault Risk Assessment (SARA) would very likely have identified the high level of risk this father presented to his family.

The Keeping Women Safe report completed in 2008 by the Critical Components Project Team states: "In cases involving s. 810 recognizances or probation orders, accountability can be achieved only where offender compliance is well monitored and non-compliance is met with swift arrest and charge."

Responding to Domestic Violence in B.C. Families

***Finding:** Today, almost four years after the deaths of these three children, a collaborative, systemic approach to domestic violence across the child-serving, mental health, and criminal and civil justice systems still does not exist. Initiatives in recent years, while positive, are not sufficient. More comprehensive work is urgently required to protect other children and families from injury and death.*

Many children in B.C. are exposed to domestic violence. These children are effectively denied the safe and stable home environment that would support their healthy development. In 2005 (the most recent data available), there were 10,273 domestic violence incidents reported to police in B.C. (Police Services, Province of BC, 2006). A very rough estimate of the children exposed to domestic violence each year is approximately 3,000 British Columbian children. This number does not include incidents that have not come to the attention of authorities, which are likely greater in number than those which have.

The 2008 Canadian Incidence Study of Reported Child Abuse and Neglect reported that 34 per cent of substantiated child maltreatment investigations identified exposure to domestic violence as the primary form of maltreatment (Public Health Agency of Canada, 2010).

When the child-serving, mental health, and criminal and civil justice systems become aware of situations where children are exposed to domestic violence, the systems must work together to coordinate and collaborate to do everything possible to ensure the safety of the children. Child protection social workers have a duty to protect children under the legislation (*CFCS Act*). However, there is also a duty to support under that legislation.

In cases where children are exposed to domestic violence, it is imperative that the appropriate levels of support are provided to the family, as prescribed by the *CFCS Act* as a least intrusive measure. The types of support that are provided are based on accurate risk assessment and risk reduction plans completed by the child protection social workers.

The Provincial Health Officer's Annual Report (2011) *The Health and Well-Being of Women in British Columbia* states that for children, witnessing family violence is as harmful as experiencing it, and they suffer the same negative consequences as children who are directly abused. Consequences can include developmental delays, early substance misuse and suicide/suicide attempts. Moreover, the impact follows the child into adulthood resulting in a loss of trust, social isolation and sometimes re-victimization.

An effective systemic response to domestic violence situations in any jurisdiction must include the following key components:

- risk and safety assessment
- victim safety planning
- offender accountability
- victim support
- information sharing
- coordination and collaboration amongst all systems
- comprehensive domestic violence policy and legislation
- specialized expertise (dedicated police, courts, Crown attorney and child protection workers)
- monitoring and evaluation (Critical Components Project Team, 2008)

Government needs to take the lead to create a truly effective system to combat domestic violence. An effective system must, of course, be adequately funded.

The province of Ontario has been a leader in addressing domestic violence for women and children. In 2005, that province released a Domestic Violence Action Plan aimed at developing a coordinated and comprehensive approach to protecting women and children from domestic violence. The plan was launched by the Premier through a Ministerial Steering Committee. The committee was chaired by the Minister Responsible for Women's Issues and involved 13 ministers (Ministry of Citizenship and Immigration, 2005).

The Ontario approach was proactive. It focused on preventing violence, and promoted broad-based interventions across sectors such as health care, education, justice, business, and faith groups. It emphasized improvements in both the justice and community services sector and targeted strategies to meet the diverse needs of the population.

The principles governing the plan included safety, equality, public leadership, shared responsibility, personal accountability of the abuser, diversity and equity of access, holistic response, balanced approaches and measurable progress over time.

The key elements of the four-year plan included:

- providing better community supports, such as enhanced counselling services and housing supports for victims
- training of front-line workers, professionals, families and others to recognize abuse and help victims get connected to supports they need
- a public education and prevention campaign, and
- improvements to the province's criminal and family justice system to better protect women and children (Ontario Government, May 2009).

Some of the promising new initiatives that have emerged in Ontario include:

- A public education campaign called Neighbours, Friends and Families, has been started in more than 170 communities across Ontario. The campaign focuses its work in neighbourhoods to educate friends and family about woman abuse.
- In February 2006 changes were made to the *Children's Law Reform Act* that require domestic violence to be considered in child custody and access matters.
- The Bail Safety Project identifies high-risk situations for victims of domestic violence where integrated teams of justice professionals (Crown attorneys, police and victim witness workers) work together to improve victim safety in domestic violence bail hearings. The project is currently operating in ten sites throughout the province.
- Establishment of expert panels which have developed core training materials and a provincial implementation plan for hospital emergency department personnel. This training is designed to increase the knowledge and skills of doctors and nurses to be more effective at identifying abused women and women at risk, and at providing the type of support these women need.

Ontario also introduced domestic violence court (DVC) programs throughout the province in 2001. Teams of specialized professionals, including police, Crown attorneys, victim services workers, child protection workers, probation workers and other community agency support workers collaborate to make sure priority is given to the safety of domestic violence victims and their children. The DVC program has an advisory committee.

Specially trained domestic violence Crown attorneys, victim support workers and interpreters, specialized evidence collection and investigation procedures by police, case management procedures to coordinate prosecutions and early intervention, a partner assault response intervention program, and expanded training for police, Crown, victim support staff, court staff, probation staff, parole staff and interpreters are all features of the program (Ursel, Tutty & Lemaistre, 2008).

An Ontario study of 1,000 offenders found significant differences when comparing the convictions/reconvictions of offenders who appeared in domestic violence courts versus offenders who appeared in other Ontario courts. The study found that offenders who

appeared in a DVC were more likely to receive a prison sentence for the original domestic violence conviction; those that appeared in a DVC were less likely to be reconvicted of a spousal or other violent offence; and those that appeared in a DVC were more likely to be reconvicted of an administrative offence than offenders who appeared in other Ontario courts (Department of Justice, 2005).

In 2011, Ontario started another innovative justice initiative called the Integrated Domestic Violence Court, which is currently being piloted in two locations in the province. This court model is based on the concept of one judge dealing with both the criminal and family cases in one court regarding one family. Each matter is dealt with separately but by the same judge. The intent is that both the criminal and family matters involving a family are dealt with sequentially on the same day. The objective is to overcome the problems that are created when criminal and family proceedings are conducted in separate courts, in different locations, at different times with no communication, coordination or sharing of information between the courts.

The children's mother told RCY investigators that she didn't want to keep her children away from their father. She believed it was important for the children to maintain a relationship with their father. This belief is not uncommon amongst women experiencing violence, especially when the abuser has not directed any violence towards the children, or when close emotional bonds in the presence of violence skew the perspective of caregivers regarding the potential harm.

Many professionals, including social workers, police, victim support workers, domestic violence counsellors and income assistance workers, were aware of the violence but did not work effectively together to support the family. What this mother needed was a coordinated, collaborative response across all systems with targeted interventions that supported her safety and built her capacity so that she could protect and provide for her children.

This is the Representative's second investigation report that examines systems of support for children and families living in circumstances of domestic violence. The first report, *Honouring Christian Lee – No Private Matter: Protecting Children Living With Domestic Violence*, was released in September 2009.

That investigation looked into the circumstances of the death of Christian Lee, who along with his mother and maternal grandparents, was killed by his father in September 2007, seven months before the deaths of Kaitlynn, Max and Cordon. Like the three children who are the subject of this report, Christian was exposed to domestic violence throughout his life.

In January 2010, in response to the Representative's report on the death of Christian Lee and a coroner's inquest into the murders, the B.C. government, under the leadership of the then Ministry of Public Safety and Solicitor General, announced that it was taking

immediate action to protect victims of domestic violence. A Domestic Violence Action Plan was launched initially under the guidance of a task force of senior inter-ministry officials and later under a Secretariat (Ministry of Public Safety and Solicitor General, 2010). The action plan attempted to address the recommendations made in the Representative's report and those arising from the inquest.

The plan was seen as a step toward a coordinated systemic response to domestic violence by the justice and child-serving systems in the province.

A number of initiatives were undertaken:

- A new domestic violence unit involving child protection, police and victims services was established in Greater Victoria.
- The BC Coroners Service convened a domestic violence death review panel in March 2010.
- The *Best Practice Approaches: Child Protection and Violence Against Women* guidelines for child protection workers was revised in December 2010.
- The policy on Violence Against Women in Relationships was reviewed and updated.
- A standardized provincial risk-assessment tool for police to use in high-risk domestic violence cases was selected.
- A standardized set of bail conditions and terms for high-risk offenders was established.
- A new domestic violence website (www.domesticviolencebc.ca) was established.
- A comprehensive review of the *Family Relations Act* was completed.

Community Coordination for Women's Safety

The Community Coordination for Women's Safety (CCWS) Initiative, managed by the Ending Violence Association of BC, plays a vital role in enhancing the community response to violence against women. This initiative is funded by the Ministry of Justice and works at the community, regional and provincial levels in collaboration with police, criminal and family justice ministries, health, victim services, transition houses, counselling programs and child protection social workers to develop new models or improve existing models of cross-sector coordination.

This CCWS program has been supporting communities in B.C. since 2001. It supports 70 communities at any given time to either start or enhance local cross-sector responses to violence against women and provides training related to improving cross-sector approaches to increasing safety for families struggling with domestic and sexual violence.

In B.C., given the focus in 2010 on domestic violence, it would be reasonable to expect that government would allocate adequate funding and support for coordinated community responses to domestic violence to support women and their children exposed to domestic violence. Dedicated monitoring and public reporting on the impact of policy changes through key indicators are crucial for the successful implementation of systemic policy and practice changes.

The Representative was encouraged when a domestic violence death review panel was convened by the BC Coroners Service in March 2010, but is disappointed that there is no plan to reconvene the panel on a regular basis. These panels review the circumstances of the deaths from a broad perspective, exploring systemic issues and looking for patterns and themes. The panel then makes recommendations to improve service delivery. Similar panels are convened in Ontario. The Ontario committee is a multidisciplinary advisory committee that was established in 2003. The committee annually reviews deaths involving domestic violence and makes recommendations aimed at preventing deaths in similar circumstances.

Although the B.C. government developed a plan that recognized the need for coordination across all systems and consistent tools and policies for assessing and responding to the risk of harm, the Representative was disappointed that not all of the recommendations in the Christian Lee report have been acted upon. While some activities have been undertaken on these recommendations, many are still outstanding.

Government's Response to *Honouring Christian Lee*

In the *Honouring Christian Lee* report, the Representative made several recommendations to MCFD. The first recommendation was that MCFD propose changes to legislation and develop policies, standards and training to provide social workers with clear directions in assessing the safety of children who are exposed to domestic violence.

MCFD indicated that it was not willing to recommend changing the language in the *CFCS Act* to explicitly include children who may be at serious risk of harm due to exposure to domestic violence. In its written response to the Representative the ministry took the view that the current definition is broad enough to include circumstances where children may be at risk due to domestic violence and also believes "listing exposure to violence as a specific reason for a child needing protection may place women and children at greater risk, and act as a barrier to women requesting services" (MCFD, 2010).

The Representative asks MCFD to reconsider that view in light of the findings and recommendations contained in this report, together with the government's recognition of family violence as an important factor in determining a child's best interests, as reflected in the recently introduced *Family Law Act*. The Representative continues to believe that listing exposure to violence as a protective factor would serve to better protect children where it is applied appropriately within the ministry's policies, standards and training.

In terms of changes to policies, standards and training, some work has been done in this area. MCFD updated the *Best Practice Approaches: Child Protection and Violence Against Women* guidelines in November 2010 and advised the Representative that some MCFD child protection workers have participated in advanced risk-assessment training that was implemented in November 2010 when the revised guidelines were released. This training however is a 'one-off' initiative and was limited to a very small number of MCFD staff.

The *Honouring Christian Lee* report recommendation to MCFD also addressed the need for a strategy to screen child protection reports for domestic violence and to record and track these types of reports. MCFD has advised they have accepted this recommendation and in March 2011 added a new factor related to intimate partner violence on their electronic screening assessment tool. The Representative will continue to monitor the implementation of this important step.

The other recommendation specific to MCFD was to strengthen services to immigrant women in circumstances of domestic violence. MCFD reported in May 2010 that they are developing specialized training for front-line staff who work with immigrant women, although the Representative has not received any further detailed information to date and considers this important matter outstanding.

Another recommendation in the report was that the Ministry of Public Safety and Solicitor General (PSSG) take the lead in a special initiative that focuses on the issue of safety and children and youth in domestic violence situations, so that a coordinated, effective and responsive system is in place to respond to these situations throughout B.C. In January 2010, PSSG did take the lead in development of the domestic action plan in response to the Representative's recommendation.

In December 2010, 11 months after B.C.'s domestic violence action plan was launched, government announced that it was complete and had been implemented. The Representative believes that announcement was premature, as an action plan of this complexity and across a number of systems requires long-term commitment, resources and leadership by government.

A clear strategy to evaluate whether the improvements have been implemented and effective or responsive, whether training and coordination is making a direct impact and a long-term evaluation and research agenda is needed to ensure practice keeps pace with evidence. A rigorous evaluation process on any new programs or policies is a must. The Representative understands that an evaluation strategy is currently being developed, but it has not yet been provided to her. The Representative expected to see some key meaningful outcomes and identified measures. Most crucial are timeliness and retention of victim participation in the system.

A training plan, with an allocated budget, is also imperative when implementing any new policies or programs. This would seem especially important when the training involves implementation of a new tool and policies across a number of different disciplines. The new risk assessment tool (Brief Spousal Assault Form for the Evaluation of Risk (B-Safer)) was selected for use in B.C. To date there have been six training sessions held between November 2010 and March 2011, followed by two sessions held by RCMP in April and November 2011.

So far, only 238 participants from police, Crown Counsel, victim services and MCFD child protection from across the province received this training during the first six sessions. Of the 238 staff, 43 were MCFD social workers. Additional training sessions are being offered on an as-needed basis. It is obvious there is no overall plan to ensure that all professionals from various systems that work in domestic violence receive the training. It is concerning that this training is not mandatory.

In her *Honouring Christian Lee* report, the Representative also directed two recommendations to the Ministry of Attorney General. The first was to undertake a review and make changes to the administration of justice in criminal matters involving domestic violence, including considering the establishment of domestic violence courts. The AG ministry has indicated that it is enhancing training throughout the court system, rather than establishing specialized courts.

Currently, there is one domestic violence court in B.C. that arose through collaboration among community partners as a strategy to deal with the high rate of domestic assaults in their community. It was started in the Cowichan Valley and has been in operation since March 2009, when the first court session occurred. The goal of the court is to promote an effective and coordinated response to reduce the incidence, severity and recurrence of domestic violence offences in the community and increased victim participation.

The benefits of specialized courts are seen in evaluations of such initiatives in Ontario, Alberta and Saskatchewan. These type of courts yield better conviction rates, as victims are less likely to recant and more likely to be attached to a system of supports to prevent recurrence of further harm.

The second recommendation was that the AG ministry undertake a review and enact necessary changes to improve the administration of justice in family law matters and domestic violence cases. The Representative is pleased that new legislation was introduced and passed in the House on Nov. 24, 2011.

The *Family Law Act* explicitly defines domestic violence, including references to victims of harassment, stalking and, in the case of a child, indirect or direct exposure to family violence. In addition, there is a new protection order that will limit contact and communication between family members where there is a safety risk. Breaches of

protection orders under the *Family Law Act* will now be a criminal offence with criminal consequences to those who breach.

The best-interest-of-the-child test has been expanded to include exposure to family violence, and the best interest of the child is now the only consideration when decisions affecting the child are made. This new legislation marks a turning point for B.C. in addressing domestic violence and will likely take 12 to 18 months to bring into force.

The Representative is pleased with the new *Family Law Act*, but more needs to be done. The fundamentals of a province-wide domestic violence strategy – or even a full response to the *Honouring Christian Lee* recommendations – are not yet in place. Not enough has been done to adequately address child safety issues in domestic violence circumstances.

The Representative urgently calls for government to make domestic violence a priority and to implement all of the recommendations in the *Honouring Christian Lee* 2009 report, as well as those in the current report, to ensure that children exposed to domestic violence in B.C. will be better protected.

Recommendations

There is ample evidence from many reports, inquiries and reviews about the need for integration and coordination of the child-serving system. The current report highlights again that there really isn't a "system" at all. The reality is that services are delivered by agencies and organizations with very different mandates, policies and training regimes. It is time to focus on ways to overcome the inherent challenges these fractured and incoherent services present for children at risk.

Coordination and integration, essential building blocks of an effective system, are meaningless concepts if professionals engaged in working with vulnerable children and families are not aware of each others' work and mandate.

When it comes to domestic violence, a collaborative, systemic approach across the child-serving, mental health, income assistance, and criminal and civil justice systems still does not exist in B.C. Recent initiatives have helped to make some improvements to some aspects of the services, but serious issues remain. Initiatives in recent years, while positive, are not sufficient in addressing the gaps.

Today in B.C., the responsibility for domestic violence policy remains with the Ministry of Justice. A Violence Against Women Steering Team, whose members include senior representatives from across government, meets on a quarterly basis to network and share information on domestic violence issues. There is no Secretariat leading the domestic violence agenda in this province. Key outcomes in the ministries of Justice, Children and Family Development and Education are not identified, measured or coordinated, although domestic violence remains a critical issue for B.C. The responsibility rests with a division

within a ministry, when it really needs dedicated senior leadership to coordinate, monitor, evaluate and champion the much-needed changes to the system of services across government.

Adult mental health professionals, along with child and family workers within MCFD and the community, need to keep a close focus on the safety and well-being of children when untreated mental illness creates a situation of violence, chaos, and disruption in the life of a family.

Schoenborn's entry into adult mental health services provided an opportunity to identify vulnerable children and a troubled family, to monitor risk and enable early intervention. This did not happen, and as a result, Kaitlynn, Max and Cordon were often unsafe, and isolated except for their mother's care. While a few professionals did identify untreated mental illness and family violence as major factors of risk in their lives, there was no well-coordinated system in the places they were living to plan for their safety and keep a steady gaze fixed on their well-being.

Had the recommendations put forward in the Christian Lee report been fully implemented, we would have more effective mechanisms in place today to support families in B.C. like this one. Although the adult mental health system was not a key factor in the Christian Lee report, those recommendations would have helped to identify the factors which, in association with untreated parental mental illness, increased the risk to the children's safety and welfare. It is not uncommon in child protection that substance abuse, domestic violence and parental mental illness are issues. Addressing them requires dedication, focus and effective collaboration across a range of systems.

The Representative makes the following recommendations to build on those already made in the Christian Lee report. The Representative is not satisfied with the implementation of those previous recommendations to date, and views this as an opportunity for government to show effective leadership on this subject across ministries. The following additional areas arise from this case and may serve to prevent future tragedies.

Jurisdictions around the world have recognized the importance of providing a complete continuum of services to families where a member has a mental disorder. The Representative has drawn from Australian work on this issue. In that country, resources, programming, publications, research and a network of services serve to strengthen robust national and state policy frameworks.

In this report the Representative makes two key systemic recommendations. The first is about increasing focus on family-oriented and family-sensitive practice in the adult mental health system to ensure the care and protection of children and family members. The other is about an overarching strategy to improve the supports and services to families who are in the grip of domestic violence.

Key Recommendations

Recommendation 1

That the Ministry of Health, in partnership with the Ministry of Children and Family Development, take immediate steps to ensure that all staff and professionals connected to their systems understand the risk factors relating to children of parents with a serious untreated mental illness, and promote the well-being of children by:

- a) putting in place procedures for the identification at intake in the health care system or child-serving system of the parental role of people with a mental illness, including expectant parents
- b) developing and implementing policies and procedures to support workers to identify and reduce risk factors for children affected by parental mental illness and domestic violence
- c) ensuring appropriate information regarding referral to services for families affected by parental mental illness without abdicating the focus on child safety
- d) developing and implementing policies for early detection of risk factors for families associated with mental illness (e.g., social isolation, frequent moves, emotional and financial instability, violent episodes).

Detail:

Improvements should include:

- policies and standards for identifying and managing cases where serious parental mental illness may jeopardize the safety and well-being of children, taking into account concurrent substance abuse
- provision for an active outreach and monitoring program across the province, and identifying and monitoring for factors which may increase the risk
- ensuring that children who have been traumatized are referred to and engaged with the child and youth mental health system
- provision for a consultation service for social workers and other professionals involved with the child so that they can better understand the dynamics in the home
- mechanisms to ensure effective links with child protection and child and youth mental health services at the local level
- ensuring this report will be used to promote practical learning in the adult mental health system across the province and among policy staff in the ministry.

A plan should be finalized by Sept. 3, 2012, and a first progress report to the Representative on implementation of the plan should be made by Dec. 31, 2012.

Recommendation 2

That the Government of British Columbia take the following actions to demonstrate a renewed and serious commitment to protect children who are exposed to or are living in circumstances of domestic violence. This means identifying and closing the gaps in policies and practices across government programs and services that touch the lives of children, including child welfare, adult mental health, criminal and family justice systems, police, victim services, education and income assistance.

Detail:

A meaningful commitment requires that deficiencies not currently addressed by recent government actions or existing government committees be addressed:

- adequate additional funding
- appointment of a permanent lead or agency of government with sufficient authority across government to be accountable for delivering on a comprehensive approach
- continuous evaluation and regular public reporting of outcomes.

The following key components must be improved in order to ensure better protection of children and support of families:

- standardized risk and safety assessment tools
- domestic violence policy and legislation, including transparency and sharing of domestic violence orders and accountability of offenders
- victim support and safety planning, including access to housing and practical supports for victims of domestic violence and their children
- information sharing, coordination and collaboration amongst all components of the system.

A comprehensive plan should be finalized by Sept. 3, 2012, and all aspects of the plan should be implemented by April 2, 2013.

The Representative also makes the following recommendations for improvements to specific components of the system. There are significant opportunities for inter-ministry and other collaborations. However, the Representative will seek reporting and accountability for recommended action from each public body named.

Ministry-Specific Recommendations

Recommendation 3

That the Ministry of Children and Family Development reconsider its previous unwillingness to implement a key recommendation in the *Honouring Christian Lee* (2009) report. That recommendation asked the ministry to "propose required changes to legislation, and develop policies, standards and training to provide social workers with clear direction in assessing the safety of children who are exposed to domestic violence."

Addressing that recommendation requires explicit provisions in child protection legislation and standards for responding when children are exposed to domestic violence.

Legislative changes should be made as soon as possible, and no later than March 30, 2013.

Recommendation 4

That the Ministry of Children and Family Development develop and implement a comprehensive plan to improve the capacity of social workers and child and youth mental health professionals to protect and support children who are living in circumstances of domestic violence.

Detail:

Improvements should include:

- training of all front-line social workers and supervisors in the dynamics of domestic violence
- clear case management standards and policies, including case transfer processes when families move
- requirements to engage and involve fathers in planning
- development of a mechanism in the office of the Provincial Director of Child Welfare to monitor and identify high-risk cases and provide specialized consultation to designated directors, supervisors and staff in complex cases
- mechanisms to ensure effective links with the adult mental health system at the local level
- standards for child and youth mental health services
- accessible mental health services for children who have been traumatized by domestic violence
- ongoing monitoring of the well-being of those children
- ensuring this report will be used to promote practical learning across the child-serving system and for policy staff in the ministry.

The plan should be finalized by Sept. 3, 2012, and a first progress report to the Representative on implementation of the plan should be made by Dec. 31, 2012.

Recommendation 5

That the Ministry of Children and Family Development develop and implement a comprehensive training plan for supervisors on providing clinical supervision to child welfare workers.

Detail:

The plan should include:

- pre-appointment training and certification for supervisors, with a strong emphasis on supporting and mentoring front-line staff on decision-making and caseload management
- clearly identified supervisory competencies
- performance appraisal linked to ongoing assessment of competencies
- clear standards and policies for clinical supervision of child protection social workers
- a strategy specific to providing supervision and management of complex, high-risk cases.

A plan should be finalized by Sept. 3, 2012, and a first progress report to the Representative on implementation of the plan should be made by Dec. 31, 2012.

Recommendation 6

That the Ministry of Education develop and implement a plan to improve the capacity of school personnel to support and protect children who are living in circumstances of domestic violence.

Detail:

Improvements should include:

- domestic violence training for school personnel
- reliable mechanisms to ensure that schools have copies of bail orders, protective orders or supervision orders, and to ensure notification of the school when those orders are changed or lifted
- training of school personnel as to the appropriate steps to be taken should they be concerned that orders are being breached or child safety is in jeopardy
- age-appropriate education of students about domestic violence and parental mental illness, and about supports and services available to them
- ensuring this report will be used to promote practical learning across the education system and for policy staff in the ministry.

The plan should be finalized by Sept. 3, 2012, and a first progress report to the Representative on implementation of the plan should be made by Dec. 31, 2012.

Recommendation 7

That the Ministry of Justice develop and implement a plan to improve legal processes related to domestic violence cases and successful prosecutions of such cases.

Detail:

Improvements should include:

- establishment of specialized domestic violence courts
- full implementation of the *Family Law Act* as soon as possible
- priority for matters involving family violence, including timely investigation, prosecution, sentencing and holding offenders to account for breaches of orders
- effective monitoring and timely enforcement of orders relating to domestic violence by police, bail supervisors and other officials
- a training program on the effective use and monitoring of various types of protection orders for social workers, school personnel, victim services workers and others who work with children who live in circumstances of domestic violence
- ensuring this report will be used to promote practical learning across the justice system, including police, prosecutors and the legal profession, the judiciary and probation staff, and policy staff in the ministry.

The plan should be finalized by Sept. 3, 2012, and a first progress report to the Representative on implementation of the plan should be made by Dec. 31, 2012.

Recommendation 8

That the Ministry of Social Development develop and implement a plan to improve the capacity of the income assistance program to contribute to the protection of children who are living in circumstances of domestic violence by improvements to its services to the families.

Detail:

Improvements should include:

- improving compliance with policies related to cases where domestic violence is a factor
- a mechanism for flagging and monitoring of cases where domestic violence is a factor
- appointment of a single specialized case manager for clients fleeing domestic violence, where vulnerable children may be at risk
- training on domestic violence and policies regarding services to victims of domestic violence
- ensuring this report will be used to promote practical learning for income assistance and policy staff.

The plan should be finalized by Sept. 3, 2012, and a first progress report to the Representative on implementation of the plan should be made by Dec. 31, 2012.

Conclusion

This investigation into the deaths of three children paints a distressing picture of the lives and deaths of Kaitlynn, Max and Cordon. They drew little attention to themselves as they coped throughout their short lives, with parental mental illness, violence, substance abuse and unpredictability in their home. The public services that had a duty to protect them and a duty to support them failed. The Representative found that these deaths were preventable.

This investigation found severe deficiencies in child protection practice, and practice issues generally across all of the components of the services and processes that touched the lives of the children and their family. The nature and extent of the father's mental illness was left unaddressed, even though it was clearly identified as a significant issue when the ministry first had contact with the family in 1999. Further, there was little evidence of an integrated approach to domestic violence, even though it is a persistent undercurrent of investigations and a regular area of practice for a range of officials in policing, justice systems and community agencies. A frustrating and sometimes fatal concept continues to exist in the child-serving system that a mother in a dangerous domestic violence situation is capable of and responsible for shouldering the staggering responsibility of protecting her children.

Children who are living in homes where there is domestic violence and untreated parental mental illness live in complicated and frightening circumstances, often hidden from others outside the home. When their circumstances come to light, a seamless system of collaboration is required to ensure their safety. Child protection officials, the adult mental health system, police and the criminal justice system, and income assistance services must work together and must be able to depend on each other to play their part. They must be well-trained and understand the dynamics of domestic violence and parental mental illness. They must also apply that understanding in the decisions they make, individually and collectively, keeping their focus on the children at all times.

The issues identified in this case are clearly systemic issues. They are not a matter of isolated failures to act according to well-articulated, well-structured, child-centred approaches. The lack of those approaches is what set the stage and led to the troubling events in this case as it unfolded over a period of years. It is abundantly clear that most of those involved did not understand the dynamics of domestic violence and the inherent risk of an untreated mental illness, and did not have a clear understanding of what was required to keep the children safe or support their mother in keeping them safe.

An investigative report like this takes the distressing but essential path of closely examining the experiences of a family enduring suffering, violence and untreated parental mental illness. This eventually led to the deaths of three innocent children. By then turning the investigative eye on the services provided to this family, we can begin to move towards elements of the necessary solutions.

We cannot change what has happened. But it is essential to push for societal change in the way we see things, and systemic change in the way we address domestic violence and mental illness.

The Representative's recommendations in this report echo and amplify those made in her report *Honouring Christian Lee*. These recommendations describe the improvements required if B.C. is to meet our duty to protect and our duty to support children who live with domestic violence.

The legacy of Kaitlynne, Max and Cordon must not be their senseless and violent deaths, but that other B.C. children are better protected in the future.



Glossary

After Hours office: the Ministry of Children and Family Development office that receives and responds to child protection reports outside of regular business hours.

Appearance notice: a notice served by police to the accused at the time of the alleged offence, directing the accused to appear in court on a specific date.

Assessment: the process of collecting information on children and families in order to make informed decisions. Different supports, programs and services may be chosen depending on the outcome of the assessment.

Aid for Safety Assessment and Planning (ASAP): A manual to support victim service workers and transition houses to identify the range of conditions that may affect a woman's safety. There are 11 abuser actions and 12 safety support factors that need to be considered and implemented when developing a safety plan.

Bail: (also known as judicial interim release) is an assurance to the court that the accused will appear in court when required to do so and that the accused will comply with any conditions set by the court.

Bail supervisor: a person who manages the accused before the trial.

Bench warrant: may be issued by a judge for the arrest of an accused person or a properly served material witness who has not appeared in court as required.

BSAFER (Brief Spousal Abuse Form for Evaluating Risk): An assessment tool that helps users to identify 10 risk factors when evaluating risk.

CPIC: Canadian Police Information Centre is composed of five distinct service areas that are responsible for the delivery and sharing of national police, law enforcement, criminal justice, and public safety information. The CPI Centre is operated by the RCMP under the stewardship of National Police Services, on behalf of the Canadian law enforcement community.

CSM: Community Services Manager for the Ministry of Children and Family Development.

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

Delusional disorder: an illness characterized by the presence of non-bizarre delusions in the absence of other mood or psychotic symptoms (DSM IV-TR). It is on the spectrum between more severe psychosis and overvalued ideas. Overvalued ideas represent unreasonable beliefs that are not firmly held. Non-bizarre delusions are typically beliefs of something occurring in a person's life which is not out of the realm of possibility. Apart from the impact of the delusion(s), functioning is not obviously odd or bizarre.

Judicial Interim Release (commonly known as bail): an assurance to the court that the accused will appear in court when required to do so and that the accused will comply with any conditions set by the court.

Peace bond: (legally known as a **Section 810 recognizance**) a protection order issued by a criminal court to help protect one person from another.

Probation Officer: peace officers who supervise persons in conflict with the law. Their goals are to reduce the likelihood of offenders engaging in further criminal activities.

Protective intervention order: means an order made under section 28 of the *CFCSA*.

Recognizance: an obligation entered into before a court whereby the accused person acknowledges that he or she will do some act required by law that has been specified.

Reviewable Service: Reviewable services are services or programs under the *Child, Family and Community Service Act* and *Youth Justice Act* and include mental health and addictions services for children. The Representative's authority to initiate a review or investigation is limited to reviewable services.

Risk: refers to the likelihood that some form of violence will take place in the future. Decisions about risk involve consideration of the imminence, nature, frequency and seriousness of the violence. Any judgements must consider who, what, where and the how of violence.

Summons: an official notice from the court requested by police, directing the accused to appear in court on a specific date.

Supervised bail order: a condition which requires the accused to report to a bail supervisor or probation officer.

Surety: a person who agrees in writing with the court to be responsible for the accused by making sure the accused appears in the court at a specified time and follows bail conditions.

Tele-bail: bail either by video conferencing or by audio conferencing – is a program that the provincial government has introduced in order to expedite a bail hearing so that those persons who are arrested by the police after hours, when courts are closed, will have access to justice.

Undertaking: a form of bail release in which the defendant undertakes to attend court and to comply with any terms and conditions that have been established for the purpose of release.

Unsupervised bail order: no condition attached to an order that specifies that correctional authorities supervise the accused.

Appendix A: Representative for Children and Youth Act

Section 12 of the *Representative for Children and Youth Act* (2006) authorizes the Representative for Children and Youth to conduct reviews of critical injuries and deaths of children in care or receiving services from the Ministry of Children and Family Development. Section 15 authorizes the establishment of a Multidisciplinary Team to provide advice respecting reviews and investigations.

Investigations of critical injuries and deaths

- 12 (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) the reviewable service or the policies or practices of the ministry or other public body responsible for the provision of the reviewable service 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.

Appendix B: Documents Reviewed and Interviews Conducted During the Representative's Investigation

Police/RCMP records

- Records from 13 communities

Ministry of Children and Family Development Records

- Mother's Family Service file
- Practice audits records (2003-2010)
- Provincial office file
- Comprehensive Case Review

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

- Child and Family Service Standards, November 2003
- Quality Assurance Standards, May 2004
- Best Practice Approaches, Child Protection and Violence Against Women, May 2004 and November 2010
- Inter-Regional Protocol, Transfer of Authority Between Directors, A Reference Guide, February 2005

Contracted Service Agency Records

- Mother's files
- Father's files

Medical Records

- Mother's hospital and Pharmanet files
- Father's hospital and Pharmanet files
- Father's files from medical clinics
- Father's files from psychiatric assessment

Ministry of Attorney General Records

- Provincial and Supreme Court proceedings and orders

Ministry of Social Development Records

- Mother's file
- Father's file

Ministry of Public Safety and Solicitor General Records

- Father's Community Corrections files

BC Coroners Service

- Kimble reports for the three children

Ministry of Education Records

- Education records for the three children

School Records

- Records for the three children

Legislation and Regulations

- *British Columbia Representative for Children and Youth Act* (2006). Victoria, BC: Queen's Printer.
- *British Columbia Child, Family and Community Service Act* (1996). Victoria, BC: Queen's Printer.
- *Alberta Child, Youth and Family Enhancement Act* (2000). Edmonton, AB: Queen's Printer.
- *Mental Health Act*, (1996). Victoria, BC: Queen's Printer.
- *Employment and Assistance Regulation, B.C. Reg.263/2002, s.4.1(4)(e).*

Other Materials

- Violence Against Women in Relationship Policy, Ministry of Attorney General/Ministry of Public Safety and Solicitor General, 2004 and 2010

Interviews Conducted in this Investigation

- Ministry of Children and Family Development staff (12)
- School staff (3)
- Ministry of Public Safety and Solicitor General staff (5)
- Ministry of Employment and Income Assistance staff (2)
- Police officers (5)
- Contracted agency staff (2)
- Family members (2)

Appendix C: Multidisciplinary Team

Under Part 4 of the *Representative for Children and Youth Act* (see Appendix A: Representative for Children and Youth Act) the Representative is responsible for investigating critical injuries and deaths of children who have received reviewable services from the Ministry of Children and Family Development (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 development disabilities
- Public health

Multidisciplinary Team Members⁶

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

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

Karen Blackman – Ms. Blackman is the Senior Director of Practice Support and Quality Assurance with the Ministry of Children and Family Development. She has 21 years of experience including work as a social worker, team leader, practice analyst and community services manager in the ministry. Ms. Blackman holds a Bachelor of Social Work degree and a Master of Arts in Leadership and Training.

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.

Ruby Fraser – Ms. Fraser is Regional Director, Quality and Risk Management for the Northern Health Authority, monitoring health care incidents across the continuum from community to acute care.

Jim Gresham – Supt. Gresham is the Superintendent and Officer in charge of the RCMP E Division Major Crime Section. He has been a plainclothes investigator involved since 1991 in the investigation of crimes against persons, including homicides and historical unsolved homicides. He is a member of the E Division Major Case Management Committee, and an accredited Team Commander for the investigation of Major Crimes.

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.

⁶ As at the time this Report was being developed.

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

Sharron Lyons – With 32 years in the field of pediatric nursing, Ms. Lyons currently works as a Registered Nurse at the BC Children's Hospital, is past-president and current treasurer of the Emergency Nurses 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 like the BC Crime Prevention Association, the Youth Against Violence Line, the Block Parent Program of Canada and the BC Block Parent Society.

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

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

Appendix D: Brief History of Domestic Violence Policy

The evolution of BC and Canadian Responses to Violence Against Women in Relationships: Significant Dates⁷

- 1929** - Canadian women are finally included within the legal definition of "persons."
- 1964** - The Criminal Code is amended so that a woman who is beaten by her husband no longer has to prove a greater degree of bodily harm than a person assaulted by a stranger.
- 1968** - Victim impact statements begin to be used on a limited basis in cases of violence against women in relationships in Canada.
- 1970** - The Canadian Commission on the Status of Women issues its report on the economic, social, legal, and political status of women in Canada.
- 1972** - The first transition house and the first sexual assault centres open in B.C. The B.C. government passes the *Criminal Injury Compensation Act*, allowing victims of crime who have suffered a personal injury to apply to the Workers Compensation Board for compensation.
- 1974** - Victim/offender reconciliation programs and compensation programs for victims are established across Canada and funded through federal/provincial cost-sharing agreements. The first police-based victim services programs begin operating in B.C.
- 1981** - *Wife Battering: A Report on Violence in the Family* is submitted to Parliament by the Standing Committee on Health, Welfare and Social Affairs. The statistic that one in 10 Canadian women experience some form of battering by a husband or boyfriend shocks the country.
- 1982** - The Solicitor General of Canada issues a directive instructing the RCMP to recommend or lay charges in cases of spouse assault where reasonable and probable grounds exist.
- 1983** - The B.C. Ministry of Attorney General approves the first *Wife Assault Policy*, which directs police to initiate a charge where there is evidence that a spouse or partner has been assaulted and to strongly encourage Crown Counsel to lay charges.

⁷ This list of key dates was originally compiled by Linda Light in 2005 for the Ministry of Public Safety and Solicitor General and updated in April 2011 for the Representative for Children and Youth.

- 1984** - B.C.'s Ministry of Attorney General implemented a new justice system policy on violence against women in relationships, called the *Wife Assault Policy*. This policy has been updated and revised several times since that time.
- 1986** - The Solicitor General of Canada provides funding to select police agencies across Canada for police-based victim assistance programs. Vancouver and New Westminster receive funding.
- 1987** - The BC Victim Assistance Program is formed and funded, and existing programs are consolidated into this program.
- 1989** - New federal legislation allows a victim surcharge and victim impact statements to be presented at the time of sentencing.
- 1990** - Wife assault coordination committees are funded in seven B.C. communities.
- 1992** - The BC Task Force on Family Violence releases its report, *Is Anyone Listening?* The report leads to funding for Sexual Assault/Woman Assault programs, Stopping the Violence Counselling Programs, and Children Who Witness Abuse programs.
- 1993** - The *BC Wife Assault Policy* is revised and updated as the *Violence Against Women in Relationships Policy*. The Criminal Code is amended to include a new offence of criminal harassment to address stalking. The "K" files flagging system is introduced to facilitate tracking of VAWIR cases by police and Crown.
- 1994** - The *Victims of Crime Act* is proclaimed in B.C. and the *Criminal Injury Compensation Act* is updated to include criminal harassment, uttering threats, criminal injuries at work, and support for immediate families of deceased victims.
- 1994-95** - The Protection Order Registry is introduced.
- 1996-97** - New Westminster and Vancouver police establish Domestic Violence and Criminal Harassment Units, with police and social workers working together from the same location to support victims of domestic violence and their children.
- 1998-99** - Enhancements are made to the BC Protection Order Registry facilitating victim notification.
- 1998** - Ministry of Attorney General responds to the Coroner's Inquest into the tragic shooting in Vernon, B.C. by ordering more in depth training for police, Crown, probation and victim service workers; tougher screening and review processes for all gun permits, licence and certificate applications; improved electronic linkages between policing jurisdictions, and educational resources on violence against women in different languages.
- *Enhanced Investigative and Interviewing Skills: Violence Against Women in Relationships Training* is delivered for police in six regions of the province.
 - *Criminal Harassment Interdisciplinary training* is offered province wide for police, victim service workers, probation and transition houses.

- *Priority Response Partnerships* for women at high risk of violence are established to encourage police, community and private sector coordination in keeping women safe. The program includes home alarms, and cell phones that link in directly to call centres in police detachments and high risk community protocols.
 - Ministry of Attorney General and BC Justice Institute host a *Community Safety Audit Forum* to bring together criminal justice staff and victim service agencies with Dr Ellen Pence from Duluth, Minnesota, to discuss safety and accountability audits.
- 1999** - Bill C-79 introduces Criminal Code amendments to strengthen the voice of victims.
- Work begins to define a coordinated risk assessment and victim safety strategy for cases of violence against women in relationships. *Managing Safety by Knowing the Risks, Current Dilemmas in Improving Women's Safety* is distributed to encourage discussion on the need for consistency in the management of risk between all justice sectors.
 - RCMP revises their operational policy *Violence in Relationships/Violence Against Women in Relationships/Criminal Harassment* emphasising the criminal nature of the crime, vigilant investigation and increased sensitivity where victims have cultural or specific communication needs. Members are cautioned to ensure they are aware of gender dynamics and accepting an argument of mutual aggression rather than determining who is the most at risk and who should be arrested. A primary aggressor analysis is introduced into all police training.
- 2000** - The Attorney General's *Violence Against Women in Relationships Policy* is revised to address Criminal Code amendments allowing police to set conditions upon release of the accused in certain circumstances.
- *The High Risk Offender Community Notification Advisory Program* is established to assist justice agencies to determine whether an offender's presence in the community merits restrictions on his behaviour or public notification.
 - *MPSSG makes grants available to selected communities to conduct feasibility studies on Domestic Violence Units.*
- 2001-2** - BC Law Courts Education Society and BC Victim Services, Ministry of Public Safety and Solicitor General launch *Joining Hands Against Domestic Violence* an Integrated Domestic Violence Training Manual for the National Prosecuting Authority of South Africa.
- 2003** - Amendments are made to the BC Crown charging policy in violence against women cases.
- *Final Report of the Ad Hoc Federal/Provincial/Territorial Working Group Reviewing Spousal Abuse Policies and Legislation* is released.
- 2004** - A revised edition of *Criminal Harassment: A Handbook for Police and Crown Prosecutors* is published by the Department of Justice Canada.
- 2005** - *Police Release on a Promise to Appear with an Undertaking in Violence Against Women in Relationships Cases* guidelines are released by Police Services Division and BC Chiefs of Police are directed to amend their operational policies to be consistent with these guidelines.

- *BSAFER (Brief Spousal Assault Form for Evaluating Risk)* is adopted by the BC Chiefs of Police as the standardized risk assessment tool for use in the province.
- 2005-6** - *The Aid for Safety Assessment Manual (ASAP)* is pilot tested in communities and interdisciplinary orientation sessions are provided on risk assessment and victim safety planning.
- *ASAP Protective Measures for Women's Safety: An Operational Framework for Interveners (A Companion Guide to Aid for Safety Assessment and Planning)* is released as a draft document to guide actions that can be taken by front-line workers, justice system personnel, health care personnel and other interveners to help protect women from further harm.
- 2006** - Ministry of Public Safety and Solicitor General in conjunction with RCMP prepares a response to a Coroner's Inquest into two tragic deaths. *The Nanaimo Action Plan* identifies 17 actions the ministry will take in response to violence against women in relationships and how the ministry will collaborate with police and victim service associations on initiatives to improve policy, practice and training
- MPSSG provides funds for a small provincial/community partnership to identify critical/desirable elements of a specialized response to violence against women in relationships with the intent of enhancing the policy and program direction in British Columbia.
 - The Centre for Leadership and Community Learning, Justice Institute of BC releases *Police Classification of Sexual Assault Cases as Unfounded: An Exploratory Study*, funded by the Federal Department of Justice, the BC Ministry of Community Services and MPSSG.
- 2007** - *Referral Policy for Victims of Power-based Crimes: Family Violence, Sexual Assault, and Criminal Harassment* issued to remind police and Victim Service Programs of legislation, policy and contractual requirements regarding referrals for victims of family and sexual violence cases (power-based crimes).
- *Aid for Safety Assessment and Planning Manual* is distributed to all victim service workers, transition house workers and Stopping the Violence counsellors.
 - Ministry of Public Safety and Solicitor General and RCMP create a *Domestic Violence Unit Best Practices Advisory Committee* to guide the development of emerging Domestic Violence Units in B.C. to ensure consistent standards and best practices.
 - Ministry of Attorney General, Criminal Justice Branch hosts a *Crown Counsel Domestic Violence Seminar* with Dr Lori Haskell on *Complex Post Traumatic Stress Disorder* and Dr Stephen Hart on *Domestic Violence Risk Assessment and Management*.
 - BC Law Courts Education, Ethiopian Women Lawyer's Association and BC Ministry of Public Safety and Solicitor General launch pilot of *Joining Hands Against Domestic Violence Integrated Domestic Violence Training in Ethiopia*. This training is based on models of training in B.C.

- 2008** - *Keeping Women Safe: Eight Critical Components of An Effective Justice System Response to Domestic Violence*, prepared by the Critical Components Project Team, is released by the Ending Violence Association of BC (EVA). This report provides a comprehensive approach for an effective specialized justice response to domestic violence. The eight critical components and recommendations are based on research and evaluations of coordinated approaches to service delivery for victims and offenders. This paper was submitted by EVA to the coroner's jury in the Lee/Park Inquest.
- *Domestic Violence Response Assessment Funds* were made available to communities to conduct a needs assessment and design pilot initiatives for specialized responses to domestic violence. The funding was based on the premise that communities with realistic, coordinated and/or innovative service delivery models improve the safety of women and children because of their consistent responses, effective planning, and collaborative action. The funds could be used to plan for domestic violence units, domestic violence response teams, dedicated police officers, dedicated court days, community protocols and/or community safety coordination committees.
- 2009** - Ministry of Public Safety and Solicitor General releases an exploratory study *Police Reported Spousal Violence Incidents in BC in Which Both Partners are Suspects /Accused*, in response to concerns expressed by victim service programs about the perceived high levels of police-reported incidents where both partners are named as suspects. The study highlights significant variation from jurisdiction to jurisdiction with respect to incidents where both partners are named as suspects and confirms that higher proportions of dual suspects in these cases are likely to result in lower charging rates.
- Collaboration begins for an online police training program on domestic violence in partnership with the Canadian Police Knowledge Network.
 - A comprehensive review of research on risk and safety, coroner's reports, and innovative models of risk and safety management practices is announced by MPSSG. The review is to inform and guide discussion on how to ensure that safety assessment and risk management are integrated into interventions by justice personnel and contracted victim services.
 - A *Domestic Violence Cross-System Monitoring and Data Collection Feasibility Project* is announced by MPSSG, in collaboration with the Ministry of Attorney General and the FREDA Institute at Simon Fraser University.
 - MPSSG releases a *Community Framework for Maximizing Women's Safety* to assist communities in assessing progress and gaps in coordinated responses in cases of domestic violence.

2010 – A Domestic Violence Action Plan is released in response to recommendations from the Lee/Park coroner’s inquest and the Representative for Children and Youth’s report on the death of Christian Lee. The focus of the action plan is enhancing and integrating the response to domestic violence by the justice system and partners.

- Ministries of Public Safety and Solicitor General, Attorney General, and Children and Family Development release a revised *Violence Against Women in Relationships Policy*. This updated policy fulfils a commitment under the provinces Domestic Violence Action Plan.
- *A Protocol for Highest Risk Domestic Violence Cases (VAWIR Policy)* is released to enhance case coordination and information sharing among justice and partners.
- MCFD updated the *Best Practice Approaches: Child Protection and Violence Against Women* guidelines for social workers.

2011 – A new web-based training curriculum on safety planning is developed by the Ministry of Public Safety and Solicitor General in partnership with the BC Ending Violence Association and BC Society of Transition Houses. Release date pending.

Fig. 1: Factors for Consideration when Assessing Domestic Violence*

Service and System Factors	Victim Safety Factors	Offender Factors
<ul style="list-style-type: none"> • Accessibility and responsiveness of services • Information to victim on case status and services • Notification of offender release to victim • Protocols for referrals, case management and information sharing 	<ul style="list-style-type: none"> • Fear, perception of future violence and personal safety • Status of relationship • Living situation, social and physical isolation • Health impacts of abuse/ medical attention • Pregnant or in early stages of mothering • Children in need of protection • Children exposed to violence • Barriers created by attitudes and beliefs • Employment or financial concerns 	<ul style="list-style-type: none"> • Abuser’s violence • Violent threats, ideation, intent • Escalation of physical/ sexual violence or threats • Violations of civil or criminal court orders • Negative attitudes • Other criminality (e.g., violent offences, alcohol/ drug offences, violations of conditional release) • Response to shifts in power and control dynamics • Employment or financial problems • Substance use • Mental health challenges

*Adapted from BSAFER and ASAP risk assessment tools

Keeping Women Safe: Eight critical components of an effective justice response to domestic violence

The following critical components are needed for an effective, specialized response to domestic violence:

- 1) Managing risk and victim safety – comprehensive, coordinated approach to risk and safety assessment and victim safety planning
- 2) Offender accountability – appropriate and consistent sentencing, enforcement of protection orders, and accessible treatment for abusers
- 3) Specialized victim support – comprehensive, proactive, and timely support with outreach and access for marginalized groups
- 4) Information sharing – consistent, timely information sharing between agencies and with the victim
- 5) Coordination – coordination and collaboration at all levels among relevant sectors
- 6) Domestic violence policy – consistent informed approach to charging, prosecution, and offender accountability
- 7) Use of specialized expertise – dedicated justice system personnel, court time and specialized training
- 8) Monitoring and evaluation – integral part of all the critical components and a systematic, comprehensive approach to collection, analysis, and publication of statistics across all justice system components

Source: Critical Components Project Team-Light, L., Ruebsaht, G., Turner, D., Novakawski, M., Walsh, W. (2008). *Keeping women safe: Eight critical components of an effective justice response to domestic violence*.

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