



REPRESENTATIVE FOR
CHILDREN AND YOUTH

Isolated and Invisible:

When Children with Special Needs are Seen but Not Seen

June 2011

June 27, 2011

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

Dear Mr. Speaker,

I am pleased to submit the report "*Isolated and Invisible: When Children with Special Needs are Seen but Not Seen*" to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of critical injuries and deaths of children receiving reviewable services.

Sincerely,

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

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Mr. E. George MacMinn, QC
Clerk of the Legislative Assembly

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

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Executive Summary

This investigation focuses on the critical injury of a 15-year-old girl with special needs. The investigation began after this developmentally disabled girl was found alone with her dead mother. Neighbours, concerned that they hadn't seen the girl and her mother for many days, looked through a front window and saw the girl on the floor beside the body of her mother. The mother had been deceased for an undetermined length of time, possibly seven days.

It is heartbreaking to envision the torment of a girl with limited intellectual ability trying to understand what was occurring, while also trying to nurture her dead mother. The emotional trauma and confusion she experienced was evident as she variously said to service providers afterwards "mom sleeping" or "mom dead." The girl suffered health problems from the incident as well. She was dehydrated and suffered stomach problems when regular eating resumed.

While that incident alone is so very disturbing, the Representative's investigation has found that details of this girl's life circumstances prior to her mother's death are also troubling. The neglect of her needs over a very long period of time, for weeks and months before her mother's death, was significant. This raises broader questions regarding the quality, accessibility and effectiveness of B.C.'s services to children with special needs. Assessment, planning and services were inadequate to meet her needs. Is this happening to other developmentally disabled children in our province? The child-serving system needed to do much better for this girl and, in the future, for other families who have children with special needs.

This report examines the adequacy and responsiveness of the Ministry of Children and Family Development (MCFD) in supporting this vulnerable girl, in their roles of providing both child protection services and child and youth with special needs (CYSN) services.

The girl was diagnosed at birth with Down syndrome and other developmental disabilities. Throughout her life, she and her family had a range of support services through MCFD and Community Living British Columbia (CLBC).

This report focuses on a period of three years and nine months – the time from when the first child protection report regarding this girl and her mother was made to the ministry (December 2006), until when the girl was found at home with her deceased mother (September 2010).

During this time the ministry received four child protection reports, including two in the last four months of the mother's life.

Service providers paint a picture of a troubled yet loving single parent doing the best she could, described by one medical professional as coping, but just barely.

Professionals involved with the family said the mother was often friendly and welcoming to them on their visits, and grateful for food dropped off. They said she'd often put a positive spin on everything despite her difficult financial and health circumstances. But things began to unravel for her when the loss of the use of her car meant the loss of her two jobs, rent becoming overdue, and a downward spiral into isolation.

Because she was the sole caregiver for her daughter with special needs, this downward spiral also had significant negative consequences for her child. The mother's struggles with poverty and her own significant health and personal issues meant that seeking a full life for her child was overshadowed by striving for their basic necessities of life. Indeed, her struggles and personal issues also meant that others who *should* have had a singular focus on the well-being of the daughter were instead oblivious to the girl's needs, focusing on the mother's challenges instead.

The girl existed for an unknown length of time in a world gone quiet, because no one checked if her hearing aids were working. She also had other significant unmet medical needs, and there were no plans in place to manage these. Over the last three years, the mother and the girl were seeing physicians less, not more, even as their medical needs steadily increased and became more complex.

The girl missed far too much school, another situation where observations by professionals can often result in needed interventions. As well, the end of the girl's increasingly infrequent overnight visits with a caring and concerned respite worker – a person who had genuine affection for the girl – meant the loss of yet another important support. The child and her mother became virtually confined inside their home for long periods of time, and more and more isolated.

Parents of children with special needs are often required to understand a variety of complex service information in order to identify, access and make informed choices about ways to best address their child's needs. There are not enough supports available for parents and caregivers who cannot meet the expectations of this complex system, or who do not wish to or are unable to navigate the spectrum of services on their own. This investigation shows the sad, full results of the inevitable breakdown when such a parent does not receive the essential support of service providers and their communities.

All children with special needs must be given full opportunities to live fulfilling and rich lives. They must also be afforded their right to have equal access to the same programs, supports, opportunities and hopeful futures as others.

They should be encouraged, as all children should be, to explore sports, music and arts, to participate in and enjoy school, to socialize with friends and relatives, and to participate fully in community activities in order to optimize their right to be included and accepted.

These equal opportunities must be a reality for children and youth with special needs. But when parents or caregivers face challenges of their own, others must take on the responsibility to help provide these opportunities. Even for parents not facing such significant personal challenges, raising a child with special needs can at times be isolating and discouraging. When life circumstances present difficult challenges to any parents, they need the lifting-up of a community of support to offer them not only help and encouragement, but hope.

When this community of support is not in place, the children suffer. This girl's struggling and eventually desperately ill mother – and a wide variety of service providers – did not have enough focus on this girl. Service providers said the girl and her mother's affection for each other was obvious. They appeared happy in each other's company and showed physical expressions of affection. As one worker said, the mother "loved her daughter to her best ability." But sometimes love of a parent isn't enough, and on the journey of raising a child with special needs, other essentials must be provided. This must be done sometimes in partnership with the community and sometimes with the active intervention of government, which has a responsibility to ensure proper supports are in place and systems are working.

Early childhood interventions, attention to common problems, medical treatment where required, a compassionate and encouraging family and community environment, and school systems that embrace an individual with special needs can improve the quality of life for not only children with special needs, but also their parents.

A particular focus of the Representative's advocacy and monitoring work has been on CYSN where child protection and guardianship concerns arise. This case illustrates what happens when there is a lack of accountability and the child is left in jeopardy. It also illustrates what happens when CYSN and child protection social workers do not effectively work together when responding to child protection reports. As well, there was no service plan developed by the various social workers who came into contact with this girl and her mother. This was a missed opportunity for the ministry to develop a coordinated approach and plan to support and monitor the family.

As noted in the Representative's February 2008 report on services for children and youth with special needs, support is lacking for families and caregivers who require or desire assistance in planning for, implementing and coordinating the variety of services and supports available to them.

The very purpose of the CYSN supports for children and adolescents must be to reduce their vulnerability to further disability, to promote their best opportunities for healthy and safe development and to support their inclusion in society.

Also of significant concern is that the mother's income assistance file was closed, with no follow-up with the family. In circumstances where it is clear that a single parent with a child with special needs is struggling financially, all efforts need to be made to make sure the child's well-being is a priority. It is shocking that income assistance benefits could be cancelled, knowing these circumstances, without any contact with the family or MCFD.

It is also of concern that the ministry did not do its own internal case review of the critical injury of this child. In the absence of any internal review, there has been no opportunity for the ministry and its front-line workers, in both child protection and child and youth with special needs services, to learn or to improve practice or services to children and youth with special needs. The Representative's investigation concludes that there is much to be learned from this tragic situation. MCFD is encouraged to ensure that front-line workers have opportunities to enhance their own practice by learning the lessons of this investigation. It is hoped that MCFD leadership will develop a plan for this with the Representative.

The Representative will follow up with the B.C. College of Physicians and Surgeons, the Ministry of Education, colleges and universities, and MCFD to develop opportunities to use the results of this investigation in professional training.

Introduction

The Representative's decision to conduct an investigation into this critical injury was made after her initial review of the girl's circumstances left many key issues unanswered. Could the emotional harm to this girl have been prevented? What monitoring and support services were in place? How could this have happened when a variety of service providers was involved with the family?

The incident that precipitated this investigation received widespread attention in the media, and that coverage included the identities of the girl and her family members. This girl is now in the care of the ministry and must not be identified publicly by name. The Representative also feels strongly that this girl deserves the opportunity to grow up unencumbered by public attention relating to this tragedy. The public and media are urged to respect her privacy as she continues her journey into young adulthood. The facts and what we can learn from this investigation about improving services to children with special needs take precedence over anything else in examining this sad situation.

The object of this investigation is not to criticize the actions of individuals, but rather to assess whether the services provided met a standard of reasonableness, given the information and circumstances present at the time. The Representative recognizes the daily challenges and difficulties faced by front-line social workers in B.C. who provide services to the most vulnerable children in our communities. The Representative believes that front-line workers function within systems that are only as strong as the resources available to them, including their training, coordination, service standards and supervision.

Although much of this investigation focuses on the actions of professionals who were involved with this family, the role played by family members and others in the community who shared a concern for the well-being of this girl must be acknowledged. Family, community members and others alerted the ministry to potential problems, and their information contributed greatly to our understanding of how this tragedy unfolded.

This is a reminder that we all share a responsibility to be vigilant and aware of the circumstances of the most vulnerable children who live among us. Each and every one of us has a legal duty to report any concerns about a child's safety and well-being to MCFD. The ministry, in turn, has the responsibility to respond, assess these reports, investigate as appropriate and take necessary action to ensure that children are safe.

An accountable system requires that we explore a full understanding of what happened, what we can learn and how we can improve our supports and services to vulnerable children in British Columbia. This investigation report is a step towards that understanding and learning.



Methodology

The *Representative for Children and Youth Act (RCY Act)* gives the Representative the responsibility and power to review and investigate critical injuries and deaths of children in care of MCFD, as well as children who have received specific government services in the past year. MCFD has a legal duty to promptly notify the Representative of deaths and critical injuries.

This report examines the period from December 2006, when the first child protection report regarding this girl and her mother was made to MCFD, to September 2010, when the girl was found at home with her deceased mother.

Interviews with ministry and CLBC regional staff were conducted in accordance with Section 14 of the *RCY Act*. Witnesses were ordered to appear, answered questions under oath, and their interviews were recorded. Family and community members were also interviewed.

The girl involved in this incident was not interviewed as part of this investigation, as the Representative determined that the facts required could be gathered through others involved and that an interview could potentially cause her further trauma. As well, advocates from the Representative's Office are providing ongoing advocacy support to the girl.

A draft report was provided to the Representative's Multidisciplinary Team (see Appendix E) for their review and comments, particularly to inform recommendations.

The Representative's Advisory Committee on Services to Special Needs Children and Youth, which provides overall advice and guidance to the Representative with respect to children and youth with special needs in B.C., also provided helpful insight.

The Representative engaged an experienced pediatrician to review, analyze and advise on the medical records of the girl and her mother.

Organizations that provided evidence to this investigation, including MCFD, were given an opportunity to review and provide comments on the facts in the report for administrative fairness.

The coroner's investigation into the mother's death was ongoing at the time of publication of this report.



Background

Special Report, December 2010

Since her office was created in 2007, the Representative has been concerned that MCFD was not reporting all relevant critical injuries to her Office. This concern was heightened when she learned on Nov. 11, 2010, through the media, of the circumstances of this girl's critical injury. This was almost two months after the girl had been found alone with the body of her deceased mother.

The Representative inquired into the situation, and the ministry advised that this was not a critical injury according to their internal policy and that it would not be reported to the Representative. The Representative analyzed the circumstances and reviewed preliminary information available from MCFD and information available at the time from the BC Coroners Service. In accordance with the *RCY Act* she determined that a critical injury did in fact occur to the child, based on the emotional trauma the child had no doubt experienced.

As a result of concerns about this particular case not having been reported, as well as the more general issue of incomplete reporting, the Representative took the exceptional step of issuing a special report in December 2010, *Reporting of Critical Injuries and Deaths to the Representative for Children and Youth*. The Representative was concerned that public confidence in her ability to carry out independent reviews of all relevant critical injuries and deaths was being eroded because of those incidents that weren't being reported. She determined that, in the interest of accountability and transparency, it was necessary to issue a special report.

In that report, the Representative recommended that MCFD develop and implement a critical injury and death notification policy in compliance with the *RCY Act*. Although the ministry has not yet fully implemented the recommendation, the Representative is satisfied with interim measures that have been taken by the ministry to improve reporting in the spirit of the recommendation and with the work that is proceeding with her Office to solve this issue.

Services to Children and Youth with Special Needs in British Columbia

MCFD funds a range of programs and services for children and youth with special needs and their families. The intent of these services and supports is to promote children's healthy development, maximize quality of life, assist families in their role as primary caregivers and support full participation in community life.

On July 1, 2005, services for children and adults with developmental disabilities were transferred from MCFD to Community Living British Columbia. As a Crown agency, CLBC was created to provide residential and non-residential family support services to children and youth with special needs, adults with developmental disabilities and their families.

During 2005/2006, MCFD and CLBC worked under a Memorandum of Understanding (MOU) regarding the temporary provision of some children's services by CLBC on behalf of MCFD, and planned for the implementation of a "Children's Agreement."

"Children and Youth with Special Needs" Definition:

Children and youth up to 19 years of age who require significant additional educational, medical/health and social/environmental support – beyond that required by children in general – to enhance or improve their health, development, learning, quality of life, participation and community inclusion" (MCFD CYSN Framework for Action, 2008).

In April 2006, CLBC and MCFD agreed not to implement the "Children's Agreement" due to concerns about possible service fragmentation, confusion for families and lack of planning coordination. While the term of the MOU was not extended beyond March 31, 2007, MCFD and CLBC continued to work within the spirit and structure outlined in the MOU.

In February 2008, the Representative released a report, *Monitoring Brief: System of Services for Children and Youth with Special Needs*. The document examined how MCFD and CLBC delivered services to children and youth with special needs and their families. The report identified six areas of key concern and provided 12 recommendations to strengthen the responsiveness and accountability of the system.

Of particular concern was the lack of support for families and caregivers who needed assistance in planning for, implementing and coordinating the variety of services and supports available to them. Based on this concern, the Representative recommended that families and caregivers receive support when needed to plan, implement and manage services and supports to their children over time.

In June 2008, the B.C. government announced changes in ministry responsibilities and a transfer of services for children and youth with special needs from CLBC back to MCFD.

In November 2008, the Representative released an update to her previous *System of Services for Children and Youth with Special Needs* report. It noted very limited progress implementing the recommendations in the previous document.

The transfer announced in June 2008 occurred on Oct. 31, 2009. Government's decision to transfer children's service provided by CLBC to MCFD was in response to criticism from families and caregivers that the division of responsibility for services to children and youth with special needs continued to be confusing and not responsive to the needs of families. Vulnerable families believed they were not receiving adequate support for their children.

In September 2010, the Representative released a second update report on the system of services for children and youth with special needs and their families, including a status summary of the service delivery system for children and youth with special needs.

Community Living British Columbia

Community Living British Columbia (CLBC) is the Crown agency responsible for providing supports and services for adults with developmental disabilities and their families in British Columbia. On July 1, 2005, responsibility to provide these services to children was transferred from MCFD to CLBC. On Oct. 31, 2009, responsibility to provide these services to children was transferred back to MCFD.

Since the lead-up to the initial 2005 transfer from MCFD to CLBC, families and service providers for children and youth with special needs have experienced numerous shifts and long-term indecision in policy direction and service provision. The Representative noted in her report that it was critical that further uncertainty not occur as MCFD underwent its planned service delivery system transformation.

The Representative's report also noted that government changes to the service delivery system for children and youth with special needs showed promise in addressing some of the concerns she had raised. Most notable was the introduction of a new service delivery model that, when fully implemented, addressed the Representative's recommendation that families and caregivers receive support when needed to plan, implement and manage services and supports to their children over time.

The new service delivery model spoke to a service component of providing family support, service coordination and problem resolution through "key worker or case manager" roles. The job description for children and youth with special needs workers reinforced these roles (see Appendix D). Much work was required to make these improvements, and in her monitoring briefs on services for children and youth with special needs the Representative has urged greater clarity and accountability in this area.

Chronology

When this girl was born in 1995 on Vancouver Island, her mother already had two teenage sons from her first marriage and was in a new relationship with the girl's father. The mother was aware of the risks of becoming pregnant in her early 40s and had repeated tests throughout her pregnancy to determine the health of her unborn child. Because the tests disclosed no abnormalities, neither parent anticipated that the girl would be born with Down syndrome.

Understanding Down Syndrome

Down syndrome occurs as a result of a spontaneously arising chromosomal difference during fetal development. The effects of this genetic difference vary from individual to individual. It is usually diagnosed by a test administered shortly after birth. People with Down syndrome typically have mild to moderate intellectual disability. A range of medical conditions is also associated with Down syndrome; these may include congenital heart defects, thyroid problems, vision problems and hearing loss. Down syndrome is not a disease that can be "cured," but specific medical conditions require ongoing assessment and treatment. Children with Down syndrome attend school, learn and develop into contributing members of their families and communities. Like everyone else, each person with Down syndrome is unique.

The girl required almost immediate surgery to correct congenital heart defects, the first of many surgeries she would undergo. She had procedures such as tubes inserted in her ears, an adenoidectomy and tonsillectomy, and correction of eye alignment. In her early years she was treated many times for upper respiratory tract, sinus and ear infections.

Almost immediately after she was born, the ministry received a report that the father was seeking support for mental health issues and alleging that the mother was drinking to the point of intoxication daily. Although an investigation at that time found no basis for the allegations, other family members clearly recall this as a time of turmoil. The mother applied for voluntary support through the ministry's child and youth with special needs program a month after the girl's birth and received approval for occasional respite relief.

Within months of her birth, the father left, at least in part due to his inability to accept his new daughter's special needs, and there is no indication that he had any further contact with his daughter or her mother. He moved around British Columbia and eventually left the country. He provided little in the way of financial support, despite court orders and the involvement of the family maintenance enforcement program. He died in the United States as a result of suicide, and the girl's mother became aware of his death months after it occurred.

There was conflict between the girl's half-brothers and their mother, which steadily escalated throughout their adolescent years and continued into their adult years. Despite the conflict, it is clear that the brothers care deeply about their sister. They remain concerned for her despite significant personal challenges in their own lives.

After the father left, the mother carried on as a single parent. Occasionally, the older brothers lived with them. The girl and her mother moved to the Lower Mainland in 1996. It appears that this move was motivated, at least in part, by a need to live closer to BC Children's Hospital, where the child had frequent medical visits. They remained in that home for the next 10 years.

After the move, the mother entered into a series of support service agreements with MCFD, which allowed her to continue to get occasional respite care. She used this service regularly.

The girl's health needs were complex. Her diagnoses at age five included:

- Down syndrome with congestive heart failure
- suppressed immunity leading to frequent infections
- low muscle tone, requiring orthopedic shoes, ankle and foot braces and physiotherapy
- hard of hearing, requiring hearing aids
- impaired vision, requiring glasses
- developmental delays

The mother received medical benefits from the ministry to provide funding for the girl's hearing aids, glasses, orthopedic shoes, and speech and occupational therapy.

By the time the girl was seven, her mother was diagnosed with Type 2 diabetes. She continued to work at a number of different jobs, including retail sales, child care and janitorial work.

In 2005, the girl was 10 and in Grade 4 and was receiving assistance in a resource room setting in the school. Testing revealed that she had a "moderate to profound" intellectual disability, functioning at the level of a two- or three-year-old.

In November 2005, her mother became unemployed and applied for income assistance. During her first visit to the employment and assistance office she indicated she had worn out her welcome at the food bank and her heat had been disconnected.

The mother received income assistance benefits from this time until her death, with the exception of a one-year period from December 2007 to December 2008. During this year she worked part time and lived on funds from the sale of the family home. When she reapplied for benefits in December 2008, she said she had exhausted all funds, was out of food and not able to work while awaiting surgery on her arm/hand. She was immediately issued food vouchers pending approval of her eligibility for income assistance.

The challenges facing the mother at this time were not solely financial. The girl's behaviours were becoming harder to manage. She had frequent tantrums and demands, and had a very short attention span. In a letter of referral sent to a consulting pediatrician, the family doctor warned his colleague that "Mom is coping, but only barely."

The family doctor also noted that the girl was big for her age and posed a significant physical challenge for her mother. The girl could be physically aggressive with others when frustrated, striking out at people around her. She was diagnosed with an anxiety disorder, as well as a moderate intellectual disability, and had behavioural difficulties in crowds and in the school setting.

When the girl was 11, in 2006, the ministry received the first of four child protection calls regarding the safety of the girl. The caller reported that marks and bruising on the girl's neck had been observed. A child protection social worker contacted the girl's school and the family doctor and followed up with a home visit. The child protection social worker found that the girl's mother was conscientious and caring and concluded there were no grounds for child protection concerns. The child protection social worker was active in linking the family to community services, including swim passes and after-school programs.

In 2007, almost a year later, the mother and child moved to a mobile home park on the outskirts of a small community in the Lower Mainland. This location was quite isolated; the only exit from the park was a long, steep road up a hill.

The girl was enrolled at a middle school in her community. She had an Individual Education Plan that focused on developing her social, behavioural and learning skills. She was receiving support from an educational assistant and being assessed by an occupational therapist through the school.

About four months after the move to the mobile home park, in March 2008, the ministry received a report of a physical altercation between the girl and her mother at the school. The altercation began when the mother arrived at the school to pick up the girl, but she wanted to stay on the playground. The girl began kicking and punching at her mother, who began dragging her toward the car. When they reached the car, the girl slammed the open car door into her mother's cheek and the mother responded by pushing her into the car. When staff approached them, they saw the girl screaming in the car and her mother crying.

The report was investigated. The child protection social worker and a CLBC social worker met with the mother at her home. The mother indicated she was relieved that someone had recognized her need for help and called the ministry. She stated that her daughter was becoming very aggressive and was now physically larger than she was. She feared the possibility of her daughter being placed in care and welcomed any help in dealing with the challenges she faced. The CLBC social worker arranged for a meeting with a behavioural support worker who could assist in strategies to deal with the girl's physical aggression.

The girl's school also took steps to address her sometimes aggressive conduct, creating a safety plan that identified potential triggers for negative behaviour and defusing techniques that could be used by staff. The girl continued to work with a resource room teacher and educational assistants. At age 13, her speaking and listening vocabulary was assessed as being approximately that of a three-year-old child.

The child protection social worker summarized the mother's situation as that of an older parent dealing with an aggressive special needs child and noted that the mother hoped her family would be in a position to take over caring for her daughter when she was no longer able. The child protection social worker explained to the mother that the CLBC social worker would assist her with services for her daughter and that if the mother felt she may not be able to deal with her daughter in the future, she should contact the child protection social worker. The investigation concluded that the child was not in need of protection, but the CLBC social worker assessed her mother as "being at her wits' end."

Because she clearly perceived the mother to be stressed and struggling, the CLBC social worker prioritized the request for behavioural support, and a behavioural support worker began working with the family about three months after the March 2008 incident. She would continue working with the family throughout 2009, seeing them six times that year, focusing on working with the mother on strategies for managing the girl's sometimes aggressive outbursts.

Although the behavioural support worker found the mother warm and welcoming during her visits she also found it difficult to schedule visits and the mother would often cancel them, saying that she or her daughter was sick. Communication and scheduling was also complicated by the fact the mother could rarely afford to buy minutes for her cellular telephone, so contacting her was often difficult or impossible. There was never a land-line telephone in the home. The behavioural support worker was also frustrated by the mother's inability to follow through with suggested courses of action.

The CLBC social worker encouraged the mother to enrol the girl in children's programs provided locally, and the CLBC social worker placed the girl on a wait list for a one-to-one worker. The mother never followed up on the suggested children's programs, and a one-to-one worker was never linked to the girl.

The voluntary support services provided by CLBC were transferred to the ministry on Oct. 31, 2009, as part of a broader initiative to return responsibility for children and youth special need services to the ministry. The services provided to the girl by CLBC were now coordinated by a ministry children and youth with special needs (CYSN) social worker. The CYSN social worker had no previous involvement with the family.

The behavioural support worker's last scheduled visit was in January 2010. This visit was cancelled at the last minute by the mother, who said she was sick. The behavioural support worker was then unexpectedly off work for a number of months, with no one replacing her.

In addition to behavioural support strategies, the girl was taking prescription medication from the family doctor that was geared to controlling her behaviour. After numerous medications were tried, the doctor selected Methoprazine, a drug used to treat mental and emotional disorders. This drug has anti-psychotic, anti-anxiety and sedating properties, and it appeared to reduce the child's physical outbursts. By early fall 2009 the family doctor noted that the girl was calmer.

The girl continued to have complex medical needs, including hearing aids, glasses and leg braces to assist her with walking. Despite these ongoing needs, during the three years prior to her mother's death, the girl had less and less contact with doctors.

| Physician Visits | |
|------------------|----|
| 2006 | 17 |
| 2007 | 20 |
| 2008 | 7 |
| 2009 | 6 |
| 2010 | 3 |

The family doctor also had concerns about the mother. The girl's brothers were aware that their mother was struggling with her health and were concerned about this as it related to their sister's care. By this time the mother had been diagnosed with diabetes, depression, anxiety, chronic obstructive pulmonary disorder, high blood pressure and high cholesterol. Her health issues were aggravated by her continued smoking. In 2009, her doctor also found her to be suffering from chronic renal failure. Her part-time work as a janitor was disrupted by a diagnosis of carpal tunnel syndrome, and she had surgery for this condition.

The mother's inability to work, even at small jobs, placed more financial stress on her. In September 2009 a request for an extension of behavioural support services noted that the mother had resorted to collecting bottles so she could continue to put gas in her car.

The girl had been receiving overnight respite care on a monthly basis throughout 2009. Respite benefits provide funding to allow for a temporary break for caregivers, either in their home or at another location. Respite care is an important resource for caregivers, who can become easily stressed and suffer from caregiver burnout. The respite caregiver, who had known the girl for several years, found her challenging, but also affectionate and charming. The caregiver was, however, becoming increasingly frustrated by the mother's apparent disorganization and poor communication. The girl would be brought for respite care with no prior arrangement having been made, or wouldn't show up for scheduled visits.

Communication was again hampered by the fact that the girl's mother relied on a cellular phone but was only occasionally able to afford to activate it. The respite caregiver found the girl's mother "odd," and assumed there were mental health issues. She also found herself being drawn into long conversations with the girl's mother during pick-up and drop-off, many of them focused on the mother's ill health.

It seems that this concern about her health was becoming larger and larger in the mother's mind. Over the Christmas holiday in 2009, then aged 56, she openly discussed with one of her sons her fear of dying. He had noted that she was steadily losing weight but attributed much of what he observed to what he believed was his mother's use of alcohol and prescription drugs. The other son was also present over the Christmas holidays and observed his mother drinking and, in his words, "going downhill fast."

At the beginning of 2010, the girl's regular visits to the respite caregiver stopped almost entirely. The respite caregiver would see her only once, during a scheduled visit on March 11, 2010. Like behavioural support, this service was provided and monitored by CLBC until the transition of responsibility back to the ministry in October 2009. After that, it became the responsibility of a ministry CYSN social worker.

On April 21, 2010, the girl's mother saw another physician in the same office as her family doctor and got prescriptions for medications to treat her diabetes, blood pressure and acid reflux. The mother's pattern of seeking medical assistance mostly for acute illnesses or refills of prescriptions meant that she was not receiving the kind of chronic disease management she required.

The day after that appointment, the girl and her mother were driving home in their older model car when the mother lost control of the vehicle and struck a curb. The impact damaged a wheel and rendered the car inoperable. Police attended the scene and completed an accident report but found nothing unusual in the circumstances.

Community members felt that the loss of her car and her resulting immobility accelerated what they saw as a downward spiral for this mother. She and the girl were trapped in the mobile home park, with the long walk up the steep road leading out of the park often too difficult for the mother to attempt.

Shortly after the car accident, she began to fall into arrears on the pad rental for her mobile home, a situation that would continue until the landlord moved to evict her in September 2010.

On May 4, 2010, a third child protection report was made when the girl's brother called the ministry to report that he had taken the girl to his home after having made up a story to get her away from her mother. The brother did not want to return his sister to their mother's care unless the ministry committed to do an investigation and provide ongoing monitoring of the situation. This was an act of desperation. The brother lived hours away from his sister and knew he couldn't take over her long-term care, but felt that a drastic step had to be taken to draw attention to his sister's situation.

The son described his mother as an "alcoholic," and he believed that she had this problem even before the girl's birth. He also believed his mother was abusing her own medication and taking her daughter's medication herself. He warned the child protection social worker about his mother's significant weight loss and told them that his sister had been out of school and confined with an angry and abusive mother. He also reported finding the family vehicle "freshly totalled" in the driveway of the home.

The child protection social worker assessed the information and, with approval of the team leader, initiated a family development response, which focuses on trying to keep a child safe within the family. A child protection social worker called the brother on May 5, 2010. During that conversation the brother described their mother as abusive, chemically imbalanced and alcoholic. He also raised concerns about the girl not attending school. School records show that the girl was absent for 38.5 days during the 2009/2010 school year. Three-quarters of those missed days occurred between January and June 2010. The previous school year the girl had been absent a total of 19 days.

On May 6, 2010, the child protection social worker made an unannounced visit to the mother's home. The mother complained that her daughter had been kidnapped and that police would take no action. She agreed the girl had not been to school over the past few weeks but stated that was because the girl had been ill. She also confirmed that she had not been using respite care in recent months. She denied all the other allegations.

She said that the car accident was the result of a flat tire that caused the car to veer off the road. In discussions with her son, however, she had told him she was experiencing prolonged episodes of memory loss that could last for up to a week, and episodes of dizziness, with the latter being the true cause of the crash. These lapses in memory also caused her to miss work and lose her job, the brother said.

She told the child protection social worker she was a diabetic, taking blood pressure medication, acid reflux medication and anti-depressants.

The child protection social worker pressed the mother again on the issue of her alcohol use, but she denied it. The child protection social worker found no evidence in the home that suggested alcohol was a factor and arranged to return with the CYSN social worker. The child protection social worker's purpose in having the CYSN social worker attend the home with her was so the CYSN social worker could determine if other services could be offered to the family.

On May 6, 2010, the child protection social worker contacted the brother and asked him to return his sister to his mother's residence. The child protection social worker explained that she had been to the residence and had determined it was safe for the girl to be there. The brother agreed to return his sister after receiving assurances from the child protection social worker that the mother and daughter would be regularly monitored.

The child protection social worker also received a telephone call from the girl's school, worried about her absence. When contacted, staff reported that the girl was back at school, although she had slept all day in class. They had no concerns other than a report from a school bus driver that he had once observed the girl's mother stumbling and weaving when she met the bus to collect her daughter. The bus driver who had reported this was unable to confirm if alcohol was the cause.

The child protection social worker returned for a follow-up visit on May 12, 2010, and brought the CYSN social worker. This was the first time the CYSN social worker had contact with the family since children and youth special needs services were transferred back to the ministry on Oct. 31, 2009. The girl was at the home during the visit. They emphasized to the mother that she had access to 28 days of respite care per year and discussed the value of placing the daughter in an after-school program and then a summer program. The mother didn't pursue these suggested supports, and the workers didn't follow up or make any referrals either.

On May 21, 2010, the CYSN social worker took the mother and daughter grocery shopping in her personal vehicle, as she knew that the loss of their car had made tasks like this a great deal harder for the mother. This was the last direct contact that the CYSN social worker had with the family until Aug. 10, 2010.

The respite caregiver had grown so concerned by the girl's absence from respite care that early in May she had driven to the residence. However, she was unable to locate either the girl or her mother. By coincidence, late in May the respite caregiver encountered the girl and her mother walking down the road in their community. The respite caregiver was shocked by what she observed. She described the mother as "thin as a rail, clothes falling off her." The mother, obviously distraught, told the respite caregiver she had lost her car and her job and then burst into tears. The respite caregiver urged her to book some respite time, which the mother agreed to do but did not follow up on.

On June 1, 2010, a meeting was held to discuss the girl's transition from middle school to high school. The mother was absent from the meeting, which was attended by two resource teachers and an educational aid.

On June 2, 2010, the MCFD child protection report was concluded and the file was closed. The child protection social worker closed the file without consulting with the respite caregiver, any medical professionals involved with the family, the behavioural support worker or the police who investigated the April 2010 motor vehicle accident.

The child protection social worker determined the child protection report was not proven and that there were no concerns or areas that need to be worked on. The outcome of assessment was that the child was safe and that an investigation was not required. The completed risk assessment indicated the child was at medium risk of harm and the family did not need services. The child protection social worker also recorded that "the family is connected to the CYSN worker and the child is going to respite and will be attending an after-school program and a summer program." This did not happen. In fact, the mother received no further respite services, and the child never participated in any of the programs recommended by the CYSN social worker at the May 12, 2010 home visit. The mother was not capable of getting these services put in place and she had no phone service or transport.

On July 14, 2010, the mother called the employment and assistance office that was handling her file. At this point, income assistance payments appeared to be her only source of income. She had been issued a cheque the previous day for living expenses, but there was some confusion about the amount of the rental for her mobile home pad, and no funds had been issued for that expense.

The mother told the worker who answered the phone that she had no phone, was in pain, and wanted to book an appointment. The worker asked her to leave a message indicating a time when they could call her back at a neighbour's home, but the mother replied she was in too much pain. The worker continued to suggest she make herself available for a phone call to clarify her situation. The mother did reach a worker at the employment and assistance office on July 16, 2010, and the issue was resolved.

On July 20, 2010, the behavioural support worker, who had been absent from work for several months, went to the home at the request of the CYSN social worker. The mother would not answer the door but did speak to the behavioural support worker through the window, telling her that she had been ill and wasn't dressed. The girl was inside the residence at this time. This brief conversation was the behavioural support worker's last contact with the family. The behavioural support worker was concerned about the mother's health and left a voice message with the CYSN social worker, detailing her observations.

On July 21, 2010, the mother went to a local walk-in clinic to get another prescription for her diabetes medication. It appears that the distance between her home and her family doctor's office was making it impossible for her to get there. She had not had any medication for three weeks, and her ankles were swollen, an indication of potentially serious medical problems. She was crying about what were described as "social problems," and her blood sugar was dangerously high. She was placed back on her diabetes medication, as well as her other medications, and instructed to come back in a week, or sooner if her blood sugar levels remained high. However, the mother did not go back to the clinic until Aug. 11, 2010.

On July 30, 2010, the ministry received a fourth child protection report from a community member expressing concerns for the girl's safety. The concerns were focused on the mother's drinking and the caller's allegation that the mother was giving a neighbour \$40 a day to buy her alcohol, cigarettes and occasionally groceries. The neighbour that the mother gave money to for these purchases confirmed this to the Representative's investigators. The caller also reported that the mother was verbally abusive to the girl, that the girl was largely confined to her home, rarely going out, and that the home itself was very dirty.

The caller was close to the situation and described the mother as a "hidden alcoholic" who concealed her drinking from those around her. The child protection social worker taking the report noted that while it was unusual to receive a complaint from the mobile home park, the caller appeared very sincere and concerned for the girl and about the mother's deteriorating ability to care for her.

The report was assessed and the decision made to investigate. A child protection social worker, a different one than had assessed the May report, immediately went to the home. There was no answer at the door. The child protection social worker saw garbage bags full of beer cans piled in the back yard of the home. Speaking to community members, the worker was told that the mother was an alcoholic, although no one had ever personally seen her drinking. One community member also observed that neither the mother nor the girl was ever seen outside their residence until the afternoon.

The child protection social worker went back to the home and knocked again. This time the mother answered the door, saying that she and the girl had been sleeping. The child protection social worker noted that the girl was there, that the home was cluttered but clean and that there was food in the cupboards. One empty vodka bottle was found, partially hidden under clothes stacked on a counter.

The mother said she didn't have the money to drink every day and, in fact, hadn't had a drink in three weeks. She explained the beer cans were given to her by neighbours so she could return them for pocket money, a statement later confirmed by the individual who gave her the beer cans.

The mother told the child protection social worker she had Type 2 diabetes, chronic obstructive pulmonary disorder (COPD) and asthma. She said she had pain and swelling in her legs, which made it impossible for her to walk up the long and steep hill out of the park.

She said that the girl had not been to respite care in months, attributing that to the lack of transport and the fact that she didn't feel any need for respite from caring for her daughter.

The child protection social worker spoke to the complainant, other community members and the CYSN social worker, and contacted the local police for a criminal record check on the mother. The CYSN social worker told the child protection social worker that the behavioural support worker was attending the home once or twice a month. This was inaccurate, as the behavioural support worker had only seen the family once in 2010, during the visit on July 20, 2010, when the mother said she was sick and did not let the behavioural support worker in the home.

The child protection social worker visited the mother and girl again on Aug. 4, 2010, unannounced, and noted that the mother still had swollen feet that made it nearly impossible for her to walk. She told the worker she could not access the bus and that she had registered for handyDART, but was going to a walk-in clinic for medical help. She said that she had held two jobs until the car accident and that now she was relying on the \$1,100 per month she received from income assistance, paying her rental from that money. The mother did not reveal that the pad rental for her mobile home was now several months in arrears.

The CYSN social worker confirmed to the child protection social worker that there had been several unannounced home visits over recent months and that there had been no signs the mother was drinking. The CYSN social worker said she remained very concerned about the mother's health and the impact that had on her ability to care for the girl.

On Aug. 5, 2010, a family risk assessment was completed by the child protection social worker, which indicated that the child was at high risk for likelihood of future maltreatment due to neglect.

On Aug. 9, 2010, the CYSN social worker noted in a conversation with the child protection social worker that the home was becoming very messy and that the mother's health issues weren't improving. The CYSN social worker returned the next day with groceries purchased for the family with the worker's own money. Concerned again by the swelling in the mother's legs, the CYSN social worker urged her to see a doctor.

The mother went to a walk-in medical clinic the following day, Aug. 11, 2010. Her blood pressure was elevated and she had widespread swelling, especially in her feet. She was given diuretics and lab requisitions and was instructed to follow up urgently with her family doctor. The clinic made two attempts to follow up with her by phone, on Aug. 13 and 16, 2010, but the phone number provided was not working. The mother never sought any further medical attention and never followed up with the lab work.

When the child protection social worker made an unannounced visit to the mother and girl on Aug. 23, 2010, the mother reported getting a prescription from a walk-in clinic that had resolved the swelling in her legs. This was a pattern of behaviour that was seen throughout the last several years of her life. The mother would seek treatment for acute illnesses from her family doctor or a walk-in clinic but was not obtaining the kind of chronic disease management care that she needed to control her hypertension, diabetes and kidney disease.

During the Aug. 23, 2010 visit, the child protection social worker noted that the refrigerator was full of food. The food was likely provided by the CYSN social worker, who had raised her concerns about the family's circumstances with other staff at the office. They had all agreed to contribute to a "Christmas in the summer" hamper that the CYSN social worker delivered to the family home on Aug. 19, 2010. When the food was delivered, the CYSN social worker found the girl at home and the mother tired and unable to stand for long, although she said she was starting to feel better.

On Aug. 24, 2010, the child protection social worker and the CYSN social worker spoke on the telephone, and the CYSN social worker reported that both the mother and the girl were doing much better, based on a visit earlier in the day. The CYSN social worker planned to visit the family twice a month or more to offer any supports the mother would like and to keep an eye on them. The CYSN social worker had received approval for a homemaker/cleaner, although the mother never actually followed up on the service.

On Aug. 25, 2010, despite the earlier family risk assessment that the girl was at high risk, the child protection social worker concluded that the investigation revealed no child protection concerns and the file was closed. The child protection social worker consulted with the team leader before making this decision.

The decision to close the file was partially based on an understanding that the CYSN social worker remained involved in supporting the family and would notify the child protection team if concerns arose. As well, the child protection social worker believed that the mother, despite her health struggles, was managing to meet the girl's basic needs.

On Aug. 27, 2010, the CYSN social worker visited the residence. She reported the girl and her mother were cheerful. The social worker raised the subject of long-term planning for the girl and the mother suggested postponing the conversation until the girl returned to school in the fall. This was the last time the CYSN social worker saw the mother.

On Sept. 8, 2010, a community member called the ministry, expressing concern that the girl had not been seen playing outside all summer. A child protection social worker not previously involved in the file consulted with the child protection social worker who had investigated the July 2010 report and who was now acting as the team leader. The decision was made not to document this information as a new child protection report in light of the just-concluded July 2010 report and the ongoing involvement of the CYSN social worker. The caller's information regarding the child protection concerns was not documented in the electronic case management system but left as a handwritten note in the file.

The same day, the CYSN social worker went to the home, but there was no response to knocking at the door. The CYSN social worker drove around the neighbourhood looking for the mother and the girl and then checked local stores where they might have been, but the search was unsuccessful.

The income assistance cheque the mother had received in July was the last she would receive. Her income assistance file was closed and her assistance terminated due to her lack of communication in mid-September.

The girl's school began trying to reach the mother by phone on Sept. 13, 2010, the first day the girl was expected to attend but wasn't there. They continued their efforts on the following two days, again without success.

On Sept. 14, 2010, neighbours became concerned by the lack of activity during the past week inside the home of the girl and her mother. They put up a ladder to the front window, looked inside and saw the girl sitting beside the body of her mother. Neither was moving.

They broke in and found the mother deceased. The girl was filthy, covered in a rash and dehydrated. Her mother had been dead for an undetermined length of time, possibly seven days, before the girl was found. Empty boxes of uncooked macaroni and bottles of her mother's prescription medicine were strewn around. It appeared that the girl had been trying to feed herself and care for her mother. The girl had been curling up in a dirty blanket, huddling tight against her mother's decomposing body. The trailer was full of flies, and the smell made it difficult for people to remain inside.

The neighbours called police, fed the girl, gave her a bath and gave her as much fluid as possible. Neighbours said the girl had lost so much weight some did not recognize her at first.

In the hours immediately after the girl had been found, the ministry contacted her respite caregiver and asked her to take the girl home. When the respite caregiver arrived at the ministry offices, she was shocked at the girl's condition. She was thin and wearing the same filthy clothes she had been found in, and the rash covering her legs was inflamed. Despite her condition, the girl was happy to see a familiar face. The food she had been given after her rescue had upset her stomach, and she had violent diarrhea. The ministry staff gave the respite caregiver only some pull-up diapers for evening use, a bottle of her prescription medication and a doll that had come from the home.

The respite caregiver couldn't reach the girl's family doctor and so took her immediately to a walk-in clinic. After the girl was assessed at the walk-in clinic, the caregiver took her home and put her to bed.

The respite caregiver managed for the next four days with very little support from ministry staff. She bought clothes and food for the girl, using her own money as none had been provided to her by the ministry. The girl, unused to her medication after more than a week of not taking it, had an adverse reaction when it was reintroduced and the respite caregiver had to rush her to hospital. The adverse reaction and hospital visit were stressful for both of them. The girl was also repeating phrases such as "mom dead," "mom sleeping" and "stinky flies" and became extremely upset when a single fly would enter a room. The respite caregiver was left to manage this trauma on her own, with no assistance. Added to this was the uncertainty of when a suitable foster home would be located for the girl.

The Representative would like to acknowledge the affection and support this respite caregiver provided to the girl in difficult and demanding circumstances, not just at the moment of crisis but throughout the girl's young life. Her truly caring support to this girl was profound and made significant differences for a child in crisis.

Subsequent Events

On Sept. 16, 2010, one of the girl's brothers filed a complaint with MCFD. The complaint had three elements:

- 1) A request for the ministry to review its response to his concerns about the safety of his sister in his mother's care;
- 2) A request for the girl to be moved to a location closer to her family, so that her brothers could have more contact with her; and
- 3) A request for a referral for the girl and her family for grief counselling and other supports.

The ministry responded in a letter dated Nov. 4, 2010. The acting practice manager who wrote the letter reviewed the file and interviewed ministry staff. It was her opinion that "all of the required standards were complied with, and as we discussed, we were not able to obtain the evidence we require (sic) to deem your sister in need of protection at that time."

The letter also said that his request for relocation of his sister was being considered, but the acting practice manager pointed out that the focus of her office was providing the girl with a stable environment.

Regarding grief counselling, the acting practice manager assured the brother that the girl was seeing a counsellor regularly and encouraged him to access counselling services that had been identified in his area.

The complaint file was closed, concluding that MCFD completed all necessary assessments and reviewed all relevant information in accordance with MCFD policy and procedures. The results of the Representative's investigation led to different conclusions.

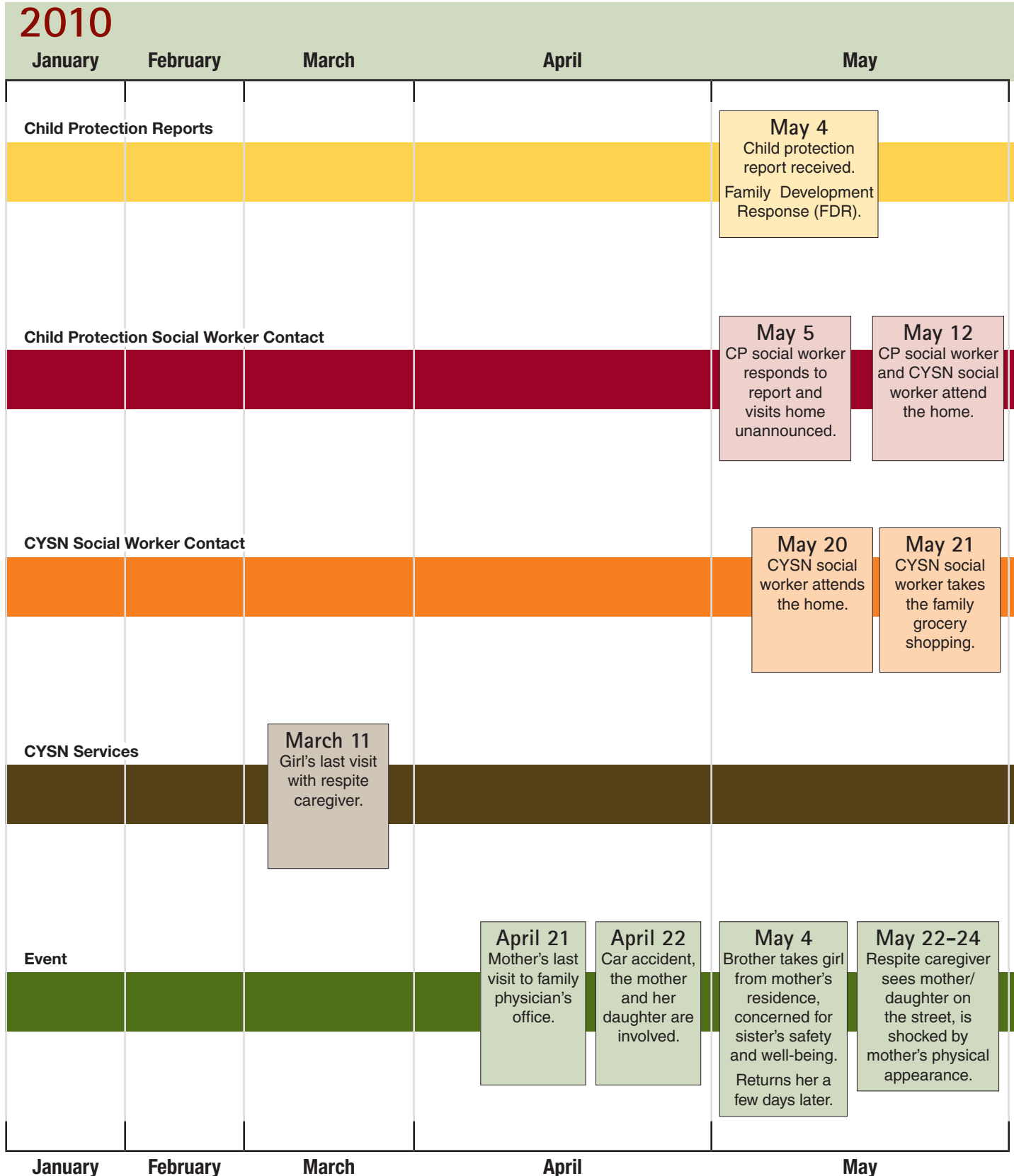
The Representative notes with concern for fair process that the staff person who reviewed the brother's complaint was also supervising the office's practice at the time the complaint was made, and should not have reviewed and responded to the complaint.

Representative's Ongoing Involvement

The Representative's Office has been involved with this girl and her family since becoming aware of the incident in November 2010, in relation to the Representative's mandate to provide advocacy services. The girl was in her original foster home placement at the time of publication of this report, more than nine months after her mother's death.

The Representative's Office will continue advocating for this child.

Timeline of Significant Events





2010

| June | July | August | September |
|--|--|--|--|
| <p>June 2 FDR complete. Child safe. Report concluded. File closed due to belief that CYSN services being provided at this time.</p> | <p>July 30 Child protection report received. Investigation.</p> | <p>August 25 Investigation concluded. No child protection concerns. File closed due to belief that CYSN services being provided at this time.</p> | <p>September 8 Child protection call received, not documented in electronic system. No follow up.</p> |
| | <p>July 30 CP social worker unannounced home visit.</p> | <p>August 4 CP social worker 2nd unannounced home visit.</p> | <p>August 23 CP social worker 3rd and final unannounced home visit.</p> |
| | | <p>August 10 CYSN social worker visits the home with groceries.</p> | <p>August 19 CYSN social worker delivers food hamper to the home.</p> |
| | | <p>August 27 CYSN social worker visits the home for the last time.</p> | <p>September 8 CYSN social worker goes to home, no response at home.</p> |
| | <p>July 20 Behavioural support worker attends home but the mother is too sick and doesn't let her in.</p> | | |
| | <p>July 14 Mother calls employment & assistance office. She is in pain and has no phone access.</p> | <p>July 21 Mother goes to walk-in medical clinic.</p> | <p>August 11 Mother goes to walk-in medical clinic.</p> |
| | | | <p>September 13/14 Teacher tries to reach family by phone but is unsuccessful.</p> |
| | | | <p>September 14 Girl found in home with deceased mother.</p> |
| June | July | August | September |



Analysis and Recommendations

Overall Finding

This vulnerable girl's needs were not adequately addressed throughout the period covered by this investigation. There was no assessment of her situation as a child with special needs requiring a range of health, education and social supports for positive development. She was not safe. She was left with compromised hearing and physical mobility, in an impoverished environment and primarily cared for by a severely ill and challenged mother. This girl was invisible. If there had been an assessment and a plan in place to ensure high visibility, the harm caused to this girl by being left with her deceased mother would likely have been prevented.

The standard of care to be applied in assessing the risk of harm to a vulnerable child with special needs is high. In this case the girl's basic needs for food and shelter were minimally being met. What was *not* occurring was subtle yet still damaging to the child.

For example, when the girl was taken into ministry care following her mother's death, a hearing examination revealed that her hearing aids were outdated and not working. Months earlier a professional who met the girl for the first time believed she was deaf and did not inquire any further in this regard. When new aids were placed in the girl's ears, she reacted with enormous surprise at being able to hear again. It is impossible to know how long she had gone without hearing, but the negative effects of this loss of hearing can be easily understood.

The reality is that many children with special needs are not listened to by those providing them with support or are unable to speak up for themselves. They are especially vulnerable because they can't tell us how they are unless efforts are genuinely made to engage with them and listen to them. For these reasons, child protection assessments involving children with special needs must be thorough and broad-ranging. Assessments must fully engage support services to ensure safety and well-being, beyond basic needs of the child.

When assessing and responding to child protection reports, it is necessary to gather information from external sources. These are referred to as "collateral checks." The selection of appropriate collateral checks has a profound impact on the quality of the overall assessment and response.

In this circumstance, a meaningful assessment would necessarily include information about the girl's entire range of physical and medical needs. Areas of inquiry should have included her medications; occupational, speech and behavioural therapy; glasses; hearing aids; leg braces and orthotics. The absence of a comprehensive plan for her care, taking into account all her needs – medical, behavioural, educational and social – should have been alarming to anyone viewing this situation. It is as if she was invisible, her existence overshadowed by the focus on her mother.

In this case, where the mother's medical issues loomed so large in the minds of the workers involved with this family, it would have been enormously helpful for them to have had a comprehensive overview of the mother's health status, information that could have most readily been obtained from her physician. This information was critically relevant to assessing her ability to provide adequate care for her daughter.

Because the issue of alcohol abuse had been raised so frequently by neighbours and family members, it would have been especially important to have delved into the issue more deeply with those who knew this mother over time. There were other key people who could have provided more perspective and insight, such as medical professionals, family members and other service providers who had been providing longer-term support to the family.

An inquiry could have been made with the liquor store directly adjacent to the exit to the mobile home park. Although workers did collateral checks with neighbours on this issue and asked the mother about her alcohol consumption, this was not enough.

Throughout this investigation, the Representative was struck by the differences between the insights and observations of family members and neighbours, and those who were providing professional services, with the exception of the respite caregiver who had been involved with the family for more than four years.

One explanation for the differences may be the length of time that people knew the family. Those who had known the mother for longer periods, including the respite caregiver, saw the deterioration in her health and appearance as shocking and alarming. Workers who met the mother for the first time in the spring and summer of 2010 would not have noticed changes in her appearance, as they had never seen her before.

Operational requirements and staff turnover dictate that it will not always be possible to provide continuity of personnel over periods of years to families in need. When continuity is not possible, there is a particular responsibility to seek out those who do have that information and who can draw valid comparisons over time.

In this case the brothers' insights into their mother's behaviours appear to have been either ignored or discounted. They had a perspective that was no doubt driven by their own experiences with their mother, but that perspective was valid and long-term and was informed by their genuine concern and affection for their sister.

They accurately saw that the deterioration in their mother's health was placing their sister at risk and did everything they could to bring that to the attention of MCFD. Their tone may have been strident, but they, more than anyone else, understood that the safety and well-being of their sister had to be the centre of their attention.

It was clear from the evidence of neighbours and family members that the car accident in April 2010 had a profound impact on this family. It effectively ended access to the family physician, leaving both the mother and the girl reliant on closer walk-in clinics that could not provide the same continuity of care or chronic disease management. It left them even more isolated, especially as the mother's mobility deteriorated and she became unable to negotiate the long, steep hill out of the park.

Around this same time, the mother stopped making rental payments for her mobile home pad. Poverty turned to abject poverty in clear view of those in the ministry and those who provided income assistance in the Ministry of Housing and Social Development (now called Ministry of Social Development – MSD).

The mother continued to receive income assistance, as she had for many years, but by the summer of 2010 the family was clearly in economic crisis. The mother was unable to continue to supplement her income assistance by taking on small house cleaning and janitorial jobs because she no longer had a car. In August 2010, the economic situation was summed up by one worker involved with them as "less than zero." Clearly, something had changed that was placing even more strain on a family already in deep poverty.

The CYSN social worker was so concerned about the financial circumstances of this family that in the months leading up to the mother's death this worker purchased groceries for them with personal funds and organized an office-wide gathering of food for the family. While caring actions, the fact this worker felt these extraordinary measures were necessary should have triggered a deeper inquiry into the family's financial situation. It would have been helpful for those engaged with the family to have worked with the Ministry of Social Development, to gather information and develop a practical strategy to address the looming financial crisis.

This becomes particularly evident when examined in light of the fact that the mother's income assistance was terminated because she stopped filing reports. Neighbours said they offered her help in filing, but the mother was apparently disinterested, another piece of information which would have been very valuable to those trying to assist her.

The focus of services for children and youth with special needs must be the well-being of the child, particularly when those needs are complex. The CYSN social worker must function as an advocate for that child, rather than merely providing referrals to voluntary support services. The child must always come first. The CYSN social worker has to take an active role as a case manager in ensuring that the child and the family are receiving the services they need to address their specific needs. Not all families are capable of taking the lead.

Part of effective advocacy is having access to all information relevant to assessing that child's needs, including comprehensive medical assessment.

In this case, where the CYSN social worker had no contact with the family from October 2009 (the time CYSN services transferred back to the ministry) until May 2010, it is difficult to conclude that a reasonable standard of service was in place for this family.

CYSN social workers must actively participate with the child protection system in the assessment and planning for the safety and well-being of the child. Their job description emphasizes that they must "participate in the investigation of alleged child abuse and neglect according to regional and provincial protocols." However, in this case the CYSN social worker was viewed only as a collateral contact in the responses to the two child protection reports made in 2010.

Many of the professionals engaged with this family commented on the loving relationship between the mother and child. The girl's brothers also acknowledge that their mother felt tremendous affection for her daughter. However, the capacity to love a child and the capacity to adequately care for a child are two separate and distinct issues.

It may never be known exactly how long the girl remained alone with her deceased mother in their home. If monitoring and support services appropriate to the degree of fragility in the home were in place, this may have prevented the child being left for a long period with her dead mother.

Her survival in these circumstances is nothing short of remarkable. The girl continues to experience a range of emotions in response to what happened, including both grief and anger, according to her foster family.

It would be both unfair and unreasonable to suggest that a single individual could have accurately foreseen what happened in September 2010. A large number of people were interacting with this family, in both personal and professional contexts, and each had some relevant information. The challenge was to gather all this information and seek more information where necessary in order to provide a clear understanding of what was taking place. That understanding could then have been the basis for an effective plan to manage the risks surrounding this child and her mother. In any system there are barriers to the exchange of information. In this case there appears to have been a degree of confusion as to the role each worker played in the life of this family and a lack of recognition that the well-being of the child should have been the paramount consideration for every person tasked with her care.

The fact that a child protection investigation was concluded as unsubstantiated, as was the case with the July 2010 child protection report, does not mean that there is not an ongoing obligation on the part of all participants to share information and to seek it out when it is not immediately available. Bringing together everyone who has information and taking opportunities to share this knowledge among the group is an obvious strategy to provide insurance against missing some vital clue that places a child at risk.

MCFD Services

Finding: There was no case manager and no process of assessment or planning in place for this child. Her special needs were not being adequately addressed, and her safety and well-being were not effectively monitored.

In examining the transfer of responsibility of CYSN services for this family from CLBC to the ministry, it became clear that there was no comprehensive and collaborative plan for this child's development or for her future. There was instead the piecemeal provision of respite care and behaviour support, neither of which was being adequately monitored. The CYSN social worker did not meet the family until almost 6½ months after the transfer had taken place. Clearly, no meaningful assessment or planning was taking place.

The loss of continuity in service that occurred when CLBC transferred CYSN services back to the ministry could have been dealt with by CYSN social workers identifying and connecting with each client and with service providers, in this case the behavioural support worker and respite caregiver. Their insights could potentially have changed perceptions of this family and the urgent need for services. It is difficult to overstate the importance of linking the observations of professionals, working together as a team, to gain an accurate view of a child's abilities and the barriers that could prevent them from reaching their potential.

The Representative's investigation found that the mother's reduced use of CYSN services following the transition from CLBC to the ministry was related to her own declining capacity and not necessarily the service delivery model. The former CLBC model and the current ministry CYSN service model are both based on providing voluntary services, a point of concern for some time.

The CYSN social worker's involvement with this family since May 2010 was limited to offering voluntary support services. A more proactive role as a case manager to collaborate and coordinate service delivery was what was needed. Although the job description for ministry CYSN social workers does not specifically include a case manager role per se, it notes a key accountability of preparing case assessments and developing service plans in conjunction with clients, family members, service providers and other relevant participants.

The CYSN social worker said she had a caseload of more than 200 families when the transfer of special needs services from CLBC to the ministry occurred in October 2009. CYSN social workers need the resources and time to be able to assess and plan with the families they serve, and must provide a case manager function for those who cannot navigate the complex system for children and youth.

Good decision-making rests on good information. The responsibility for gathering together those individuals who each have some part of that information rests with a case manager. A coordinated and collaborative approach ensures everyone with responsibility for the care and development of the child is fully informed and able to act in concert. This approach assists in identifying situations such as this, where it was clear that the mother's capacity both to make good decisions about the development of the child and then act on those decisions was wholly inadequate.

A coordinated approach with a dedicated case manager can yield great results for children and families, but it also requires adequate time and resources. It is encouraging to see that such an approach is now being applied in planning for the girl's future, although it is arguably late in coming and arose from perilous circumstances.

Finding: Responses to the 2010 child protection reports relating to this family were inadequate and provided a poor foundation for effective assessment and decision-making. People with information about and knowledge of the family were not contacted.

There was not enough focus on the child, who had significant unmet medical needs, was isolated and was essentially confined to her home for long periods of time with a desperately ill mother.

The *Child, Family and Community Service Act (CFCS Act)* provides the legal authority for child welfare services in British Columbia. Section 13 of the *CFCS Act* sets out the circumstances of when a child needs protection (See Appendix F) and Section 14 provides for the legal duty to report if a person believes that a child is in need of protection.

Duty to report need for protection (*Child, Family and Community Service Act, 1996*)

- 14 (1) A person who has reason to believe that a child needs protection under section 13 must promptly report the matter to a director or a person designated by a director.
- (2) Subsection (1) applies even if the information on which the belief is based
- (a) is privileged, except as a result of a solicitor-client relationship, or
 - (b) is confidential and its disclosure is prohibited under another Act.
- (3) A person who contravenes subsection (1) commits an offence.
- (4) A person who knowingly reports to a director, or a person designated by a director, false information that a child needs protection commits an offence.
- (5) No action for damages may be brought against a person for reporting information under this section unless the person knowingly reported false information.
- (6) A person who commits an offence under this section is liable to a fine of up to \$10 000 or to imprisonment for up to 6 months, or to both.
- (7) The limitation period governing the commencement of a proceeding under the *Offence Act* does not apply to a proceeding relating to an offence under this section.

The ministry's framework for delivery of child protection services is further articulated in the Child and Family Service Standards (CFS Standards). These standards provide the mandatory framework for providing child protection services in the province.

Standard 12 provides direction in determining the most appropriate response to a child protection report. The standard indicates that a social worker will assess every child protection report and determine the most appropriate response within five working days, unless the child is at immediate risk of harm.

Standard 12 requires that:

- relevant information be gathered within the timeframe appropriate to the reported circumstances
- the information gathered be used to determine the most appropriate responses
- standardized assessment tools that have been developed and endorsed by leading practitioners and researchers be used to inform clinical judgment.

Once the information has been gathered and assessed, the social worker has the following options in responding to a child protection report:

- taking no further action
- referring the family to informal and formal support services
- providing a family development response
- conducting a child protection investigation.

If a family development response is chosen as the response, then Standard 14, Family Development Response, of CFS Service Standards applies. This standard describes the response as "an approach to child protection reports when, according to an assessment, the risk of harm can be managed through the provision of intensive, time-limited support services. It includes a strength-based assessment of the family's ability to safely care for a child, and provision of support services, instead of a child protection investigation."

This type of response requires that the family is cooperative and engaged, and that community services are involved to address identified risks. A family development response can include, with family consent, contact with collateral sources who can provide further information on the family circumstances.

The application of a family development response to the May 2010 child protection report was inadequate. Although the mother appeared cooperative, any of the service providers could have reported that the family really was not engaged with services. The assessment of risk of harm to the girl was insufficient and a plan with support services was not put into place.

The initial assessment on May 5, 2010 that it was safe for the girl to be returned to the home by her brother was not adequate – given the seriousness of the safety concerns reported, the girl's special needs and her extreme vulnerability – and this assessment was based on only one home visit and interview of the mother. It further indicates there was very little credibility given to the girl's brother's report to the ministry.

When the child protection social worker returned with the CYSN social worker on May 12, 2010, again no plan was put in to place for assessment and coordination of services for this family. The CYSN social worker didn't participate in the assessment. The child protection social worker had limited knowledge of the services that were being provided through child and youth with special needs. Child protection believed that only respite services were being provided but did not know that the family had been involved with a behavioural support worker and never inquired further on the details of these services.

The CYSN social worker saw her role as offering voluntary support services to the family and had little knowledge of the details of the child protection report or the outcome of the report. She only knew what the mother told her – that the child protection report was closed and the mother was relieved because it made her nervous. There was no coordination or collaboration regarding service planning between child protection and child and youth with special needs.

The assessment of the risk of harm to the child was flawed as it did not include contact with important collateral sources, with the exception of contact initiated by the school. These collateral sources could have provided valuable information about this family's circumstances.

Contact with the behavioural support worker, the former CLBC social worker and the respite caregiver would have informed the child protection social worker that the mother was known for not following through on suggestions or recommendations, had a history of cancelling appointments as she was too tired or too sick, and had been struggling for at least the last five years to manage her daughter's behaviour.

The child protection social worker was not aware of the involvement of the behavioural support worker. Somehow this information did not get shared between the CYSN social worker and the child protection social worker. Had it been shared, it would also have become evident that the behavioural support worker hadn't met with the family since December 2009, as the scheduled appointment in January 2010 had been cancelled by the mother. These were voluntary support services, and it appears none of those involved were concerned about the mother's lack of engagement and declining use of these services.

The former CLBC social worker could have advised the child protection social worker that the mother needed more than voluntary service, and that there would have to be some externally imposed accountability to guarantee positive outcomes for the child. The former CLBC worker's history with the family would have brought the mother's lack of capacity to parent effectively into sharper focus.

The failure to contact the respite caregiver was particularly unfortunate, as the respite caregiver had known the family for four years, and was in a unique position to provide information. She had also recently encountered the family in the community while this child protection report was being assessed, and her observations of the mother's physical and emotional condition would have contributed to the understanding of this family's current circumstances.

The child protection social worker was not able to establish whether the mother was abusing alcohol or prescription medication. However, it would have been informative to contact the family doctor and other medical service providers in this situation to find out if they were aware of any issues regarding alcohol or prescription medication abuse and to better understand the medical history of both the mother and her daughter. This would have added to the understanding of their circumstances.

If collateral contacts had occurred with relevant medical professionals it would have become immediately evident that they had numerous health issues with no plans in place to manage an increasingly fragile situation. Over the course of the last three years a concerning pattern was also developing as the mother and the girl were seeing physicians less often, not more, even as their medical needs were steadily increasing.

The girl's complex medical needs were not assessed during the family development response process. The girl requires hearing aids, glasses, leg braces and orthopedic shoes and these were not taken into consideration at this time. If workers had inquired about this, they would have learned these supports were lacking, that there was inattention to her medical needs and healthy development and that the mother did not have the capacity to address these.

Since the risk of harm to the child was not adequately assessed, there were no intensive support services put in place for this family as described in the service standard on family development response. In fact, there was no plan put in place by child protection services to support the family as they were under the impression, when they closed the report, that CYSN services were being provided. This was not the case, and the hand-off of responsibility was not effective or responsive, and it fell well below the standard expected. There was absolutely no plan for this child or her mother. This was a missed opportunity for the ministry to develop a coordinated approach and plan to support and monitor the family.

When the July 30, 2010 child protection report was received, it was investigated immediately. CFS Standard 16, Conducting a Child Protection Investigation, provides child protection social workers with details on the steps involved in conducting an investigation. The standard states that:

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 and/or child.

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

The July 2010 investigation fell below the prescribed standard by failing to obtain information from people who had relevant knowledge of the family's circumstances. Although some key collateral sources were contacted, such as police and community members, other collateral sources in possession of critical information were not considered in response to this report. Contact with the police should have been done in response to the May 2010 child protection report as well, as the mother had been in the car accident in April.

The CYSN social worker was used only as a collateral source for information and was not involved in assessing and developing a service plan for the child and did not participate in the child protection investigation, which is inconsistent with the job description. The job description clearly states that CYSN social workers assess needs and develop service plans for children and youth with special needs and participate in the investigation of alleged child abuse and neglect according to regional and provincial protocols. The Representative notes that there are no regional or provincial protocols that outline the roles and responsibilities of the CYSN social worker in a child protection investigation, despite the fact that they are referred to in the current job description.

Again, contacts with the respite caregiver, former CLBC social worker, behavioural support worker, medical professionals and the employment and assistance worker would have been valuable, just as they would have been for the May 2010 report. The child protection social worker would have also learned that the behavioural support worker tried to meet with the family on July 20, 2010 but the mother would not let her in, saying she was too sick. The mother told the behavioural support worker things were not going well. She couldn't afford her diabetic medication and was not feeling well. This was important information for the child protection worker to know in conducting the investigation as the mother's health was rapidly deteriorating, and this would have an obvious impact on her ability to care for her daughter.

Collateral contact with medical professionals would also have been imperative in this investigation given the knowledge that would have been gained regarding the mother's ongoing health issues. The mother did not have an overall chronic disease management plan, and she did not follow through on medical advice. In the last few years of her life the mother had numerous serious chronic medical conditions, such as anxiety, asthma, chronic obstructive pulmonary disease, Type 2 diabetes, chronic renal failure, high blood pressure and high cholesterol.

The child protection social worker would have also found out that during the same time the child protection investigation was in progress, there were immediate concerns about the mother's health. During a visit at that time to the walk-in clinic, she received medical support for her immediate needs, but there were concerns that further medical tests were urgently required. She was told to follow up immediately with her family doctor, but she never did. The walk-in clinic tried to follow up with her by phone on August 13 and 16, 2010 but her phone number was not working. The mother never sought any further medical treatment before her death.

Contact with the employment and assistance office would have informed the child protection social worker of the increasing financial pressures facing the mother. She had not paid the July 2010 pad rental for her mobile home, there was a pending disconnection from Hydro that she had managed to avert, and the income assistance worker was going to begin issuing her pad rental directly to the landlord, presumably because she was not able to manage this herself. Other indicators of financial distress included the need for the food purchased by the CYSN team and the groceries purchased by the CYSN social worker. Even these did not appear to raise a red flag.

Contact with the employment and assistance office would have also resulted in knowledge of the July 14, 2010 phone call made by the mother detailing her physical pain and inability to use the neighbour's phone for contact with that office. A "signal" or alert had been put on her file, which meant that she needed to speak to a worker before her check would be issued. As evidenced by this call, this was proving almost too difficult for the mother to manage, although contact with the worker was eventually made and she did receive her July income assistance. However, August income benefits were not received when she failed to file the necessary reporting documents.

MCFD staff noted that it is not helpful to conduct collateral checks with employment and assistance workers in the current service delivery model since they no longer carry a caseload and no one key worker is regularly involved with the family and understands their overall circumstances. Families deal with a different person every time they go to the employment assistance office, so this collateral check is not done by child protection social workers as often as it used to be.

The absence of significant collateral checks during the course of this investigation is more surprising given the most recently completed audit of the office that had responsibility for conducting this child protection investigation. The ministry conducts internal audits to measure compliance to the practice standards.

A re-audit of this office was done in October 2006. During the re-audit, 44 files were rated for compliance to the child and family service standards. The overall compliance to Standard 16 (which is the standard for fulfilling the requirements of a child protection investigation) was 65 per cent. This means that in 35 per cent of the files reviewed, not all of the required steps in the investigation process were completed. This standard measures whether all case records have been reviewed, the child's living situation has been directly observed and information from people who have relevant knowledge of the family has been obtained.

Of particular note in the re-audit report is a statement that an area identified for improved practice in this office is the use of more collateral sources for information gathering in investigations. Specific reference is made to contacting medical sources.

Closing this investigation with a finding that the girl was not in need of protection was not appropriate. It was still incomplete, as important information from a number of sources was not gathered and assessed. Once again, the needs of this vulnerable girl were missed.

On Sept. 8, 2010, when a community member called to report that the girl had not been seen over the summer, the call was not documented as a child protection report and further information was not collected from the caller. At the very least, the call should have been documented on the ministry case management system as required by policy. Without a formal record of the call, this information would not have been known or accessible to anyone subsequently involved with the family. The information from this call was left as a hand-written note in a paper file. It is not clear why this report was noted in this way and not followed up on. This was not appropriate and reflects sub-standard practice.

During the four months prior to the mother's death there was misinformation and large gaps in the information gathered by the professionals involved with the family. If there had been a coordinated response to the intakes, the risk of harm to this child would have been evident, and it is likely the harm she experienced could have been prevented.

It appears that the well-being of this vulnerable child with special needs was not given priority in either the May or July 2010 responses to the child protection reports. The mistaken reliance by child protection services on the ongoing involvement of CYSN services created a false sense of assurance that this child was safe.

Overall, the response from both the special needs and child protection service streams was characterized by role confusion, and a lack of focus on the needs of this vulnerable child. Clear direction to staff and supervisors is required to support improved practice. This does not suggest consideration should be given to transferring responsibility for CYSN services back to CLBC. It means that MCFD must articulate a clear program of supports and services, and ensure that resources are adequate and staff are fully trained and supervised.

Recommendation 1

That MCFD, working in collaboration with the Ministry of Education and the Ministry of Health as required, develop a detailed strategy for provision of services to children and youth with special needs. The strategy should be supported by the necessary resources to ensure that children and youth are receiving the services that they require.

Details:

The strategy should be informed by the following:

- a clear description and analysis of current and projected caseloads
- an analysis of current staff and financial resources
- a needs-based assessment of required resources.

The strategy should address the following:

- the need for clear guidelines for assessing children's needs and the family context they are living in
- the need for clear guidelines for matching the case management approach to the results of that assessment
- for each child and youth a clearly identified key worker/case manager who is expected to actively assess, plan and ensure that appropriate services are in place to support optimal development
- a mechanism to identify children and youth who are especially vulnerable due to their family circumstances, and provide a more assertive case management approach for them
- the need for clear guidelines for collaboration with school personnel, health care providers and other services providers, depending upon the case management approach identified for the case
- clarification of roles and responsibilities of CYSN workers and child protection workers in relation to child protection investigations, to promote effective, integrated practice
- clarification of roles and responsibilities of CYSN workers in planning for transition to adulthood
- updated job descriptions, as required
- clear expectations for supervision
- training and resources tools to support best practice
- tracking, evaluation and public reporting of access to services, wait lists and wait times, and outcomes.

The strategy should be developed by Dec. 30, 2011, and fully implemented across the province by June 29, 2012.

Recommendation 2

That MCFD review plans of all children and youth transferred from CLBC to ministry services, to ensure vulnerable children and youth have appropriate plans that address both their safety as well as their needs.

The review, along with a report to the Representative, should be completed by Dec. 30, 2011.

Recommendation 3

That MCFD develop and implement policy and guidelines with respect to checking with collateral sources of information when conducting child protection investigations.

Details:

- Policy and guidelines should outline expectations of front-line staff and supervisors.
- Policy and guidelines should identify an effective process for MCFD child protection investigators to consult with MSD workers.

Policy and guidelines should be implemented by Oct. 31, 2012.

Income Assistance Practice

Finding: *The decision to close the mother's income assistance file with no follow-up with the family was not in the best interests of the child. In circumstances where it is clear that a single parent with a child with special needs is struggling financially, all efforts need to be made to make sure the child's well-being is a priority. It is shocking that a file could be closed – knowing these circumstances – without any contact with the family or MCFD.*

This family's circumstances had become clear during their years of engagement with income assistance. The employment and assistance office knew the mother was a single parent trying to cope with a child with complex special needs yet they chose to close her file in September 2010 without any effort to connect with her.

Beginning in 2005, when the mother first applied for income assistance, it was apparent that she was having difficulty managing her daughter's increasingly difficult behaviours and that this was limiting her availability for work. Her well-documented and ongoing medical challenges also had a direct effect on her employability and by May 2010, income assistance appeared to be the sole source of income for this family.

The mother was clearly in desperation when she called the employment and assistance office on July 14, 2010. This should have triggered concerns about the circumstances for this family, especially about the well-being of the girl.

Because the mother didn't submit reporting documentation required to receive benefits after July, it is possible that she knew her next income assistance payment might not be forthcoming. This would surely have contributed to her desperation.

Recommendation 4

That MSD work collaboratively with MCFD to develop a proactive policy and process so that income assistance to families with dependent children or youth with special needs will not be terminated without a joint review by MCFD and MSD.

Details:

- The health, safety and well-being of children and youth should be the primary consideration.
- The policy should clearly articulate a problem-solving and dispute resolution process for cases where there is disagreement between the two ministries.
- Personal contact, including a home visit, should be made to ensure effective supports are in place before income assistance is terminated.

The policy and process should be developed by Dec. 30, 2011, and fully implemented across the province by June 29, 2012.



Conclusion

This girl with special needs was found sitting with her mother who had been dead for several days. How alone she must have felt. Had she not been found by concerned neighbours, would she too have died? Many people in our province were deeply saddened and outraged when they heard of these events.

Equally sad and outrageous is what we find when we scrutinize the circumstances in which she lived for most of her life. Our systems of services and supports did not address her complex needs. Those needs were not even thoroughly assessed. The system was passive, and the result was long-term neglect.

Her care and well-being were largely left in her mother's hands. That is appropriate when a parent is up to the challenges of navigating complicated service systems, understanding the needs of a disabled child and capable of being a strong advocate. That is a tall order for most parents, even for those with every advantage.

This mother did not fit that description. She had complex medical needs of her own, struggled with addictions and lived in poverty and isolation. Toward the end of her life, she could barely walk. She could not look after her own health care, let alone seek out help for her daughter. Loving a child and being able to meet their needs are not the same. The mother's isolation and incapacity was a grim reality for her daughter.

When this child was found, she could not hear. The reason for this was that her hearing aids were not working, and they hadn't been for a long time. Professionals involved in her care assumed she was deaf. Her sight was also impaired. Her behaviour had been controlled in recent years by strong psychoactive drugs. In other words, her isolation was much more profound than being restricted to her small home or not participating in her community. Her senses were impaired, and this limited her development.

This is not what we expect for a child with Down syndrome in British Columbia, or for a child with any special needs. As a caring and affluent society, we want all children, including all disabled children, to develop to their full potential and to contribute to and benefit from a rich community life. We have publicly funded programs of specialized services to support that vision, and we have charitable organizations that help to enrich those services. We have the benefit of knowledge and skilled professionals. We have laws and practices that support the dignity of life and fair treatment for all. Despite all of this, this child led a life that was impoverished, in every sense of that word.

Is this the only child in British Columbia we are letting down in these ways? Is this a unique circumstance, a cruel anomaly? Tragically, it is not. We know, for example, that this child shared one of her support workers with almost 200 others. We know that in that worker's office, there was great confusion about roles and responsibilities. And we are well aware of wait lists for therapy services and challenges in meeting the needs of children with special needs in our schools.

It would be easy to blame the front-line workers who did have contact with this child and her mother. Although standards were not met, that would take us in the wrong direction, and would not address the central issue. The systems they work in failed, and these systems must improve. They must focus on the children and the supports and services they need. Not grand schemes of reorganization or governance, but solid, cost-effective, accountable programs that improve outcomes for vulnerable children. We need clarity about who does what, and we need programs that require child protection social workers, special needs workers, therapists, physicians and teachers to work together effectively with the child as the focus.

We also need systems that treat people with respect. In this case, two brothers who tried to get the system to pay attention to a desperate situation felt that they were not taken seriously. When they complained, they believe they were rudely dismissed. Community members' concerns were not paid sufficient heed. A respite worker, a key positive figure in this child's life, was treated with disregard as she tried to help the girl through the trauma of the mother's death.

All of these people had the interests of this child at heart. We need systems and staff that can apply that caring to the benefit of children.

What happened to this child can't be undone. Thankfully, according to recent reports, she is thriving. It can't be known what long-term negative impact the last few years may have on her. The Representative is hopeful that the current attention paid to her developmental needs will continue and that everything will be done in the future to give her the best chance possible. Through advocacy on her behalf, the Representative will monitor this.

We can show this girl the respect that is due by taking every opportunity to learn from the results of this investigation. We must act on opportunities for change to ensure that other children will have the best care and development possible, so they will not face the isolation and invisibility she endured.

Glossary

Adenoidectomy: a surgical removal of the lymph masses in the wall of the air passageway just behind the nose.

Child protection social worker: collects information, responds to child protection reports, conducts child protection investigations, removes children from unsafe circumstances, attends court, works with families and plans for the return of children or for continuing custody.

Child and Youth with Special Needs (CYSN) social worker: coordinates placements, resources and services for children with special needs and negotiates and monitors contracts for appropriate resources/services to ensure contract compliance and quality of services.

Child protection investigation: a process of inquiring into or tracing through inquiry the collection of information and interviews with parents, teachers, daycare providers, public health nurses, physicians, and extended family members to determine whether a child is in need of protection.

Child protection report: a report received about a child's need for protection due to abuse or neglect. Reports are assessed pursuant to sections 13 and 14 of the *CFCS Act*. Possible responses include taking no further action, referring the family to support services, providing a family development response, providing a youth response (if the child is a youth), or conducting a child protection investigation.

Community Living BC (CLBC) social worker: confirms eligibility, provides support to families as required, assists families to develop informal supports and linkages to generic community services, assists families to develop plans for their children who are eligible for CLBC services and assists families/guardians of eligible children to apply for funding for autism services.

Employment and assistance worker: determines eligibility and authorizes employment and financial assistance (temporary and continuous) through reference to related legislation, regulations, policies and procedures, and promotes programs and services designed to move clients towards sustainable employment.

Half-brother: a sibling who shares only one biological parent with another sibling.

Intake: a process by which child protection reports and requests for service are introduced into a ministry office. These reports and requests for service are discussed at intake meetings and are assigned to social workers for follow-up.

Respite care: is provided on a temporary basis for the purpose of providing a break to a parent by placing the child with an alternate caregiver.

Team leader: a supervisor of a team of social workers.

Tonsillectomy: a surgical removal of tonsils or a tonsil.



Appendix A: Representative for Children and Youth Act

Section 12 of the *Representative for Children and Youth Act* 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 during the Representative's Investigation

Ministry of Children and Family Development Records

- The mother's family service file
- The mother's daycare subsidy file
- The child's child and youth with special needs file
- The child's child and youth mental health file
- The child's child service file
- The foster parents' records regarding the child
- Reportable circumstances report
- Regional Director's file
- Director's Case Practice Re-Audit Report, completed 2007

Ministry of Children and Family Development Policy and Standards

- Child and Family Development Service Standards, Nov. 2003, revised June 2004
- Family Development Response or Investigation, Determining the Most Appropriate Response to Child Protection Reports, Dec. 2004
- British Columbia's Family Development Response, Children and Family Development, May 2004

Ministry of Children and Family Development, other documents

- Child and Youth with Special Needs Generalist – position description
- Children's field service protocol between CLBC and MCFD, Dec. 2006
- Children's field service protocol between CLBC and MCFD, Oct. 2008

Ministry of Health

- The mother and the child's Medical Service Plan (MSP) and PharmaNet records

Ministry of Education

- Records on the child

Ministry of Public Safety and Solicitor General, Motor Vehicles

- The mother's driving records

Ministry of Public Safety and Solicitor General, BC Coroners Service

- Kimble report on the mother's death
- Toxicology report on the mother's death
- Report of post-mortem examination

Ministry of Social Development

- Income assistance records
- Family maintenance records

Community Living British Columbia (CLBC)

- The family's records

School Records

- School records on the child

Medical Records

- The mother and child's files from their family physician
- The mother and child's files from medical clinics
- The mother and child's hospital files

Police Records

- RCMP records

Other Records

- Respite caregiver's records
- Community living association records
- Contracted service providers' records

Legislation

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

Appendix C: Interviews Conducted During the Representative's Investigation

Staff of the Ministry of Children and Family Development

- Three child protection social workers
- Team leader
- Child and youth with special needs social worker

Others

- Respite caregiver
- CLBC social worker
- Behavioural support worker
- Neighbours
- Family members

Appendix D: MCFD Position Description



**BRITISH
COLUMBIA**

POSITION DESCRIPTION

Ministry of Children and Family Development

| | | | |
|---|--|---------------------|---------|
| POSITION TITLE: | Child and Youth with Special Needs Generalist | POSITION NUMBER(S): | Various |
| DIVISION: (e.g., Division, Region, Department) | | | |
| UNIT: (e.g., Branch, Area, District) | | LOCATION: | |
| SUPERVISOR'S TITLE: | Team Leader - Child and Youth with Special Needs | POSITION NUMBER | Various |
| SUPERVISOR'S CLASSIFICATION: | Social Program Officer 28 | PHONE NUMBER: | |
| FOR AGENCY USE ONLY | | NOC CODE: | |
| APPROVED CLASSIFICATION: | | CLASS CODE: | |
| ENTERED BY: | | PHONE NUMBER: | |

PROGRAM (OPTIONAL)

The Ministry of Children and Family Development works with provincial ministry partners to build an integrated system of programs and services to support families and communities in the process of raising their children. The Ministry provides a range of services to eligible children and youth with special needs and their families.

PURPOSE OF POSITION

Reporting to the Team Leader, the Child and Youth with Special Needs (CYSN) Generalist provides a combination of Resource Worker and Family Support Worker functions, which includes, but is not limited to: confirm eligibility of applicants for ministry funded services; support and enable children and their families to access unfunded services and informal supports, as well as paid formal supports; work with the children and their families to resolve problems, create and implement Plans, as well as for support the building of networks of support and involvement in the community; interpret child welfare legislation, ministry policy and standards to plan and review recruitment, development and maintenance of a range of resources for alternative care arrangements in which to place children (respite homes, foster homes, group homes, specialized residential resources such as emergency assessment and treatment homes/centres); evaluate resources and ensure appropriate service delivery; and participate in the investigation of alleged child abuse and neglect according to regional and provincial protocols.

Some CYSN Generalists will be required to provide guardianship services to children in care of the Ministry, and are delegated by the Director of Integrated Practice under the *Child Family Community Services Act (CF&CSA)*.

To be effective the CYSN Generalist have and maintain a comprehensive knowledge of the *Child and Family Community Services Act (CFCSA)*, the *Child and Family Development Service Standards and Caregiver Support Service Standards*, priorities, initiatives, significant current and pending issues and linkages with other jurisdictions and agencies.

The CYSN Generalist must ensure that the rights of children in care are being met under Section 70 of the CFCSA, and that services are consistent with priorities identified in the Strong, Safe and Supported: A Commitment to BC's Children action plan and guided by the CYSN Cross-Ministry Framework for Action.

The position must establish and maintain strong working relationships and attend to the appropriate protocol needs in interaction with other ministry staff, community partners, stakeholders and children, youth and families. The CYSN Generalist must understand the theory of social work and interpret child welfare legislation, ministry policy and standards in order to carry out its functions.

Key responsibilities include:

- Provision of quality, children, youth and family oriented services.
- Inclusion of effective strategic planning processes.
- Effective monitoring of services delivered.

Child and family-centred, Independent Planning Support Services include the development of social, life or other particular skills by the child and/or the development of child management, or other parenting skills by the family. It may be provided for a specific limited time, or on an on-going or intermittent basis.

Service may be provided in a variety of locations in the community so as to facilitate the participation of the child and family in community activities as well as the development of specific skills. Service may be provided individually or in groups; however, the particular need of each child must be documented and in accordance with the program objective. These services are expected to be provided within a dynamic integrated and collaborative practice environment.

NATURE OF WORK

POSITION LINKS

The CYSN Generalist convenes with individuals and/or families, service providers, community partners, contracted agencies, foster parents, etc. to determine the best resources and services, to coordinate placements, resources and services for children, and to negotiate and monitor contracts for appropriate resources/services to ensure contract compliance and quality/appropriateness of services.

- **Applicants (Children, Youth and their Families/Caregivers)** – reviews submitted applications for funded services/resources, determines eligibility, and notifies applicants of outcome.
- **Foster Parents** – recruits, orients, studies and makes recommendations to approve; monitors and provides support to foster parents; and resolves issues.
- **Local foster parent associations and regional councils** – resolves issues and provides information of mutual interest.
- **Respite Homes Providers/Family Members** – works with respite care providers/family members to maintain and enhance the independence and quality of life for families of children with special needs.
- **Contracted Agencies/Service Providers in the Community** – negotiates and develops individual funding/contract agreements outlining goals, objectives, standards, quality, cost, etc.; monitors contract compliance and quality/appropriateness of services; and responds to service related crises and for the investigation and satisfactory correction of situations affecting the care or safety of individuals.
- **Community** – assists in the development of personal networks for those without a personal network. Community Development work to address gaps in supports and services.

SPECIFIC ACCOUNTABILITIES/DELIVERABLES

1. Assesses needs and develops service plans for children and youth with special needs:
 - a) reviews psychological assessments, medical reports and other documentation to assess and determine eligibility for services
 - b) prepares case assessments and develops service plans and objectives in conjunction with clients, family members, service providers and other relevant participants
 - c) assesses family needs for available services and negotiates contracts for homemakers, family support workers and other related services
 - d) monitors and assesses the provision of contracted services by reviewing services with family members and contractors, making modifications to service objectives as required, ending services when goals are achieved and terminating unsatisfactory services if necessary
 - e) provides goal-directed counselling and advice to clients and families in dealing with children and youth with special needs and developing goals
 - f) provides referrals to educational, vocational treatment and social development services
 - g) plans school placements and medical treatment for children and youth under guardianship and documents planning in accordance with *Child, Family and Community Service Act*
 - h) plans and arranges services for families eligible under the Autism Initiative by providing advice on individual and group services available, writing contracts with service providers, monitoring services and making modifications as required
2. Co-ordinates At Home Program for children and youth with special needs:
 - a) conducts income tests to determine eligibility for funds
 - b) prepares agreement with the family on standards and objectives
 - c) maintains ledger of funds remaining for each family and processes billings for payment
 - d) assists families to locate Ministry Special Care homes for respite as required including completing intermittent special care agreements and related documentation
 - e) provides information to the public, other ministries and community agencies on services available
3. Performs other related duties:
 - a) sets up and maintains client and service files
 - b) participates in budget development by suggesting services and programs for clients
 - c) drives automobile to transport clients
 - d) performs resource worker work
 - e) trains and functions as a resource for junior social workers

FINANCIAL RESPONSIBILITY

Develops and negotiates the terms and conditions for contracts with services providers, including monitoring and evaluating contract compliance and quality/appropriateness of services and verifying for payment.

DIRECT SUPERVISION (i.e., responsibility for signing the employee appraisal form)

| Role | # of Regular FTE's | # of Auxiliary FTE's |
|--|--------------------|----------------------|
| Directly supervises staff | | |
| Supervises staff through subordinate supervisors | | |

PROJECT /TEAM LEADERSHIP OR TRAINING (Check the appropriate boxes)

| Role | # of FTE's | Role | # of FTE's |
|--|------------|---|------------|
| Supervises students or volunteers <input type="checkbox"/> | | Provides formal training to other staff <input type="checkbox"/> | |
| Lead project teams <input type="checkbox"/> | | Assigns, monitors and examines the work of staff <input type="checkbox"/> | |

SPECIAL REQUIREMENTS

Delegatable under Section 4 of the *Child and Family Community Services Act*, as the worker may be expected to provide guardianship services to children in care of the Ministry.
 Successful applicants must consent to a criminal record review and police record check.
 Occasional overnight travel (e.g. to communities within the catchment area).
 Possession of a valid class 5 Driver's Licence.

TOOLS / EQUIPMENT

WORKING CONDITIONS

Expose to children and youth with development disabilities.

WORK EXAMPLES

COMMENTS

PREPARED BY

| | | |
|-------|-------|--|
| NAME: | DATE: | |
|-------|-------|--|

EXCLUDED MANAGER AUTHORIZATION

I confirm that:

1. the accountabilities / deliverables were assigned to this position effective: (Date).
2. the information in this position description reflects the actual work performed.
3. a copy has / will be provided to the incumbent(s).

| | | |
|-------|------------|-------|
| NAME: | SIGNATURE: | DATE: |
|-------|------------|-------|

SELECTION CRITERIA

Experience/Education

- Bachelor's of Social Work, Masters of Social Work (MSW) or Bachelors of Arts in Child and Youth Care (BA CYC); or M.Ed. Counselling/M.A. Clinical Psychology, having completed a practicum in child and family welfare.
- Experience working in social services sector with children and youth with developmental disabilities, and providing support/guidance to family and/or caregiver.

Knowledge

- Knowledge of how community services and supports operate.
- Knowledge of child-centered planning and community development processes, community development theory and practice.
- Knowledge of Section 70 under the *Child, Family and Community Service Act (CF&CSA)*.
- Knowledge of the Ministry of Children and Family Development's legislation, policies, structure, goals, issues and activities.
- Understanding of the social service sector, including current trends, developments and issues in social services.

Skills/Abilities

- Ability to facilitate group and individual planning.
- Ability to apply child-centered planning and community development processes, community development theory and practice.
- Ability to develop and implement individual plans.
- Well developed written and oral communication skills.
- Well developed interpersonal skills, ability to listen, understand and articulate the desires and needs of children, youth and their families.
- Ability to apply appropriate analytical, problem solving and judgement to the development and implementation of plans.
- Ability to manage multiple tasks and produce results within deadlines.
- Ability to develop and maintain productive relationships with children, youth and their families, service providers and colleagues.
- Ability to exercise tact and diplomacy when dealing with children, youth and their families, community members, non-government organizations, business and government staff.
- Strong negotiation and mediation skills to deal with community and service providers.
- Ability to work with children, youth and their families to identify required supports with imposing personal or professional bias.
- Ability to accept feedback from children, youth and families and others involved.
- Ability to network with, develop and enhance links to business, industry, health, municipal and regional councils, school boards, and community services.
- Ability to demonstrate a high degree of ethical practice in their relationships with children, youth and their families, service providers and other professionals.
- Ability to work independently within a policy framework in an unstructured setting, with supervision, to identify flexible and creative support options for children, youth and their families.

COMPETENCIES

Building Partnerships with Stakeholders is the ability to build long-term or ongoing relationships with stakeholders (e.g. someone who shares an interest in what you are doing). This type of relationship is often quite deliberate and is typically focused on the way the relationship is conducted. Implicit in this competency is demonstrating a respect for and stating positive expectations of the stakeholder.

Analytical Thinking is the ability to comprehend a situation by breaking it down into its components and identifying key or underlying complex issues. It implies the ability to systematically organize and compare the various aspects of a problem or situation and determine cause-and-effect relationships (“if...then...”) to resolve problems in a sound, decisive manner.

Impact and Influence is the ability to influence, persuade, or convince others to adopt a specific course of action. It involves the use of persuasive techniques, presentations and negotiation skills to achieve the desired results.

Teamwork and Cooperation is the ability to work co-operatively within diverse teams, work groups and across the organization to achieve group and organizational goals.

Appendix E: Multidisciplinary Team

Under Part 4 of the *Representative for Children and Youth Act* (see Appendix A), the Representative is responsible for investigating critical injuries and deaths of children who have received reviewable services from 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 Members

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 currently 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.

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 F: Child, Family and Community Service Act, 1996

When protection is needed

- 13 (1) A child needs protection in the following circumstances:
- a) if the child has been, or is likely to be, physically harmed by the child's parent;
 - b) if the child has been, or is likely to be, sexually abused or exploited by the child's parent;
 - c) if the child has been, or is likely to be, physically harmed, sexually abused or sexually exploited by another person and if the child's parent is unwilling or unable to protect the child;
 - d) if the child has been, or is likely to be, physically harmed because of neglect by the child's parent;
 - e) if the child is emotionally harmed by the parent's conduct;
 - f) if the child is deprived of necessary health care;
 - g) if the child's development is likely to be seriously impaired by a treatable condition and the child's parent refuses to provide or consent to treatment;
 - h) if the child's parent is unable or unwilling to care for the child and has not made adequate provision for the child's care;
 - i) if the child is or has been absent from home in circumstances that endanger the child's safety or well-being;
 - j) if the child's parent is dead and adequate provision has not been made for the child's care;
 - k) if the child has been abandoned and adequate provision has not been made for the child's care;
 - l) if the child is in the care of a director or another person by agreement and the child's parent is unwilling or unable to resume care when the agreement is no longer in force.
- (1.1) For the purpose of subsection (1) (b) and (c) and section 14 (1) (a) but without limiting the meaning of "sexually abused" or "sexually exploited", a child has been or is likely to be sexually abused or sexually exploited if the child has been, or is likely to be,
- a) encouraged or helped to engage in prostitution, or
 - b) coerced or inveigled into engaging in prostitution.
- (2) For the purpose of subsection (1) (e), a child is emotionally harmed if the child demonstrates severe
- a) anxiety,
 - b) depression,
 - c) withdrawal, or
 - d) self-destructive or aggressive behaviour.

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