



News Release

For Immediate Release

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CHILD-SERVING SYSTEM DESCENDED INTO DISARRAY RATHER THAN RISING TO PROTECT INFANT

VICTORIA – An investigation into the chaotic life and unexpected death of a four-month-old infant illustrates holes in how government and delegated Aboriginal agencies work together, and in how courts assess potential caregivers.

“A child at the most vulnerable stage of life was not well-served by jurisdictional shifts between agencies with a duty to care for him,” said B.C.’s Representative for Children and Youth today in releasing her investigation report. “Everybody knew there was a problem - family, community members and agencies – but no one saw through the confusion and took concrete action to safeguard this little boy.

“Rather than descending into disarray when increasingly challenging issues appear in the life of a vulnerable child, a strong child-serving system must rise to function at its best in these dire situations,” she said.

The report, *So Many Plans, So Little Stability: A Child’s Need for Security*, identifies troubling inadequacies in planning, case management and decision-making. “The focus was not on the needs of this First Nations infant, and there was no observable logic to what happened regarding his care,” says Mary Ellen Turpel-Lafond. “There was limited consideration given to the safety, stability and consistency required for a newborn to thrive. Instead, chaos and confusion prevailed throughout his brief life.”

Eleven different placement plans for the infant’s care were made over a four-month period, ranging from the infant being cared for by various different relatives to the infant being brought into the legal care of the ministry. But with no follow-through or oversight, most became nothing more than ideas and theories, and were later abandoned.

Sixteen social workers touched this case before the infant’s death, as did lawyers and the family court. The infant’s file was transferred five times between the Ministry of Children and Family Development (MCFD) and the delegated Aboriginal Agency (DAA).

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“In our investigations and in our advocacy work, issues of stability in placements are very common,” said Turpel-Lafond. “Living arrangements must be stable with consistent caregivers able to respond appropriately to the children whose lives are placed in their hands.”

Turpel-Lafond said she cannot conclude, in this particular case, whether the infant’s death was preventable or find any evidence that links this baby’s death to the care he received. But this does not minimize concerns raised by this investigation, she said, because case management was clearly chaotic and this child’s best interests were not considered.

“This case does not illustrate an isolated instance,” she said. “Instead, it is another example in a troubling pattern. Previous investigations completed by my Office have identified similar issues, which must be examined with greater urgency and resolved.”

Turpel-Lafond said the three recommendations in this report point to ways to help improve the child-serving system, by addressing the need for:

- understandable accountabilities for Aboriginal child-serving services, with each regional director of child welfare responsible for the delegated agencies in the region
- clearer expectations and actions when good case management is put at risk because of frequent changes in custody arrangements, locations, child protection offices or workers
- B.C. to follow Ontario’s recent family law reforms. This should include amendments to help ensure that court decisions regarding guardianship of a child are made with the advantage of critical information about the capacity and background of any proposed non-parent guardian.

Turpel-Lafond said that the *Family Relations Act* does not give judges the necessary tools to make a meaningful decision regarding the child’s best interests, particularly where custody is being transferred by consent from a natural parent to a non-parent. The *Act* does not require information be given to the court about the non-parent caregiver’s capacity to provide adequate and safe care in the child’s best interests, including if that person has a criminal record or a history of child abuse or neglect.

The investigation also found that important investigative opportunities were missed in the hours following the infant’s death. The Representative believes that it is critical to treat all unexpected deaths of children as suspicious, no matter how traumatic the circumstances. This will help ensure that an opportunity is not lost to prevent future deaths based on what is learned. The Representative will be following up with police and the Coroners Service as part of ongoing discussions.

Note: In this report, care has been taken to avoid identifying the infant and his family by name or location. Out of respect for the ordeal this infant’s family have been through, the Representative requests that others also respect their privacy.

Note: The full report, “*So Many Plans, So Little Stability: A Child’s Need for Security*”, is available on the Representative’s website (www.rcybc.ca)

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