

# A Boy's Sacred Story



# Beginning in a Good Way – The Spirit of Colby’s Family

This report braids together learnings arising from an investigation into the sacred life and tragic death of a child we have named Colby, a review of key aspects of current child- and family-serving systems, and ideas drawn from the engagement of close to 2,000 people in B.C. who care about child, youth and family well-being. Throughout all this work, we have been guided by the Sacred Teachings from our Cultural Advisors.

As we begin the telling of Colby’s story, we wish to start in a good way by reflecting these Sacred Teachings and demonstrating our respect for his family, honouring the relationships they tried so hard to sustain, and lifting up the ways this family was bound together by love, laughter and hope.

One of the threads that ran through his story – and the stories of most children and families involved in the system of care – was that of diminished dignity for the family. Dignity was stripped away, bit by bit, through the use of stigmatizing language, judgmental attitudes, and harmful actions. Yet, we will also speak about the fact that every family, community, Nation, organization and system has not only shadow – things that bring darkness to their world – but also light – good things that are happening.

This is true for Colby and his family. Their story will reveal much shadow and darkness, so it is important that we enter into it with dignity for the family by remembering that they also had light.

Colby’s mother was described as a beautiful spirit and one that so many looked up to. His father is a creative and talented artist and entrepreneur.

Colby was loved by his parents; and was considered by his mother as her miracle baby. They aspired to hold their family together, even when violence and adversity tore them apart.

Despite the barriers that severed the family, they would continue to seek and seize opportunities to reconnect – whether through a word, an earnest request for a visit, an exchange of looks, or a pair of socks being passed between fences of separation.

Family members relive the laughter and love through home video footage of Colby and his younger sister giggling over popcorn carefully eaten with chopsticks on the family couch. These memories are artifacts of the family’s love and joy.

A photo of five siblings, reflections of their parents’ smiles, shows the children with matching shirts and braided hair, squeezed together on a picnic blanket at the park, holding one another. The sparkle in their eyes reminds us of their spirit, promise, connection and belonging.

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# Sacred Story Investigation

## Preface

When we first learned the facts regarding the death of the young boy – Colby – who is at the centre of this story, they quite literally brought us to our knees. The details about the torture that this beautiful, innocent boy endured were excruciating to hear and demanded an urgent effort from our Office to learn more about how and why this boy's life was taken from his family, the many people who cared about him and his community.

It's important to know that this boy grew up in a small community that has experienced, and is still experiencing deep and lasting harms. The ongoing legacy and trauma of settler colonialism spans generations. The memories of colonial harms, including residential schools, are still fresh. The stories of agents coming to take children and the desperate efforts to try to hide them, to keep them safe and bonded with their families, were told to us as a reminder of where so much of the hurt and trauma began.

The community Colby was part of is on a healing journey that is unique but, in many ways, similar histories and experiences are also seen in the journeys of other Indigenous communities across Canada. In learning Colby's story, we were vividly reminded of the strength and resilience of this child's community. We learned that this community highly values its traditional roots and believes that culture is central to who they are.

Yet despite this light, there was also shadow. Cultural values varied among families in the community and, although deeply rooted, sometimes became a source of disconnection.

As we continued our work learning about this child's story, we saw the light and shadow not only that this family experienced, but that all families and communities have. This family was known for the love that they had for each other, for the laughter and the joy that they shared together. They also experienced complexities and, while their experience may be different from our own, the themes of imperfection, unpredictability and struggle are common challenges we collectively share.

In telling Colby's story, we know that the pain of losing a precious little boy is deep, and healing for his family and for the communities connected with his story is by no means over. Our intent in this work is that, in compassionate truth-telling, we do not add to the intense harms this boy's death and the tragedies before have caused. As a result, we have made an intentional decision not to share some of the details that we have gathered.

Our goal is to share enough of this beautiful boy's story that readers feel the love and compassion that inspired us when telling it. We encourage you to open your heart, mind and spirit to experience the discomfort, pain and compassion in whatever way you need to support moving away from old, harmful, colonial, or oppressive ways of thinking and toward a place of healing and change. It is our hope that this love will spark a collective desire by all who read this to want to be part of the change that is needed to ensure that the devastating and unspeakable torture and resulting tragic death that Colby experienced will not be another young person's story.

Our investigation into what happened to Colby and his family was broad and deep. It included dozens of interviews with family members, leaders, community members, staff from the Child and Family Support Department (the Department) operated by Colby's Nation, MCFD staff, RCMP, and health and education professionals. It included a review of thousands of pages of documents and hundreds of files – records of the interactions that he and his family had with various agencies and professionals. While we went to great lengths to piece together where the system let this boy down, there were some records that could not be accessed and some people who would not participate in interviews. However, the information we did receive provides a comprehensive and thorough account of why and how a young boy died.

Importantly, RCY's investigation relied on the continuous support and advice of the three Cultural Advisors – each with extensive experience in child welfare issues – who guided our staff through learning sessions, ceremony, and sense-making exercises as we prepared to tell his story.

In our telling of this story, we are guided by Sacred Teachings gifted to us by our Cultural Advisors who have first-hand lived experience

with intergenerational trauma. These teachings focus on the need for reciprocal relationships, for respect and for repair and have translated into an approach by our Office that aims to do no further harm. We recognize the inevitability that reading this story will be difficult for many but sitting with the discomfort is part of the learning and change process. It is our hope that in the telling of this story, what happened to this boy and his family will lead to a strong collective commitment and action to achieve a transformational shift in supports for and services to children and families. This will require a clear and strong vision and strategic direction, aligned legislation and policies, adequate financial and human resources, and a willingness to learn and continually improve on the basis of evidence.

To all who shared their thoughts and perspectives with us, we are so grateful. Colby has taught us so much. He has reminded us of the strength and resilience of a child and of the enduring power of love. We know his spirit and his story will teach many others.

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*Note to readers: To protect privacy, all references to the location of where this tragedy happened have been removed. Names have also been changed to protect the privacy of all of those involved.*

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## A beautiful boy with so much promise

He was a boy like so many other 11-year-olds. His tousled dark hair grazed sparkling brown eyes that were always looking for fun. Whether on the soccer field, immersed in Minecraft, reading *Archie* comics or marvelling at the power of monster trucks, he was a boy who loved to play. His smile was wide and contagious, and he had a gentle way about him that touched others deeply. Documents describe how when Colby saw his sister in the hallway at school, he would give her a hug. She said she remembered feeling safe whenever he laced his fingers through hers.

If you walked into the classroom where he went to school, you would have seen him keenly taking part in class discussions and projects. During math and science classes, he was particularly engaged and worked hard – his favorite subjects brimming with problems he loved to try to solve. “He was eager to learn,” said one teacher. “He was curious and was always asking questions.” When he came into class, he was bubbly, another teacher remembered. “Kids loved him, everyone loved to be around him.” He was so caring and considerate of others, another school staff member recalled. She shared that he liked to hug each of his classmates good morning when he arrived at school.

Colby’s love of learning extended to teachings about his culture. As a First Nations boy

growing up in a small community steeped in rich history, he showed a curiosity and desire to learn about his culture. When he was nine, he was particularly excited to take part in an honouring ceremony held by his Nation. He was also curious to learn about God. He believed in the power of prayer. Born with complex health needs, including a heart condition, Colby prayed for a new heart.

Colby’s curiosity, joy and gentleness were shared with his large family. He was the second oldest of five siblings. He had one older sister (three years older), two younger sisters (three and eight years younger), and a baby brother born nine years after him. He also shared his father with three other siblings born to a different mother.

His maternal grandmother was a fixture in the family. She remembers holding him close and recalls how he would run his fingers over a butterfly-adorned T-shirt she used to wear to feel the sequins. She remembers how enthralled Colby was when he first saw monster trucks rumbling past and how she bought him a monster truck video that they were never able to watch together. She remembers how important his family, his community and his culture were to him. She remembers, too, how important he was to her, and how deeply she misses a beautiful boy with so much promise.



## The resilience of a child

Colby was born in the Spring of 2009 by emergency caesarian section. The surviving sibling of a twin pregnancy, he was born with complex health problems that easily could have crushed his spirit. But many people RCY spoke with described this boy as someone who approached his challenges with courage and a remarkable, positive spirit.

He was born with a genetic disorder that was thought to be either VACTERL Syndrome<sup>10</sup> or Oculoauricular Syndrome.<sup>11</sup> As a result, he had skeletal abnormalities, respiratory challenges, a cardiac condition, and renal disease. He was born with no right thumb, just one kidney, bilateral hip dysplasia and a 13<sup>th</sup> rib on one side. Just four days after his birth, he required a vesicostomy – a life-saving procedure that allows bodily waste to pass through a surgically created stoma, or opening, on the abdomen.

His chronic kidney disease required surgical reconstruction of his urinary tract and there were constant concerns over the health of his heart. His kidney disease was at Stage 3 at the time of his death and would have eventually required a transplant. He was also diagnosed with left pulmonary artery sling – a cardiac condition that can impact energy levels and cause shortness of breath. He required heart surgery in both 2018 and 2019. Because of the extensiveness of his health needs, family members feared that Colby might not live long. Instead, he would die at the hands of extended family caregivers who were supposed to love, care for and protect him.

“He was a sweet, sweet baby, but he made me really nervous,” a relative recalled. “You really had to watch his breathing, had to pay attention to it when he was small. He was also a quiet baby. When you were changing his diaper, you had to use two diapers ... one regular and then one wrapped around [the ostomy stoma].”

“It was like taking care of a doll. He was so small, [it was] hard to feed him. You would have to take your finger and massage down the front of his throat to help him get it down.”

– Relative remembering Colby as a baby



<sup>10</sup> VACTERL association is a disorder that affects many body systems. VACTERL stands for vertebral defects, anal atresia, cardiac defects, tracheo-esophageal fistula, renal anomalies, and limb abnormalities. People diagnosed with VACTERL association typically have at least three of these characteristic features. Affected individuals may have additional abnormalities that are not among the characteristic features of VACTERL association. VACTERL association: MedlinePlus Genetics

<sup>11</sup> Oculoauricular Syndrome is characterized by a series of complex ocular anomalies.

Colby's various conditions required ongoing medical care from pediatricians, urologists, and cardiologists in addition to careful attention from caregivers who needed to make sure they were keeping track of the medications and providing the supplies Colby needed. For example, he needed daily medication to control his blood pressure and kidney function, the use of an inhaler twice daily for asthma, daily iron and vitamin D supplements. He and his caregivers needed regular transportation to and from more than 70 medical appointments that were scheduled throughout his life – almost a quarter of which he would miss.

Dehydration and infections were a constant concern for Colby. His health was so fragile that he was taken to the hospital repeatedly over his life for a variety of reasons including surgeries, MRIs and other testing, appointments at renal and cardiology clinics, and treatment for urinary and upper-respiratory tract infections, fever and cough, difficulty breathing, pneumonia, infections and high potassium levels. Despite having significant involvement with MCFD through his life, the level of understanding, resources and supports to address those needs would vary between his many different caregivers.

Because of the intense complexity of his physical needs, it was hard, family members said, to not see Colby as fragile. One family member remembers how terrified they were when they signed him up for soccer that he would get hurt. He was so small compared with the other players. Family members worried, too, about how the other kids at school would tease him but they were amazed at how he was able to smile, and push through his many challenges.

“He was always just really happy. He wanted to be like every other kid, no matter what he was going through in his life.”

– Community member

Colby's health needs would have been incredibly challenging for any parent, but family poverty and lack of support, and communication issues between caregivers and health care providers made things even more difficult. The cost alone of the lengthy list of required medical supplies was daunting, not to mention basic supplies like food, diapers and clothes. For example, Colby's specialized formula cost \$200 a month and, because supports were not offered in a timely manner, his parents felt that their only choice was to dilute it with water until financial help was arranged. To make things even more challenging, it was hard for Colby to swallow even the limited nutrition he was receiving.

Documentation from a visit to the BC Children's Hospital (BCCH) renal clinic – when Colby was just two months old – noted he was below the third percentile for height and weight. His mother, Violet, told a BCCH social worker about the difficulties she was having affording formula and, as a result, the worker wrote a letter to the band, explaining that Colby was a medically fragile child whose family required additional financial support. Both the band and MCFD responded, and the ministry arranged support via MCFD's At Home program, a government-funded program that provides young people who have complex care needs with money for things like medically necessary supplies.

## Growing up in a complex environment

Long before she had Colby, Violet was determined to provide a more stable life for her children than what she had experienced herself growing up. She was raised as the middle child between two brothers by her mother in a home environment that, alongside laughter and love, was at times chaotic.

According to those who knew her, Violet's mom worked hard to support her and her brothers, but her struggles with problematic alcohol use and its impacts in the home made for a hard life. Violet was often left to look after her younger brother and keep him safe, but her own safety was in question in at least one instance shared with RCY.

When Violet was in Grade 10, she returned home from a school trip and told her family she had been raped. She had bruises on her neck and a swollen face, but she was told by a close family member not to disclose the rape.

And so, Violet kept her trauma from the rape to herself and went on with her life. "She would talk to my parents about wanting to have a different life for herself and her children," a relative remembered. She worked hard to be a good older sister. She volunteered with homeless people and stayed connected with her culture. She was smart and graduated from her community's high school. "She was a leader in that [dance] group. She braided, French-braided, the girls' hair, she got them ready and put their regalia on. She was always active with the [dance] group growing up," another community member told RCY.

But she had another side. She was a fighter, quite literally. She would participate in street fights and would return home with money she earned through fighting. Fighting was a skill she learned in her youth and it would become an ongoing fixture in her life.

But even with the harsher sides that were a part of who she was, at root Violet was described as "a beautiful spirit" who was loving and wanted to be loved.

### Complicated Decisions

Although it is not clear to investigators what led to the decision not to report Violet's rape, it is common for RCY to receive reports in which a young person has been sexually assaulted and either they or those around them decide not to report it to police for a number of understandable reasons. This seeming lack of response by Violet's family when she was a youth, and the multiple instances in Colby's family's story where subsequent acts of violence were concealed, must be considered in the context of the Indigenous experience in Canada. A mistrust of the intervention of authorities has created an environment in which silence and concealment are often used to prevent intrusive measures by government agencies like MCFD and police. How could you trust government systems that had harmed your people? Why would you report violence when your children could get taken away? Why would you want to disclose secrets that might lead to conflict in your family or community relationships?

## A community of contradictions

Violet grew up in a community, like so many, that is full of both light, and shadow. There is breathtaking beauty – mountains and rivers carve through the lands and there is profound beauty in the spirit and traditions of the people who have lived there for millenia. This is a place where, for the most part, neighbours and friends look out for each other and there is a sense of deep strength. But there is also pain and complex dynamics between and within families.

As in so many small communities, family hierarchy and perceived favoritism was something that many people talked about. In interviews, community members shared their perceptions that families dealing with similar issues and risks were treated differently depending upon their familial and political connections. RCY was told that Colby's family was one of the families that was more likely to be perceived negatively and that this might have translated to inconsistent, and in some cases non-existent, support for the family throughout the years.

However, this community has worked to build its strength and its capacity, and to be independent. It's important to note that Colby's community is a Nation that is proceeding to resume responsibility for the welfare of its own children – a responsibility that rested with the provincial government for decades prior to new federal legislation and provincial legislative amendments.<sup>12</sup> It has worked hard to develop a child and family services program (Department) to deliver services to its children and families and is looking forward to cutting ties with colonial systems. This significant work, which began in 2020, continues to be a work in progress, however. At the time that the tragedy of Colby's abuse and subsequent death was unfolding, the Nation was in a period of a new and confusing transition where roles and responsibilities were not clearly understood despite there being clear legal lines. This confusion combined with inaction and concealment would contribute to the loss of this young boy's life.

<sup>12</sup> *An Act respecting First Nations, Inuit and Métis children and families* was passed by Parliament in 2019 and proclaimed in January 2020. The *Indigenous Self-Government in Child and Family Services Amendment Act* was passed by the Legislative Assembly in B.C. in 2022 and proclaimed in 2022.



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## Young parents try to find their way

As her community grew and prepared itself for change, so too did Violet. At 19, a young man walked into her life. Colton was six years older than Violet. He had been born into an Indigenous family in southwestern B.C. before being adopted at birth, just as his birth mother had been before him. A DJ involved in the rave scene, he was smitten with Violet. “I fell in love with her,” he told us. “I saw her walking around the community every day on my way home from work. I tried to call her and she’d be all shy, like playing games.”

But after a little while, Violet agreed to go out with him. “It took months, I was persistent. I waited, and I waited for a long time, like six months, seven months ...”

On their first date to see the fireworks in Vancouver, Colton took extra care to make her feel comfortable. He said it was just fine if she brought her friends and one of their mothers along. “She was like being real cautious. And her friends were all questioning me, and I answered the right questions. Yeah, I passed.”

The relationship intensified quickly and, by the time Violet was 20, the couple had their first child, a girl. As their relationship grew in love for one another, it also developed a dark side, marked by poverty, instances of violence by both partners, housing insecurity and substance abuse as well as involvement with both police and the child protection system. This was when Violet’s long and difficult relationship with MCFD began. An incident between the couple in September 2007 would bring Violet to the attention of the ministry for the first time.

It was a violent fight that left them both injured, with Colton requiring hospitalization. Police called MCFD’s After Hours<sup>13</sup> line, which transferred this incident to an Indigenous Child and Family Service Agency (ICFSA). As a result of this report, RCMP arranged for Violet and her daughter to go to her mother’s for the night until a social worker could further assess their safety. The ICFSA made some initial inquiries and, once it realized that Violet was living on-reserve, in a community for which it had no responsibility, it transferred the incident to the MCFD social worker who was assigned to the Nation. The assigned social worker, however, was on leave with no coverage provided and the first in-person contact with Violet and her child did not occur until seven months later. This left the family unclear about what was expected of them and fearful of what actions MCFD might take next.

A Family Services Case was opened for the “*monitoring and development of [a] positive support system for [the parents]*” however, due to poor ministry documentation, it is unclear what supports, if any, were offered to the young couple after this incident. What was clear was that Colton and Violet were struggling and were in need of supports that could help them address not only the recurring intimate partner violence (IPV) but also the underlying issues of substance use, intergenerational violence and poverty. Such supports could have helped to ensure that their children were safe and secure.

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<sup>13</sup> After Hours refers to responses by MCFD between 4 p.m. and 8:30 a.m. on weekdays and 24 hours a day on weekends and holidays. Provincial Centralized Screening (PCS) was established in 2015 and is now the central number for all child safety reports as well as general inquiries for support services. When a staff member needs to go out to see a child or family after hours, there is often a call-out list for larger offices but smaller offices rely on staff voluntarily answering calls. Staff on call-out lists receive some compensation for being available to go out after hours.

Colby was born less than three years later, at BC Women's Hospital in Vancouver. Violet referred to him as her "miracle baby" given the complicated conditions of the pregnancy and birth. Because he was born with multiple medical complexities, he was admitted to the neonatal intensive care unit at BCCH. Both Violet and Colton helped to care for the tiny boy while he was in hospital growing strong enough to be able to go home.

As Colton and Violet's relationship was precarious, documentation shows that Violet planned to return to living with her mother on-reserve on Colby's discharge from hospital. This might have seemed like a practical solution but, within nine months, that living arrangement broke down. Violet and her mother had a late-night fight, resulting in her mother telling her they had to leave her home immediately.

With nowhere to go, Violet took the children to Colton's home, even though there had been a no-contact order served for the couple because of ongoing violence between them. It was cold and raining, Violet was crying, and Colton felt like he had no other choice but to let her and the children stay with him despite the no-contact order. Without MCFD assessing the circumstances to further understand why the no-contact order was initially in place, or exploring other interim options for the family, RCMP arrested Colton for the breach. Fortunately, with the help of the social worker at the Department, Violet was able to move into her own apartment. It seemed like it could be a fresh start for Violet and her children.

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## A new father figure – Violence and struggles to keep Colby healthy continue

However, things would change yet again for Violet. When Colby was about a year old, she started a relationship with a new partner, Matt, and the couple lived together intermittently with Violet's children. According to records, Matt physically assaulted Violet on at least five occasions during a relationship that would span seven years. A relative recalled that he was probably the most prominent father figure for the children, although he was far from stable. "There was a lot of turmoil and lots of violence," the relative said. "They would reconcile, struggle, slip with substances and separate again." During one of their periods apart, Violet entered into another relationship, and she became pregnant.

Colby became a big brother with the birth of Violet's third child when he was 3½-years-old. Now a mother of three little ones, she

continued to experience the same struggles, and her ability to care for a child with extremely complex medical needs was being tested even more. With little help provided for transportation to appointments and child care for the other children, Violet was unable to consistently get Colby to his medical appointments. She reconciled with Matt and new questions were raised about whether he was a safe parent. MCFD was contacted with information that he had criminal charges and/or convictions and he was not permitted to be around children. RCY could find no evidence that these concerns were followed up by the ministry with either Matt or Violet.

What was documented, however, was that Violet continued to face violence at the hands of Matt. Documents show that concerns about his violence were being raised by Colby's older sister to staff at her school. According to an

email exchange between staff at the school, the young girl disclosed her growing concerns about violence toward her and her mom in the home and the fact that Matt was “drinking drugs again.”

This information was provided to the ministry, but there is no record of Violet or her children being interviewed by MCFD about this disclosure or the ministry offering any interventions or services to mitigate the violence or protect Violet and her children.

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## Escalating pressures, and the impact on parents

As a young child, Colby was living through the chaos that his mom was experiencing. While his health care needs remained a constant challenge, he was curious and loved to play like young ones do. Just as Violet found joy in watching her son grow up, she also experienced the weight of caring for a child with complex health needs, two other children, inconsistent housing, multiple moves, and an on-again, off-again relationship characterized by violence – all with no notable services to support her and her family.

Violet’s mental health challenges were intensifying and became so severe that, on several occasions over the course of Colby’s life, she would require hospitalization. According to MCFD case notes regarding one of her hospitalizations, Violet “*said she is better now and has talked to [the doctor] about anti-depressants, her depression, struggles as a single mom and her break up [with Matt]. Violet was worried her children would be taken away when she heard [a social worker] had been to see [her brother].*” To help manage her mental health challenges, Violet was able to make an arrangement with MCFD to temporarily place

her eldest daughter with her aunt under an Extended Family Program (EFP) agreement<sup>14</sup> for five months between Nov. 1, 2014, and March 31, 2015, while she continued to care for the younger children.

Violet’s mental health and substance abuse challenges continued and her relationship with Matt continued to be off and on. In January 2017, when she was pregnant with her fourth child, there were worries about her physical and mental well-being and a decision was made jointly by the Department and MCFD to place the three children with Violet’s mother in an EFP agreement. Documents show that both organizations were aware of the grandmother’s own problematic issues with alcohol, but it is not clear what measures were taken to mitigate these concerns or provide support to the maternal grandmother as she cared for both the children and a relative with significant mental health concerns.

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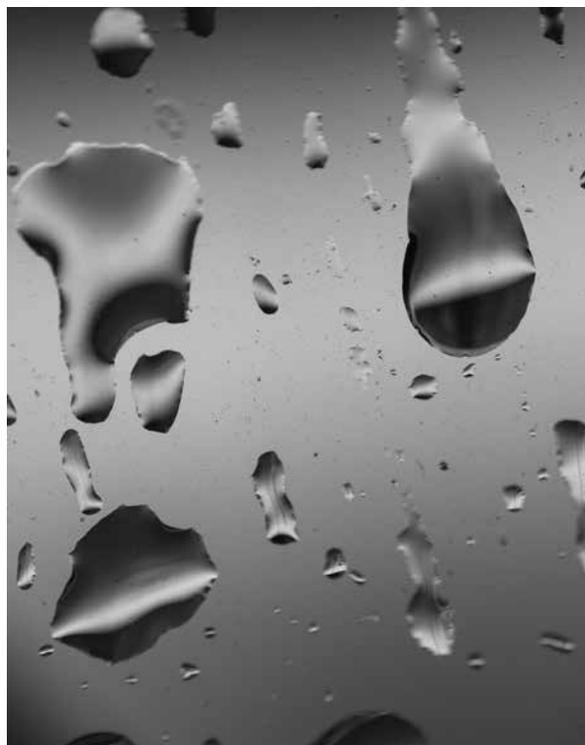
<sup>14</sup> Ministry of Children and Family Development, Section 4 – Out of Care Policy. Extended Family Program (EFP) is an agreement under s.8 of the *CFCS Act* to support a child who is being temporarily cared for by a person other than the child’s parent. The parent remains the legal guardian and chooses the care provider, who agrees to exercise the parental responsibilities on behalf of the child/youth’s parent. MCFD provides financial payments to the care provider but does not have parental decision-making authority and is not able to limit access to a parent.

When Violet gave birth to her fourth child four months later, medical records show this baby girl was born showing signs of exposure to substances in utero. MCFD issued a birth alert<sup>15</sup> for the newborn, citing concerns about Violet's transience, increasing mental health issues and self-reported daily use of fentanyl, crystal methamphetamines, cocaine and alcohol. Two days after the birth, MCFD entered into Safety Plan<sup>16</sup> with Violet.

Under this plan, she was able to continue caring for the baby while in hospital, but it also stipulated that Matt, the baby's father, was not permitted to come to the hospital until he met with an MCFD social worker and made plans to address his substance use and his violence against Violet. RCY identified a key issue with this plan: Matt was not part of the planning process or the agreement, and the onus was placed on Violet, not MCFD, to apprise Matt of the expectations and to ensure he stayed away from the baby until the issues were addressed to MCFD's satisfaction.

<sup>15</sup> Birth alerts were a practice used in B.C. for many years allowing child welfare or hospital staff to alert one another that a newborn might be at risk for harm, without informing expectant parents. Evidence suggests that this practice led to many traumatic child apprehensions soon after delivery and disproportionately impacted Indigenous women. The use of birth alerts was discontinued in 2019 with the government moving to a voluntary model with expectant and new parents to ensure plans and supports are in place.

<sup>16</sup> Policy in place at the time (Dec. 2015 – Feb. 2018) under Chapter 3 Child Protection Response Policies, December 2015, Policy 3.2) *"Developing a Safety Plan: If safety factors have been identified, develop the Safety Plan collaboratively with the child/youth's family. With the parent(s)' agreement, and in a manner that does not compromise the child/youth's safety, also (when possible) involve the following in identifying effective approaches to protecting the child/youth: Extended family members; Community members (including cultural community and, where needed, involving a translator); and If the child/youth is Aboriginal, members of his/her Aboriginal Band or Community. Obtain the parent(s)' agreement for putting in place any intervention in the Safety Plan and have the parents sign the plan. This does not apply if the decision is to remove the child/youth from the home or to seek a court order. The policy for Safety Plans was changed in 2018 and 2021."*



## Efforts to heal

Violet knew that, to get the children back into her care, she needed to get better. She knew healing would not be easy, but she was determined and took the time to apply to attend the Nation's healing house, a resource that would allow her to address her substance use issues while safely caring for her newborn. The baby was placed in a temporary Voluntary Care Agreement<sup>17</sup> with relatives while Violet waited for space to open up. Violet texted these relatives as she was waiting, saying she was "*falling apart*" and was going to seek help, although it is not clear, beyond the healing house application, whether she approached MCFD or the Department for any additional support or if anything more was offered.

Violet desperately needed everything that the healing house was described as offering. Nevertheless, she changed her mind about attending – possibly because she learned that people in her community had stated that she would not be successful.<sup>18</sup> She also missed her children and wanted to care for all four of them in her own home. But that was not to be. While her mom continued to care for her

older three children, the relatives temporarily caring for her baby couldn't continue and, with concerns about Violet's capacity to safely care for the infant, MCFD subsequently decided to remove the baby from her care and place her in foster care.

On the day the baby was removed, Violet was admitted to hospital once again where she was diagnosed with post-partum depression, substance use disorder and drug-induced psychosis. Like so many people on their healing and recovery journeys, Violet didn't give up. She tried again to get help, this time entering a treatment centre for women in recovery. She left only a week later.

As Violet's mom continued to care for Colby and two of his siblings, she was supporting another family member who had a significant mental health condition that posed a potential risk to the children. Although this situation was known to MCFD on placement, there is no evidence to suggest that proper procedures were followed to ensure the safety of the children in case there was a mental health crisis that impacted them. There were at least four instances over a four-month period between July and October 2017 that were described as "*mental health episodes*" while the children lived in the home.

In an apparent attempt to mitigate the concerns about Colby and his sisters living in this arrangement, MCFD and the Department approved Violet and the children to temporarily reside in the Nation's healing house. They remained there for two weeks before the Nation identified a different home on-reserve where the grandmother and the children could live. MCFD found a bed for Violet at a women's residential treatment program in a neighbouring Nation, but she refused to attend. Instead, in an effort to continue parenting her children, she moved

<sup>17</sup> Voluntary Care Agreements (VCA) are described in MCFD Policy 2.3. VCAs enable parents/guardians to temporarily have their child(ren) reside in an approved resource (may include a restricted foster parent who is kith or kin) while parents and children receive the supports to enable family reunification. VCAs are used when parents are temporarily unable to care for their child and no less disruptive means and services are available. Under a VCA, children are in the temporary care of MCFD and the agreement describes roles and responsibilities. Maximum timelines under Section 6(7) of the *CFCS Act* apply to ensure permanency for children and youth. The initial terms of the agreement must not exceed: 3 months for children under 5 years of age; and 6 months for children/youth 5 years of age and older. Care plans must be written for children under a VCA.

<sup>18</sup> The Representative, while visiting the community and developing relationships with community leaders, had a number of informal conversations (i.e., not under oath and not recorded) and this information was shared with her during a community visit.

herself and her children into the home that had been identified for her mother, while her mother remained in her own home.

This arrangement might have made sense to Violet and her mother. At this point, Violet had been parenting the children in the Nation's healing house for several weeks, she was no longer in a relationship with Matt and she was expressing a desire to continue her healing and become a social worker. However, the move went against the EFP agreement and, as a result of Violet's actions, the ministry decided to end the EFP, remove the children and pursue a Restricted Foster Home<sup>19</sup> placement for Colby and his older siblings with the children's great aunt and uncle.

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<sup>19</sup> Restricted Foster Homes provide kith and kin caring for children and youth in the legal care of MCFD. Section 8 MCFD Resource Policies states: *"a restricted family care home may be considered if the living arrangement best meets the child/youth's needs, all out-of-care options have been exhausted, and the prospective caregiver: has a significant relationship with the child/youth or the child/youth's family or cultural community."* Restricted foster caregivers are screened and approved using the same processes as for regular foster caregivers but there is a 90-day interim period whereby children can be placed in the home under due diligence steps. This enables children to be placed in the home under emergency situations to avoid multiple placements while waiting to be approved as a restricted foster caregiver.



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## A period of calm

Records indicate that MCFD closely adhered to policy in making the decision to place Colby and two of his siblings with their great aunt and uncle. It was clear that these new caregivers had a deep commitment to caring for their relatives. They painted the children's rooms, gathered toys and books and bought a larger car to enjoy family outings and get the children to where they needed to be.

This period of Colby's life was described by several people RCY spoke with as one of the most stable times in his life. This was a home that was safe and nurturing, with two adults living with love and support for one another, and without all the stressors and lack of support that had been Violet's experience. There was structure and the kids were encouraged to set goals for themselves. Under the great aunt and uncle's love and care, Colby transitioned from having two pads covering his ostomy stoma to having an ostomy bag. In an interview with RCY, his great aunt recalled how proud Colby was that he could stay dry through the night and was now able to go swimming. "Oh my God, it changed his world. He'd never, ever gone swimming in his young life ... [now] he could just wear the onesie and go swimming like all regular kids, you know, he was just a regular kid, and he was so happy."

Colby's great aunt and uncle had the ability to make the health and well-being of Colby and his siblings a priority. They would make scrambled eggs every day for breakfast and Colby would do a Hulk Hogan-like muscle pose to show his great uncle that he was getting stronger. He started playing soccer and his older sister was active in canoe pulling. When the family ate together, their great uncle would share cultural teachings as Colby listened enthusiastically and wanted to hear more.

In the meantime, while the children were living with their great aunt and uncle, Violet had been having supervised visits and trying to find ways to get them back. She wanted to get healthy, and she had completed educational upgrading with the goal of working in a daycare. She had also returned to the recovery home she had previously been in and completed the three-month program. Violet continued to try to meet the ministry's requirements, but there were community reports that she experienced some slips in her sobriety and recovery journey. Nonetheless, she wrote to both MCFD and her MLA, pleading to have her children returned to her. During this period, the great aunt and uncle were experiencing difficulties in communication with Violet and how best to support the children given Violet's messaging of wanting to resume caring for them.

Nine months into the placement at their great aunt and uncle's, a very small amount of cannabis was found in the great aunt's vehicle.<sup>20</sup> In an interview with RCY, Violet's MCFD social worker said Violet learned of this and "ran" with the concern, insisting that her children needed to be returned to her care.

The great aunt and uncle let MCFD and the Department know they were finding it too difficult to deal with the stressors following these events and meet the children's needs.

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<sup>20</sup> MCFD policy indicates that substance use in itself is not a child protection concern, but rather its impact on children is a concern. Given that there was no assessment, it is unclear how, or if, this cannabis use was impacting the care of the children. It is also unclear how or if the views of the children regarding this placement and ultimate move were sought or considered as nothing was documented.

Sadly, the placement ended abruptly, and the children were returned to their mother's care. It's important to note that the discovery of the cannabis was made just several months prior to legalization.

According to documentation and interviews, it is clear that the great aunt and uncle were not provided with an opportunity to fully discuss the situation including MCFD's concerns about the use of cannabis, nor does it appear that any efforts were made to mediate the tensions between Violet and her great aunt and uncle about visitation and resumption of care.

Despite the tensions, MCFD did not adequately plan to transition the children and, ultimately, the three children were returned to Violet's care. MCFD did not give the great aunt and uncle the chance to say goodbye and they would not see the children again. "The MCFD social worker came to the door and told us she had picked up the kids [from school] and taken them to their mother's house. She told us to pack up their belongings. It was just like, they're gone," the great aunt recalled.

The decision to return the children to Violet's care was made in collaboration between the Department and MCFD but there were conflicting perspectives on whether it was a good idea. While RCY learned that the Department advocated for reunification, MCFD direct service workers who had worked with the children had concerns about them returning to their mother's home.

"That is something that I didn't want to see," said one social worker. "[Violet] was not in a good space. She was still using."

Another MCFD social worker recalls a Team Leader telling her that "family belongs with family. The Band wants the children back with Mom." This worker also asked if the children were to be returned to Violet, whether the Nation's healing house – which was empty at the time – could accommodate them. She was told by her Team Leader that Violet and her children "didn't fit the criteria."

“I just kept pushing back that we are setting [Violet] up to fail if we don't put all the supports in place. First, if we don't make sure that she's able to connect with the supports and follow through, we're going to hand her back all these children. She's gonna have the baby and something awful's gonna happen because she's not gonna be able to cope.”

- MCFD social worker

## Set up to fail

Violet resumed parenting in mid-August 2018 under an “extended visit” arrangement and then resumed full-time care of three of her four – soon to be five – children in September 2018 under a supervision order.<sup>21</sup> Just three months after her three eldest kids were returned to her, she gave birth to her last child, a son. Her now second-youngest child, who had been removed from her care shortly after birth, was also returned to her care that same month. This was clearly a tremendous change in her life. A young mom with a history of post-partum depression and other mental health concerns as well as ongoing struggles with substance use was for the first time parenting all five of her children, four of whom were under 10, with two under the age of two – all on her own.

Violet now also had the added pressure of a supervision order with a lengthy list of 24 terms she had to meet. Among many other things, she had to:

- not consume alcohol or drugs
- attend a family treatment program in B.C.’s Interior when Colby was able to undergo travel as directed by a medical professional
- ensure the children attended all scheduled medical and dental appointments

- ensure the children attended counselling sessions
- engage weekly and follow the direction of her own trauma/cultural counsellor
- not allow any other persons or children to reside at her home without the prior approval of MCFD
- not allow the children to be cared for by a third party unless approved by MCFD

MCFD and the Department recognized that Violet would need supports to help her manage. They jointly arranged to provide respite, have an Elder provide Violet with guidance, and a homemaker to help keep her house clean and orderly. The MCFD social worker told RCY that Violet clashed with the Elder and didn’t want her help. Case notes also indicate that the homemaker arranged through the Department stopped coming and MCFD instead sought out professional cleaners. According to people in the community, it was clear that Violet needed more effective and appropriate supports from MCFD and the Department than she received during this period.

More pressure was put on Violet, as Colby’s health remained a constant concern. In the midst of the hectic pace of caring for five children, Violet would also deal with Colby having his first open heart surgery, after returning to her home on the “extended visit”. This was a critical and precarious time for Colby. After the surgery, he needed a series of follow-up appointments at BCCH, approximately a two-hour drive from his community.

Early in the year, Colby was admitted to hospital due to shortness of breath caused by influenza. His maternal grandmother stayed with him in hospital, sleeping beside his bed, as Violet was taking care of her infant at

<sup>21</sup> Supervision orders (SO) are detailed in the *CFCS Act* and granted by a judge to ensure child safety while the child remains in the care of their parent or guardian. Initial length is up to six months and can be renewed to a maximum of 12 months. SOs expire unless an application is filed to renew the order. A child protection worker should not allow an order to expire without the child protection issues being remedied. S.41.1 states “the court may attach to a supervision order terms and conditions recommended by the director to implement the plan of care”. If the 12 months expires but safety issues remain, a child must be removed or MCFD must continue to work with the parent but on a voluntary basis via a Family Plan. These plans are collaboratively created to detail what changes need to occur and the services that MCFD will provide.

home. The hospital social worker noted that *“Grandma appears to be an excellent support to [Colby].”* The social worker also described Colby as *“highly anxious”* during this stay, but

there were no concerns expressed about his mother’s ability to meet his needs and those of her four other children upon discharge.

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## A mom needs supports – but where are they?

As Colby continued to recover from his surgery, there were concerns about the children’s well-being in Violet’s home. In a two-month span, MCFD would receive at least four reports from community and professionals expressing those concerns.

For example, relatives and members of the community reported to MCFD that they had concerns about the pressure being placed on Colby’s eldest sibling, who was apparently often left to provide care for her younger siblings when her mother was unable to do so. There was concern that she was tired and that the pressure was taking a toll on her well-being.

Callers also reported concerns about problematic alcohol use by relatives in Violet’s home, that her house was unclean, and that Violet’s new boyfriend and brother had moved in. There is no evidence that MCFD responded to these reports, despite the fact that the supervision order clearly required that no other adults or children could live with the family without prior approval by MCFD. A relative told RCY investigators that during this period Violet didn’t receive adequate supports from MCFD or the Department. *“I would take the kids when I could see the stress on her face,”* the relative said. *“We knew that the best place for them was going to be with their mother, but she needed supports.”*

Through numerous interviews with community members and MCFD staff, RCY learned there was a perception that services from the Department were not being adequately and equitably delivered to the community,

especially when it came to certain families, including Colby’s. However, in an interview, the designated band representative who was also the Department’s family advocate manager at the time, told RCY investigators that Violet did not accept any services from the Department when they were offered – *“like with the Elders, she wouldn’t let them in,”* she said, adding that Violet would go to another nearby Nation to seek out services. Why Violet chose to go to another Nation for services is unclear, as is what else was offered to her by the Department.

An agreement, arranged through and funded by MCFD’s Aboriginal Services Initiative, articulated the Department’s plan to provide a wide variety of supports to ensure the safety and well-being of children, youth and families in the Nation, including but not limited to areas such as: permanency planning, stability and connection or reconnection to culture and community, strengthening families in their capacity to care for and protect their children, parenting skills, transportation, and addressing family violence issues through safety planning and awareness and education programs.

When asked to describe what services the Department provides to the Nation now, the current executive director of the Department explained to RCY investigators that it generally involves shadowing MCFD employees in their work with families to ensure that work is done in a culturally appropriate way. If services such as counselling or treatment are needed to address safety concerns, these are often

contracted out. It was unclear to RCY how this met the terms of the ASI agreement.<sup>22</sup>

A number of MCFD staff raised concerns with RCY about the lack of reporting and documentation. “We provided the money, but we always wondered where was the bang for our buck?” a former MCFD staff member said. “We were constantly looking at money and asking for monthly reports ... In two years, I didn’t see one report on family supports.” However, it is not clear to RCY what the understanding was between MCFD and the Nation and Department with respect to reporting, and whether MCFD worked with the Department to support capacity building for documentation and reporting.

RCY also learned during interviews with both MCFD and Department staff and in the records that many assumptions were made about whose responsibility it was to provide support services. This lack of communication and understanding about what supports were available, what was provided, and who was responsible for what is concerning.



<sup>22</sup> During the administrative fairness process for this report, MCFD advised that if there were services required outside of the Department’s available services, then MCFD would work with the Department to identify the services to meet the needs of the family. RCY could not find any documentation to this effect in the file records.

## MCFD intervention involves the courts

As his mom struggled to get support for her chaotic home life, Colby would have moments of relaxation and calm. A relative remembers caring for nine-year-old Colby while his mom celebrated her birthday. Lying in a field near her home, with his head in her lap, the relative vividly remembers what Colby said to her: *"I always feel so relaxed here ... It's always so comfortable, I don't have to worry about anything ... I wish I could live here."*

But Colby didn't get that wish. He and his siblings remained with their mom despite reports continuing to come into MCFD about Violet's capacity to parent. The Nation's community health manager reported that the home was very messy. Additional reported information included that there was animal excrement inside the house and concerns that Violet's boyfriend and brother were living there. Unfortunately, MCFD had very recently let the supervision order pertaining to the eldest three children lapse, without appropriate assessment of how Violet was doing as a parent. RCY could not find evidence that the MCFD social worker or team leader assigned to Violet had completed the necessary steps to ensure Violet had been successful during the term of the supervision order. The supervision order pertaining to her youngest daughter was in place until June 2019 but, again, no assessment appeared to have taken place.

Another new report was made regarding inadequate care and supervision of the children. The MCFD social worker responsible for the family's file initially attended to this report and sought consultation with her acting team leader about removing the children from

Violet. However, this social worker told RCY investigators that she was instructed by the acting team leader to stop her assessment. In an interview with RCY investigators, the acting team leader said that it was clear the social worker didn't like Violet and he finished the assessment himself. The assessment completed by the acting team leader did not support removal and, instead, MCFD offered house cleaning and groceries. While the practical assistance was helpful, what Violet needed was much more intensive home and family support.

In October 2019, an incident in Violet's home resulted in the final removal of her children. According to MCFD case notes, Violet invited a man who had recently been released from prison to her home and there was a multi-day party at her place. While Violet arranged for the children to be cared for by relatives for the first night, they were brought back while the party continued. RCMP attended the home after it was reported that the man had assaulted Violet and then allegedly sexually assaulted one of her children as well. Colby would later say that he was scared to be in the home during the party and showed social workers where he and the other children had hidden.

The assailant was arrested, and a physical examination of the child by a forensic nurse at the regional hospital confirmed abuse. MCFD subsequently documented observations by professionals who attended the scene that Violet was uncooperative with RCMP, *"not responding protectively"* of her children and was instead *"protecting her boyfriend."* MCFD documented that Violet's family shared similar

sentiments regarding her behaviour toward the incident. However, Violet did ride with her child to hospital in the ambulance and consented to a forensic examination.<sup>23</sup>

Following a consultation between social workers, an MCFD acting team leader, and Department workers, a plan was made for Colby and his four siblings. Notes from the consultation said: “legal removal to take place within two-week safety plan timeline” and that “children will be safety planned... for the children’s immediate safety due to Violet and [her mother’s substance] issues and a family meeting will be arranged with band rep and [Department] staff to plan for the children’s safety.”

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<sup>23</sup> During the administrative fairness process, the ministry suggested that their records indicated that Violet refused to consent to the forensic examination, which was a factor in the decision to remove the children. However, RCY investigators noted that there was conflicting information in the ICM records, with case notes suggesting that Violet had consented, based upon medical notes from the forensic nurse who examined the child. The nurse had indicated that Violet had provide her consent. It appears that, while Violet consented for her daughter, she did not consent to an examination for herself and this decision was conflated with the information about Violet’s consent for her daughter’s assessment. The hospital records indicate that there were no concerns about how Violet was presenting. Given the incomplete documentation on file, it appears that there was a lack of clarity, assumptions were made and no further conversation or clarification was sought. Decisions were then made on the basis of this incomplete and inaccurate information. A full review of the information that was available at the time, from various sources, may have led to a different decision. RCY also notes that, in describing the reasons for removal, the ministry worker documented many past issues that callers had raised concerns about (e.g., cleanliness of house, supervision of the children, etc.) even though the ministry had not followed up on these concerns at the time.

While policy requires it, there is no documentation of an interview with Violet regarding the incident that prompted this removal of her children. Nor is there any evidence of a documented safety plan being created in accordance with MCFD policy, which would have included written consent being provided by Violet.

Despite MCFD calling this a “two-week safety plan,” the children were effectively removed from Violet’s care without her being informed. An email from the MCFD social worker to the Department child and family advocate on the day of the removal recommended: “to avoid any unpleasant emotions in front of the kids can you not bring Violet and [the grandmother] here to [the Department office] before 2:30. [Staci] is going to pick up [the children] at 2:30 at [the Department office].”

While there was no documentation indicating that MCFD had followed up on previous community reports regarding the state of Violet’s home and the supervision of her children, the information from these reports was included in court documentation as a contributing factor to the children being taken from Violet’s home after this incident.

The children were legally removed from their mother’s care by MCFD. Violet contested the removal, but an Interim Custody Order was granted to the ministry on Feb. 5, 2020. In court documents, MCFD cited the following reasons for removal: “Due to the concerns of drug and alcohol use, lack of parental and adult supervision of the children, sexual abuse, deplorable conditions of the home and the numerous reports from the community it was determined in collaboration with the Band and Acting Team Leader that the children would need to be removed from their mother’s care as there was no less intrusive measures to keep the children safe.”

Colby and his eldest sister were safety-planned together to the home of Violet's cousin Staci and her partner in a neighbouring First Nation, his middle sister was temporarily placed with a community member, and his

two youngest siblings were placed in an MCFD-approved foster home in a nearby community. None of Violet's children would return to her again.

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## A fateful placement

Violet's cousin Staci lived on another small reserve nearby with her partner Graham. The couple resided in a modest duplex with three children of their own. A month after Colby and his eldest sister were moved to this home, their middle sister was moved there as well.

Staci and Graham had close neighbours and their house was near both the band office and community leaders' homes. In a small community, it was hard to miss the busy lives of these caregivers who were now looking after six children between the ages of four and 13.

The question of whether the MCFD social worker assigned to the family did her job adequately would become central to Colby's story, but it was by no means the only critical question. How the placement of these children happened is also at the core of this story.

According to ministry documentation, the decision to place Colby and his siblings with Staci and Graham was a joint decision. Documentation on the ministry's Integrated Case Management (ICM)<sup>24</sup> system entitled "*Incident Outcome*," dated Oct. 21, 2019, says the Nation's designated band representative, the Department executive director at the time, and both the social worker and acting team leader from MCFD were all involved in deciding where the children were to be placed.

<sup>24</sup> ICM (Integrated Case Management) is the data system used by MCFD for documentation and case management of client records such as case notes, court documents, planning documents, and so on. Family Service (FS) files and Child Service (CS) files are two examples of how information is gathered and organized in ICM.

Ministry records show that all parties involved "*agreed with these placements.*"

Through interviews with MCFD staff involved, RCY learned that other options had been considered. For example, the children's maternal grandmother was suggested by MCFD, but the Department rejected that decision, one interviewee said. It is unclear why other close family were not considered, including the great aunt and uncle with whom the children had previously lived and had a close and loving bond. In an interview with RCY, the great aunt and uncle said they had not been approached to take care of the children during this time and that, had they been asked, they would have accepted.

It's important to note that this placement decision was being made against an historical backdrop and a growing awareness that current colonial child welfare practices were disproportionately harming Indigenous children and youth. With the 2019 passing of the federal *An Act respecting First Nations, Inuit and Métis children, youth and families*, many Nations – including Colby's – were looking forward to restoring their traditional laws and practices for child well-being and resuming jurisdiction over the welfare of their children. This was a new and unknown landscape and a time of transition marked by confusion and a blurring of roles and responsibilities as MCFD and the Nation navigated through the transition to jurisdiction. In interviews with MCFD senior staff who were involved with this transition period, one thing became clear: maintaining good relationships with the

“The MOU between the Nation and MCFD from this period says that social work should be undertaken *“in a manner that supports self-determination; reflects local culture, customs and language; takes a holistic approach to child and family development; is non-discriminatory; and, includes proactive strategies for identifying and addressing the system[atic] and structural barriers that impact the well-being of children, families, and the [Nation] community.”*

“I think there was a lot of trust,” said one senior MCFD staff person. “Given the work we were doing, there was a lot of leeway provided to staff ... they were on a path to jurisdiction and it wasn’t for the ministry to stand in the way of that or to challenge that in any way.”

Nation was imperative to ensuring a smooth handover. While strong relations are essential to the trust and respect that supports the complex jurisdictional planning, negotiations and transitions, on the ground this translated into confusion around decision points and accountability for direct service MCFD workers.

At this time, the Department and MCFD were working collaboratively on child welfare in the Nation, under a Memorandum of Understanding (MOU) dated November 2011.

The ministry still had legal responsibility,<sup>25</sup> but RCY investigators were told by several interviewees that direct service MCFD workers were often instructed to take the Department’s lead when it came to decision-making as they best knew the children and families in their communities.

Interestingly, in informal conversations, community leaders suggested that MCFD often did not appropriately engage them in decision-making or respect their wishes and suggestions.<sup>26</sup>

This confusing working environment would play a role in the critical placement decision for Colby. According to MCFD records and interviews, when the Department’s then-executive director suggested that Staci and her partner could care for the children, MCFD agreed. An MCFD executive director of service noted that Staci and her partner were described as “good people” by the Nation. However, RCY learned that two Department staff were aware, due to familial connections, of Staci’s past abuse of her own child but that

<sup>25</sup> During the administrative fairness process, MCFD advised that Bill 26 - the *Child, Family and Community Service Amendment Act* in 2018, passed in 2018, recognized that Indigenous families and communities shared responsibility for the upbringing and well-being of Indigenous children and ensured greater opportunities for Indigenous communities to participate in planning, supporting, and caring for their children. Orientation sessions for MCFD and ICFSA social workers were held throughout the Province within each Service Delivery Area. Additional sessions were held for newly hired social workers in regional communities of practice. The amendments were also incorporated into the training new employees receive. The ministry confirmed that they still had legal responsibility and that this was communicated to staff. Despite this, RCY investigators learned from local MCFD staff that they were not afforded the opportunity to exercise their authority and that they were to follow the lead of the Department. A senior provincial MCFD staff person advised RCY that the *“they were on a path towards jurisdiction and it wasn’t for the ministry to stand in the way of that or to challenge that in any way.”* This is a clear example of the current confusion experienced by direct service workers.

<sup>26</sup> The Representative, while visiting the community and developing relationships with community leaders, had a number of informal conversations (i.e., not under oath and not recorded) and this information was shared with her during a community visit.

this knowledge was apparently not heard or explored during the decision-making process for the placement.

The placement decision was made without consultation with Colby's family, including his mom, the children's fathers and the grandmothers. Colby's maternal grandmother told investigators that while Staci was technically family, she, Violet and the children didn't know her at all.

When speaking with RCY investigators, the paternal grandmother of Colby and his eldest sister said she reached out to MCFD and offered to care for those two children. An Indigenous woman, she said she was willing to sell her home, relocate to a larger centre closer to a hospital and bring the children back to the Nation for cultural events. The MCFD social worker called the paternal grandmother back two days later to let her know that the Department had rejected the idea. This was despite Colton's support of his mother's plan and the strong cultural and familial connections that they were able to offer.

Ultimately, the legal responsibility to ensure that Graham and Staci were appropriate to care for three of Violet's children belonged to MCFD. There is no question that the ministry neglected to take a number of steps to screen the prospective caregivers prior to the emergency placement or as soon as possible thereafter as policy required.

A simple search<sup>27</sup> would have revealed to MCFD that Staci had several substantiated

child protection concerns involving a child from a previous relationship and, as a result, had limited contact with that child. The search would have also revealed that there were allegations of intimate partner violence by Graham against Staci and concerns about Graham regarding alleged sexualized violence against children. All of the concerns about Staci that would have shown up in these checks, which weren't completed, were already known to some extent by Department staff.

Finally, no initial home visit was conducted to ensure that the home was ready for the children despite the fact the MCFD social worker had specifically requested and received from a colleague a detailed summary of what steps had to be taken in order to place a child. Records show that a home visit was not done until a month after the placement. Colby's child service record categorized him as "Living with Relatives" in this new placement, however MCFD did not establish a corresponding resource file, which would have allowed for the proper documentation of correspondence, training, support, contract funding and decision-making. RCY staff could find no clear reason why this important step was not taken. This chain of missteps was in stark contrast to the rigour that had been shown by MCFD when the same three children were placed with their great aunt and uncle in 2018.

Why these checks were not done is unclear as there are multiple perspectives. The MCFD social worker indicated to RCY that an excessive workload led to these missteps. MCFD senior staff have differing opinions. A former leader of MCFD puts the blame squarely on the assigned social worker who, in their view, was a vivid example of bad practice. "If the social worker had done her job at the end of the day, this wouldn't have happened," she said.

<sup>27</sup> MCFD Section 3.1. – Initial Record Review (IRR). An Initial Record Review (IRR) reviews past or current involvement with MCFD or an ICFSA. If a child protection response is required or for a home assessment, a Detailed Record Review (DRR) is completed (formally known as a Prior Contact Check or PCC). A DRR is a review of any electronic and physical files to determine how previous issues or concerns have been addressed; the responsiveness of the family in addressing the issues and concerns; and the effectiveness of the last intervention.

Another perspective shared in retrospect was that, because of the Department's depth of knowledge of the family, there was an assumption that its staff would have known of any "secrets" and concerns about the new caregivers' backgrounds. One senior staffer shared the possibility that MCFD social workers might have had concerns but didn't feel safe to speak up for fear of being labelled racist. Other MCFD staffers indicated there was implicit messaging from senior ministry leadership not to challenge decisions made by the Department "because of the amount of political noise that was impeding and guiding

and influencing a lot of those decisions at that time." Not doing basic checks, said one senior MCFD staff member, "smacks of receiving some kind of direction from someone above."

Clearly there are many different and conflicting perspectives on what was going on. In trying to understand the dynamics of the time, RCY believes that many assumptions were made but that poor communication and lack of clarity about roles and responsibilities contributed to these assumptions and beliefs not being checked out.



## The new caregivers – Appearance and reality

To some, Staci seemed like the perfect person to take on her new caregiving role. She was active in her community, involved in the canoe program and participated in the smokehouse. She had worked for the Department as a receptionist. “She presented herself really well,” the Department’s then-Executive Director told RCY. “She had that part in her that she was always doing her job.”

In the beginning, feedback about her care was glowing. At an October 2019 renal appointment for Colby, it was noted that Staci “had good rapport” with Colby. In an email to the Department’s family support worker regarding finding more spacious housing for the caregivers, the Department’s executive director wrote: “We need to support Staci to continue to care for the children. Staci has been doing [an] amazing job caring for children.” The MCFD social worker assigned to the family described Staci as an excellent caregiver and recalled that, at the time, she had “zero concerns.” “I talked with Staci and she texted me weekly. She would send pictures and she would come into the office...”

Despite the confidence that many had in the caregiving situation, a team leader who was covering this MCFD region queried in an email whether steps were being taken to establish Staci and Graham as MCFD-approved caregivers: “Is there work being done to get Staci set up as a restricted home?” This is important, as it suggests that there was awareness that the due diligence checks, and a corresponding home study, were incomplete.

Other cracks also began to emerge, particularly with the onset of the COVID-19 pandemic, declared by the World Health Organization in March 2020 just four months after the children were placed in the home. On at least seven occasions Staci expressed

by email and in conversations with MCFD and medical staff that she felt “overwhelmed” caring for the children and was finding homeschooling six children during COVID extremely challenging. “We are falling behind and it’s driving me bonkers,” she told the social worker in an email. She had also emailed a social worker saying one of Colby’s siblings had stolen money from her. When asked how she knew this, she indicated that they had installed video cameras in their duplex. RCY could find no follow-up documents highlighting any concerns about the monitoring of the children by video, which was a violation of their right to privacy.<sup>28</sup>

Staci emailed the MCFD social worker in June asking, “When can we start getting respite again? I’m starting to lose my mind. Kids have been home for months.” Just a few months later, Staci emailed the social worker once more asking for a meeting of Colby’s care team, stating again that she was feeling overwhelmed. Yet again, the next month, Staci emailed the social worker, asking her thoughts on whether the children should be kept home from school due to high COVID-19 cases in the area: “I kept them home today Urgh idk it’s driving me batty. I know I’ll get called out for there [sic] attendance.” Three weeks later, in another email to the same social worker Staci stated, “I’ve been asking and asking for a care team meeting for over a month now... We need one.” It’s important to note that Staci’s calls to the social workers or school were often responded to and there are records showing

<sup>28</sup> During the administrative fairness process MCFD suggested that there is no evidence that the care providers were using the cameras to monitor the children, however, RCY notes that the care providers used the cameras to “catch” one of the children “stealing” and yet there was no questioning at the time about the intention of the security cameras and how the care providers were using them. The ministry documented first being aware of the video cameras in 2019.

that Staci would sometimes not attend the meetings she had in fact requested when they were finally set up. This inconsistency – requesting help and then not engaging with help – was apparently not explored with Staci.

MCFD Centralized Screening<sup>29</sup> received a concerning report in October 2020 about the children being around Graham, saying that Colby and his two siblings were placed in a home where the male caregiver allegedly had a history of sexual abuse against children. Documents show that the ministry did not assess this information as a child protection concern, nor did the report prompt the assigned social worker to undertake further due diligence on the caregivers. This report was sent to the local MCFD office and attached to Violet’s family service file. There was no evidence of further follow-up on these concerns.<sup>30</sup>

Colby’s maternal grandmother also raised concerns within the community and there is no documentation to support where those concerns went or how they were addressed. She told RCY investigators that when the children were first placed with Staci and Graham, they attended a school right beside the daycare in which the grandmother worked. When they were outside, the children would run over to talk with her and, at times, would tell her they were hungry.

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<sup>29</sup> Provincial Centralized Screening (PCS) is a division within MCFD that answers calls related to child protection reports and family support requests for the province. It operates 24 hours a day, 365 days a year. Staff at PCS assess the calls to determine what type of response should be provided. PCS also answers the toll-free Helpline for Children and a line dedicated to providing after-hours caregiver support services.

<sup>30</sup> During the administrative fairness process, MCFD advised that they reviewed ICM records and determined that the concerns that were raised at the time about Graham were screened out as third hand information. The ministry also noted that concerns about Graham had been considered in 2012 and he was determined not to be a risk any longer. RCY notes that this information was not searched at the time of the placement decision being made however, nor were records checked when the call came in about Graham’s past.

The grandmother told investigators that she would give the children food from the daycare. She also recalled that, one day, Colby didn’t have any socks on, so she gave him her own socks through the fence that separated the daycare from the school. These kinds of situations happened often enough that the grandmother began proactively bringing clothing to the daycare in case the children needed it.

The grandmother indicated to RCY investigators that she didn’t know how to go about expressing her concerns to the Department or MCFD. The grandmother’s supervisor at the daycare tried to help her navigate MCFD with her concerns about the children, but RCY investigators could find no documented evidence that this resulted in any reports or complaints received or acted upon by the ministry. It is possible that complaints were received at the local office but not documented.

Simultaneously, family planning meetings for the children, arranged by the ministry, were occurring without Colby’s grandmother or any other family attending. Despite the Department employing a child and family advocate, the grandmother felt the need to ask her supervisor at the day care to advocate on her behalf for the children.

The grandmother also recalled that, during one visit with family not long after the children were placed in Staci and Graham’s home, Colby would not let go of his great uncle and begged not to be returned to their home.

## The isolation of Colby – A hidden child

During the last seven months of Colby's life, Staci withdrew him and his younger sister from all contact with family members and professionals outside her home. The pandemic allowed this isolation to go unquestioned leading up to Colby's death. Records obtained by RCY showed that gradually – and possibly intentionally – there would be fewer and fewer eyes on Colby and the other children living in Staci and Graham's home.

"When they first came [to the home], they were involved with youth groups,

canoe paddling – they were always playing outside," the designated band representative for the neighbouring Nation where Staci and Graham lived, told RCY investigators. However, as the pandemic continued, the designated band representative said he and other community members didn't question why they weren't seeing Colby anymore. They assumed, he said, that Staci and Graham were keeping him separated due to his health issues. "It was a perfect time that something like this could happen."



## Isolation from family

Gradually, Colby's family would see him less and less. Case notes indicate that seven family case planning conferences (FCPC)<sup>31</sup> were held by the ministry during the time the children lived with Staci and Graham, but Violet only took part in one and no other family members participated in any. Family members state that they were not invited and were not aware that they were taking place, and ministry records don't indicate who was invited to participate – only those who were in attendance. According to interviews with RCY investigators, family members who tried to visit the children were often rebuffed by Staci.

Despite assertions by Staci to MCFD social workers that no family members had tried to visit the children, Colby's maternal grandmother and great aunt both told RCY investigators that they attempted to see the boy and his siblings while they were placed in Staci and Graham's home. The great aunt recalled using Facebook to contact Staci, who agreed that she could come for a visit. However, when she arrived at the home after a 45-minute drive, Staci answered the front door and told the great aunt that the children wouldn't be taking part in a visit that day because one of the children "had been bad." Colby's grandmother said she was told by MCFD to connect with Staci if she wanted to see the children, but that Staci would not return her calls and changed her phone number. One of Colby's paternal

grandmothers shared a similar experience. Colby's maternal grandmother told RCY investigators that she also visited Staci and Graham's home in person but was not permitted to see the children.

Colby's dad did manage to see him and his older sister. He had two visits with them early on in their placement. His final visit with Colby came in December 2019, just two months into their stay in the home. It would be the last time Colton would see his son alive.

"When I saw him last has been haunting me a bit," an emotional Colton told investigators. "I dropped him off at that house, he just latched onto me, grabbed me and squeezed me. I took it as he's going to miss me, you know – he just has to get out [of the car] now and I'm going home. But he [seemed] like: 'Don't drop me off here', you know, like I just wish he [had actually said something] – 'Dad I don't want to go here anymore.' I would have been like, 'let's get out of here, no problem.' I don't care about the ministry at that point. I would have just drove away..."

Seven months into their placement, MCFD documentation shows that both Colby and his older sister had been referred to counselling as they were "*starting to feel the absence of their family.*" Documentation shows that the children were connected to a counsellor through Fraser Health but no further details were available in MCFD records.

Colton emailed the MCFD social worker near the end of October 2020 inquiring about arranging more visits with his two children. The social worker responded by saying she would contact Staci to work out connections with them. However, no visits occurred for Colton as a result.

<sup>31</sup> A family case planning conference is a collaborative meeting with families, MCFD and other supports, and is often hosted by a neutral third party to create plans for children and youth. Section 20 to 24 of the CFCS Act provides a legal basis for these conferences which are referred to as "*mediation or other alternative dispute resolution mechanisms.*" The CFCS Act and MCFD policies also support traditional decision-making for Indigenous families and may look different for each Nation. MCFD often refers to these processes as Collaborative Practice and Decision Making (CPDM). MCFD Section 3.4 describes CPDM processes in greater detail.

"I asked him [MCFD team leader] about video calls with [Colby] as he wants to talk, and I have video [Facebook] calling if he would like to ever call," Colton wrote in an email to the MCFD social worker. "Mon-Fri his little sister [Daisy] and I are always around after dinner time. Best time to call as she asks about her brother and sister quite often. It would be awesome for them to get to know each other a little more. 😊"

Colby's maternal grandmother also told RCY investigators that Violet attempted to contact MCFD to arrange visits with her children or receive updates about them and didn't receive responses. She said that her daughter would sit in the office shared by MCFD and Department staff waiting for the MCFD social worker, but that the social worker would leave out the back door rather than see Violet.

**“I dropped him off at that house, he just latched on to me, grabbed me and squeezed me. ”**

**- Colby's father Colton**

In an interview with RCY investigators, the MCFD social worker offered a much different recollection of this period. She said that Violet did not make the same effort to visit her children as she had when they were placed with the great aunt and uncle. "This time was different," the social worker said. "[Violet] held so much guilt for what happened [the alleged sexual assault of Colby's younger sibling], I don't think she would be able to face the kids." The social worker added that other family members had not asked her for access to the children. "They knew how to get a hold of me," she said, "but [the maternal grandmother] didn't ask - nobody really asked at all."

The community was closed to non-residents for a significant period of time following the onset of the COVID-19 pandemic. This would have restricted on-reserve visitation with children in care from their non-resident family members. However, RCY found no indication through interviews or documentation that the Department staff attempted to connect Colby and his siblings with his family in other ways during this placement, despite one of the Department's stated key priorities being to ensure that "[Nation] children and youth have permanency, stability, connection/reconnection to their families, culture and community."

## Isolation from professionals

As well as isolating Colby and his siblings from his family, Staci and Graham also steadily withdrew the children from a host of other interactions with professionals that would have ensured they were noticed by other people in the community.

What would appear to be a pattern was noted in the first three weeks that the children were placed with Staci and Graham. In an email, Staci told the MCFD social worker that she didn't want the drug and alcohol counsellor

who had previously worked with Violet to speak to the children. The counsellor lived near Staci and Graham and later told RCMP she was concerned that Staci was not allowing family members to visit the children.

Shutting people out would continue and was particularly concerning considering Colby's ongoing complex medical needs. Colby was seen by his family doctor at an on-reserve clinic on May 13, 2020, due to a sudden onset of vomiting and fever. This marked the last

time he was seen in-person by his family physician. Over the next nine months, Colby would miss at least six documented medical appointments, with Staci usually explaining that the boy was sick or citing COVID-19 concerns as reasons for the missed appointments with physicians or for medical testing.

The MCFD social worker accompanied Staci and Colby to the BCCH Cardiology and Renal Clinics on July 27, 2020. Notes from this visit show that he weighed 28.3 kilograms, which was an improvement from 10 months earlier but still placed him in the fifth percentile for boys his age. Despite his fragile health, this would mark the final time Colby was seen in-person by either a member of his medical team or MCFD staff.

Medical professionals attempted many times to reach out to both Staci and MCFD in response to Colby's missed appointments. Between early August and October 2020, there were multiple emails from the boy's medical care team to the MCFD social worker and Staci. The following chain of communications vividly shows the frustration Colby's medical team experienced in trying to see him:

A BCCH staff member emailed in September: "Hi [Staci], labs have not been done and it is very important to repeat labs given the elevated creatine. I will ask for the social worker's help in getting [Colby] for labs if you are having trouble getting him in."

Later that month, the same BCCH staff member emailed the social worker, asking for help to get Colby in for bloodwork. And on Oct. 15, she emailed the social worker once again, writing: "I have emailed you as well as emailed [Staci] many times. Labs have not been done on [Colby] since July. We had wanted full labs in August and despite numerous reminders and emails this had not been done. What is going on?"

Records show that the social worker responded that same day in an email, explaining that she had been off work for two months and had just returned. On Oct. 21, 2020, the BCCH staff member emailed the social worker yet again: "[Colby] needs to have labs today and if he is quite sick he may need to be seen in emergency."

Colby's blood work was finally completed in late October 2020. After receiving the results, a BCCH representative emailed Staci to report that Colby's iron levels were far lower than ideal and asked whether he had been taking his prescribed iron supplements each night. Staci responded that he had been taking them.

On Nov. 2, Colby took part in a Zoom appointment with the BCCH Renal Clinic that included Staci and the MCFD social worker. BCCH had requested Colby's height and weight measurements be provided for this meeting, but Staci did not offer them. The social worker recalled that Colby "looked happy, smiling, talking" during this session. This marked the last time MCFD or medical professionals would see Colby virtually.



On Dec. 9, BCCH's associate chief of surgery personally reached out to the MCFD social worker. In an email, he indicated that, due to Colby's health issues, as well as the complex reconstruction of his kidney, he required post-operative follow-ups: "Our multiple attempts to book him for an ultrasound [have] failed. The family has not shown up to their last appointment which was booked at BC Children's Hospital for the ultrasound." The social worker replied the same day, promising to take action and forwarding this email to her team leader, indicating that she was concerned and that she would speak to Staci about it. RCY investigators could find no documentation indicating that this was addressed with Staci.

On Feb. 4, 2021, BCCH again contacted the social worker with concerns about Colby. The email stated that the boy had not been seen by the hospital's associate chief of surgery since early April, 2020, when Colby's stent was removed. It indicated that his last ultrasound had been done on July 27 and that he had been due for a follow-up ultrasound in October. Both the doctor and his assistant were concerned as they had attempted to reach Staci and the social worker multiple times via email and phone but received no response. The social worker responded the same day, saying she would call as soon as possible. But two weeks later, BCCH sent a follow-up email saying that the doctor's assistant still had not heard back from the social worker.

The BCCH administrative assistant told RCY investigators that communication with the MCFD social worker had been fine for years until just before COVID-19 hit when "things really went dark." "[We] couldn't get a hold of her," she recalled. "I did email various times, [saying] I'm worried about the patient, [the

surgeon] was worried ... I remember the very end me emailing her, calling the office... trying to find a manager for her. To say something was going on. The care people, the caregiver kept cancelling."

The BCCH associate chief of surgery expressed his frustration to RCY investigators about a lack of communication by the MCFD social worker and about not being able to see Colby: "[There were] lots of no shows .... sometimes no explanation."

The children were also eventually isolated from the respite care providers who had provided Staci and Graham with hundreds of hours of relief starting in March 2020.

The female respite care providers told RCY investigators that Staci had instructed her not to feed Colby and his middle sister as a form of punishment during one late fall weekend in 2020 while they cared for the children. Neither respite care providers agreed with this and they did not follow Staci's instructions. The female respite care provider said that, when Staci found out the children had been fed, she was upset. This led to the end of their respite arrangement. However, the respite care providers did not report Staci's direction to withhold food from the children to the Department or MCFD.

The male respite care provider recalled to RCY investigators that, after one earlier stay with the couple, Colby had disclosed that he didn't want to go back to Staci and Graham's home. The male respite caregiver said he reported this to the Department's family advocate manager, who said she would look into it and talk to the children.

## Not seen by his social worker for seven months

While Colby continued to be isolated from family and medical professionals, the lead social worker on his case did not see him, either. According to MCFD policy, a social worker must visit a child in care in the home at least every 90 days and, when a child has complex medical needs, best practice suggests these visits should occur even more often. Even at the height of COVID-19 pandemic, the requirement for in-person visits continued to apply unless an exemption was approved by a Director. RCY could find no evidence of such an exemption in Colby's case.

While she may not have had contact with the children, the social worker did have extensive contact with Staci, including three in-person

meetings, during those seven months. Records show that the social worker was also in contact with Staci at least 50 times through texts, messages and email exchanges.

The social worker also had one in-person interaction with Colby's sibling – a Jan. 22, 2021, meeting at the band office when Crown counsel interviewed her regarding the previous sexual assault allegations. There is no record of the social worker having a private conversation with the sibling on this date or the worker noticing anything unusual about the sibling's appearance or presentation despite this meeting occurring at the height of the children's abuse.

### MCFD Practice Guidelines In Response to COVID-19

MCFD Interim Practice Guidelines came into effect March 23, 2020, in response to the COVID-19 pandemic. They *"were intended to minimize in-person contact whenever possible, while ensuring the safety of vulnerable children, youth and families, support for youth in conflict with the law and public safety."* These guidelines were applicable to all service lines (Adoptions, Child and Youth Mental Health, Child Protection, Guardianship, Resources, Services for Children and Youth with Special Needs, and Youth Justice). Practice bulletins were regularly updated and guidance was provided to ensure that orders from the Provincial Health Officer (PHO) were followed. When a child protection report was made, staff were to "interview all children and parent/s in person. Exceptions must be approved by a Director of Operations/DAA Manager".... *"Any exception for a Resource Worker not to complete an in-home visit as a result of COVID-19 needs to be approved by a Director of Operations/DAA Manager. This exception needs to be documented in the RE [Resource] file, along with a plan for when the in-home visit will occur."*<sup>32</sup>

<sup>32</sup> Source – <https://intranet.gov.bc.ca/assets/download/579D5A236E7446F7AAC6AE3DAFF83331> retrieved May 23, 2024.

## Isolation from school

In September 2020, Colby was back at school. COVID-19 restrictions were relaxing and he started the school year appearing to be happy and healthy, according to his teachers. But his attendance suddenly dropped, with records showing 21 absences in one 26-day period during September and October. In short order, neither he nor his middle sister were attending at all. Meanwhile, Staci was sending her own children to school with much more frequency. A teacher told us “We were seeing the bio kids and not the foster kids – right away we were thinking what is going on here?”

A number of teachers told RCY investigators that they and other school staff raised concerns about the children’s attendance with the principal, but nothing came of it. “I don’t know why more pushing wasn’t done – [we were] definitely concerned about it. I felt like I did communicate my concerns.”

A teacher recalled that the school tried to contact Staci regarding Colby and his

younger sister’s attendance. “Between [the principal] and myself and [another teacher], I know we made several phone calls about the attendance – ‘Anything we can do?’ Quite a few calls went out. Always an excuse as to why they weren’t coming.” This teacher recalled asking her principal about Colby after he stopped attending. She also recalled questioning why he and his middle sister weren’t attending when other children in the home were. “I did ask about that a couple of times, but never got a response on it.”

A number of school staff told RCY investigators that Staci came across as “cold” and would only meet with them over Zoom. One recalled asking why Colby and his middle sister couldn’t go to school when they were going to respite care and band activities. “[Staci] was very angry,” she said. The same staff member said she would ask Staci during Zoom meetings if Colby and his middle sister could come on camera, only to be met with a “they’re busy” response from Staci.



The school district's child and youth in care advocate<sup>33</sup> emailed the MCFD Team Leader about Colby's attendance on Oct. 19. The following day, the MCFD social worker attended a meeting with district staff, during which alternative schooling options were discussed for the boy. Notes from a subsequent school-based care team meeting on Oct. 26 indicate that neither he nor his middle sister had attended much school. Staci explained during this meeting that this was due to COVID-19 and because Colby had been ill. The next month, the MCFD social worker emailed BCCH to discuss obtaining a doctor's note recommending home-schooling, although the worker did not attend the home or arrange to meet with Colby to make her own assessment.

During this period, several alternate options for Colby's education were offered to Staci. The school district principal reached out to the head of the district's Hospital Homebound Program as a possible solution. The principal also told RCY investigators an alternate online option was offered, as was the possibility of the boy attending the temporary schooling being offered by the Nation office twice a week in late 2020, but that Staci wasn't interested in these options.

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<sup>33</sup> Some school districts have engaged advocates to support students who are also children in care, who serve as key members of a child's school-based team. Further information on supports for children in care within the education system is available at Supporting children and youth in care in the K-12 education system – Province of British Columbia (gov.bc.ca).

Staci attended a school-based care team meeting for Colby in November, where it was documented that the team would indeed be moving toward involving him in the Hospital Homebound Program. Colby was scheduled to begin this program in January 2021 but, despite multiple attempts, the Hospital Homebound Program worker wasn't able to get the caregivers to engage.

Meanwhile, staff at the school were making efforts to reach out to the family and a computer, box of food and some resources for Indigenous activities for the children were taken to the home. "I showed up there... nobody came to the door..." His classroom teacher prepared a package of materials for Colby to work on from home. "It never got done," she recalled.

Six days before Colby's death, Staci sent an email to the principal of his elementary school advising that Colby and his younger sister would not be returning to the school and would be transferred to a new school. The principal forwarded this email to the district's advocate for students in care. Records show that both professionals were surprised and confused by this decision. The MCFD social worker had also been unaware of Staci's decision to switch schools for the children again. She subsequently reached out to the new school that Staci had chosen to set up a transitional meeting.

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*Note to readers: The following sections contain information that you may find disturbing. Please read with caution and reach out to supports listed earlier and at the end of this report should you need them.*

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## The final days of Colby's life

Colby never would return to school. On Feb. 26, 2021, while the other kids in the house were getting ready to go to a birthday party, video footage would capture Staci repeatedly beating him to the point where he became unresponsive. Evidence would show Colby on the couch with Staci beside him with her cell phone in her hand. It would be 40 minutes before she called 911. As she waited, she did not seek help from anybody in her small, close-knit neighbourhood or from her brother who was in another room in the duplex where she lived.

She would eventually make the call to 911. She told them Colby had fallen down the stairs. She was “*freaking out*” she said. She was telling him to wake up, she told the 911 operator, and he was not.

Five ambulances arrived on the scene. When first responders headed to the house, Colby was unresponsive. One paramedic described being “flabbergasted” by what she saw. Colby was so thin, and cold. His situation was so grave, Air Ambulance and Advanced Life Support were called. The RCMP was also called.

According to documents, Staci told first responders and police a variety of conflicting stories. In one version of events, she said Colby had been in the living room playing video games and eating when he collapsed. In another, she said that he had fallen down the stairs and hit his head. In another, she recounted that he had gone to get a bowl of cereal and collapsed. And in yet another, she said that he had fallen off the couch and gone into cardiac arrest.

As Colby was being flown by helicopter to Vancouver, paramedics worked to keep him stable. Even through the months of intense and sustained abuse that would soon become known to the health care practitioners, Colby's resilience would show itself again. His fragile

heart that just half an hour before had stopped beating, would start beating well again. “His heart was good,” recalled one of the paramedics.

But it was the other injuries that started to concern the first responders – signs of increasing swelling and bruising that just weren't adding up with the story they had been told about Colby falling. Their concerns that something else had happened proved to be right.

Colby was examined by several specialists at BCCH. He was found to have injuries to his head, brain, lungs, abdominal organs and skin. He was chronically malnourished, weighing just 28.8 kilograms when he died, compared to the average weight of a child his age of 48.9 kilograms. The specialists believed his injuries were non-accidental. Radiology revealed that he had multiple fractures and a CT scan showed that he had a traumatic and inoperable brain injury that was incompatible with life.

Colby would keep fighting over the course of the next two days but he succumbed to his injuries and he was declared neurologically dead. Although Violet and Colton were initially prevented from visiting their son following his hospitalization, they were able to see him on this date. His maternal grandmother said her goodbyes via the ministry – she asked that a simple message be passed along – “Honey boy, grandma loves you really lots and I'm always thinking of you.”

Colby was removed from life support four days after the assault and died.

Representatives from the two Nations where Colby had lived agreed on a cultural ceremony to be performed at the hospital as he was taken off life support. Later that week, Colby's body was returned to his home community where he was buried.

## Three months of horror behind closed doors

While Staci was sending texts to the social worker showing the kids with Santa and seemingly enjoying family outings and activities, video footage seized from the house following Colby's death would tell a very different story.

The video cameras installed in the home of Staci and Graham captured nearly 1,600 clips comprising more than 400 hundred hours of horrific abuse experienced by Colby and his younger sister in the last few months of his life.<sup>34</sup> During the sentencing hearing for Staci and Graham in Provincial Court that abuse was summarized by the judge in the following words:

*"It is incomprehensible how someone can inflict such pain, suffering and violence on an innocent child. [The children] were put in [the caregivers'] care for protection. The exact opposite occurred. Their actions against these children were evil and inhumane."*

They would go on to say that the abuse was

*"deliberate and protracted and at times involved the use of weapons, restraints and the infliction of severe physical and mental pain and suffering."*

According to an Agreed Statement of Facts used during sentencing, Staci and Graham abused Colby and his middle sister repeatedly and for prolonged periods of time between Dec. 1, 2020, and Feb. 26, 2021. The RCMP's records of their interview with Colby's older sister note that she said the abuse in the home

began in 2019, within the first three to five weeks of the children moving into the home.

It was learned through the courts that the couple abused the two children both separately and together. Colby and his middle sister were subject to extensive physical abuse including being grabbed by the throat, picked up by their ears, pulled by their hair, kicked, stomped on, held down, punched, dragged, pushed, swung around, choked, knocked down, restrained, blindfolded and gagged. They were struck hard with various weapons including a 2x4 (wood), a broom handle, a cellphone, kitchen utensils, a bucket, a belt, keys, a spray can of Lysol, and the butt-end of an axe.

Colby and his middle sister were forced to do repetitive exercises such as squats and jumping jacks for hours at a time, often while naked or wearing diapers and sometimes while blindfolded or with their eyes covered by duct tape. Video evidence showed Staci and Graham at times laughing at and mocking the children as they were being horrifically abused.

Once, Staci shaved Colby's head as a punishment. But the abuse went beyond physical punishment. These two children were excluded from activities such as baking and sitting on the sofa watching television with the other children in the home. Colby and his middle sister would at times be locked in a dark closet under the stairs of the duplex where the hot water tank was housed.

Food deprivation was used as a form of torture. Colby and his middle sister were not provided with the same food as their older sister or Staci and Graham's own children, and instead had to watch the other children eat. When Colby snuck food from the kitchen late at night because he was hungry, he was punished as a result. On more than one

<sup>34</sup> In the Agreed Statement of Facts presented at the sentencing hearing, Staci and Graham acknowledged that the abuse and torture of the children occurred in all but one room of the house, although the video cameras only captured the abuse occurring in the kitchen and living room. It is therefore clear that the children suffered even more than what has been documented.

occasion, Colby was forced to eat dog food out of a can. What he didn't eat was put outside for the dog. In some instances, he and his siblings were also forced to eat their own feces or vomit and drink their own urine. At times during the abuse, Colby experienced difficulty breathing. And although he was supposed to use an inhaler daily, no active inhalers were found when police later searched the residence.

Perhaps most shocking was that the evidence revealed that Staci and Graham forced other children in the home to also enact violence on the two young children.<sup>35</sup>

On the day Colby suffered his fatal injury, a nine-minute video clip horrifically shows the real truth of what happened to Colby. He hadn't fallen down the stairs or suddenly collapsed, Colby had been dragged into the kitchen, thrown to the floor and attacked by Staci multiple times as another child was made to look on. He was kicked, slapped in the face, and choked as Staci placed her bodyweight on top of him.

As he tried unsuccessfully to stand up and put on his shirt, Staci picked up Colby again and threw or dropped him toward the floor. Because his arms were trapped inside his shirt as he was trying to pull it on, he couldn't brace for the impact and his head hit the hardwood floor. The location of Colby's fatal head injury appears to line up with how he crashed to the floor in this instance. Within minutes of this incident, he became unresponsive, and Staci picked him up and threw him into a recliner chair.

The horror that the children were experiencing throughout this time went undetected by MCFD and the Nation and, at the same time as the abuse was intensifying, MCFD was

<sup>35</sup> This is a particularly disturbing aspect of the violence that Colby and his sister endured at the hands of their caregivers. The caregivers' actions constituted abuse of children who were forced to inflict violence on another child. The Representative will not be sharing further details out of respect for the surviving children.

considering these caregivers as a permanent option for the children.<sup>36</sup>

Even though there had been no initial checks on Staci and Graham, Colby had not been seen in seven months, and numerous concerns were being raised by health care and education professionals, MCFD had begun planning to do a home study on the couple as a step toward approving them to take permanent custody of the children they had been torturing.

“We're telling you we have concerns. I don't see this kid [at school]. And you're telling me you're going to put him [in that home] permanently? And he literally died that weekend.”

– School-based worker upon learning that permanency planning had begun for the children with Staci and Graham

RCY investigators learned through interviews that the MCFD resource social worker assigned to complete the study was scheduled to meet with Staci and Graham in their home on Feb. 26, 2021, the day Colby was taken to hospital. Colby's grandmother told RCY investigators that, following her grandson's death, the MCFD team leader visited her home and advised her and her brother not to tell anybody about what had happened. She recalled that this felt like a threat.

<sup>36</sup> A s.54.01 order under the *CFCS Act* is the permanent transfer of custody to a person other than the child's parent (kith or kin) who are currently under an EFP or Out of Care temporary custody order. A s.54.1 order is the permanent transfer of custody of a child from MCFD under a Continuing Custody Order (CCO) to a person other than a parent (kith or kin). Both orders are considered permanency options. Supports (i.e., health supports and post majority supports) under s.54 orders varies and for some services is less than interim and temporary out of care orders and agreements. The assessment processes for prospective care providers are different between s.54.01 and s.54.1 orders. Indigenous children require specific approval process for both orders.

## The criminal proceedings

The Integrated Homicide Investigative Team (IHIT) took over the criminal investigation on Feb. 27, 2021, once it was determined Colby would not survive his injuries. IHIT recommended a number of charges against Staci and Graham in its report to Crown counsel, including that Staci be charged with second-degree murder in the death of Colby, failing to provide the necessities of life to both Colby and his middle sister, and both assault and aggravated assault on the sister. IHIT recommended that Graham be charged with manslaughter in Colby's death, failing to provide the necessities of life for Colby and his middle sister, assault and aggravated assault against the sister and discharging an air pistol with intent to wound Colby.

The Crown decided to lay manslaughter charges against each of Staci and Graham for the death of Colby as well as charges of failing to provide the necessities of life, unlawful confinement, aggravated assault and the use of a weapon in committing assault against both Colby and his middle sister. Graham was charged with an additional count of using a weapon to commit an assault. The couple were arrested on Aug. 6, 2021, and released on conditions five days later.

Trial was avoided when Graham and Staci each pled guilty in August and November, 2022, respectively, to one count of committing manslaughter against Colby and one count of committing aggravated assault against both Colby and his middle sister. Sentencing

concluded on June 16, 2023. The process included the presentation of Gladue<sup>37</sup> reports which documented the care providers' childhood exposure to and experience of violence, including physical and sexual assault as children and adults, exposure to alcohol use, parental mental health disorders and learning challenges.

The judge agreed with Crown and defence counsels' joint sentence proposal of 10 years each for Staci and Graham for the manslaughter conviction and six years each for the aggravated assault conviction, to be served concurrently.

Victim impact statements spoke to the immense grief and loss that those who knew and loved Colby have suffered as a result of his horrific abuse and death. One described how everyone fell in love with Colby due to his personality, kindness and smile.

A number of family members made victim impact statements, including Violet, who communicated through the probation officer who did the pre-sentence report. Violet told the officer that, as a result of what had happened, she felt "untrusting of child protection services who were unable to keep her child safe" and that she felt "isolate[d] in her community due to the tension [Staci and Graham's] behaviour has caused."

<sup>37</sup> Gladue reports identify relevant systemic and background factors in the individual's life that can be considered by courts when sentencing an Indigenous offender. In accordance with the British Columbia First Nations Justice Strategy, effective April 1, 2021, the program transitioned from Legal Aid British Columbia to the British Columbia First Nations Justice Council (BCFNJC). Anyone who self-identifies as First Nations, Métis or Inuit has Gladue rights and can request a Gladue report. The BCFNJC prepares Gladue reports for bail, sentencing, appeals, long-term offender hearings, dangerous offender hearings and parole hearings. Information available at Gladue Reports | Info on report requests, report writing, and more. (bcfnjc.com).

Violet's mother and her aunt both expressed to the court how much Colby's death had hurt their family. The grandmother said she was suffering "physically, mentally, emotionally and spiritually" as a result, and believes Colby "died under the impression that he was unloved because she was unable to interact with him prior to his death."

Statements in pre-sentence reports by representatives from both First Nations spoke to the negative effects on the surviving children and on both communities by what happened to Colby. A representative from Violet's community said it has caused "disruption between families and family relationships and a deep distrust within the community." They went on to state, "Overall,

this offence has created widespread harm in both Indigenous communities which will take time, effort and resources to manage."

A community impact statement was provided by the Chief and Council of Violet's Nation. The statement sets out the makeup of the community. "It is a small and close-knit community grounded in culture, tradition and teachings. The loss of [Colby] has had a devastating impact upon this community. In particular, the circumstances under which he died have devastated the community ... [Colby's] light is now gone ... in honour of [Colby], the community is dedicated to ensuring that no other child will ever be taken in this way and will work diligently to keep their children safe from harmful individuals."



## A story with no ending

When Violet first learned that her son had died, she desperately wanted to be with her own mother but couldn't find anybody who would give her a ride. It took her several hours to walk alone, in the winter rain, from Nation lands to find the consolation only her own mother could give her.

In the days and months that followed, Violet's mental health and substance use challenges would continue as she struggled to live with the pain of losing her miracle child and the cumulative grief and loss in her life. Substances were a way to numb the deep pain that she was experiencing. Violet died 20 months after her son had died from what was believed to be a toxic drug poisoning.

The excruciating loss of Colby was – and still is – deeply felt by his family, his community and those who were touched by his gentle and resilient spirit.

### Where are the siblings?

Following Colby's death, Violet participated with MCFD in a collaborative practice and decision-making process to discuss planning for her surviving children. They were placed in three different homes after being removed from Staci and Graham's care and each of the children has since been moved to other placements. One child has been moved several times. In December 2023, in order to achieve the placement of two siblings together, one of the children was moved from a safe and stable placement with extended family and placed together with a sibling in an off-reserve staffed residential home (group home) and they remain disconnected from their other siblings. RCY has since received a reportable circumstance concerning mistreatment of one of the children by a staff member, witnessed by the other child. Family members have



expressed significant concerns about the well-being of the children in their current placements and continued lack of belonging and connection. RCY shares their concerns. The ministry and Department hope that some of the children will be able to live together in the future. Only one child is currently living with a family member and there remains a lack of family connection for the children despite requests from several family members.<sup>38</sup>

RCY continues to be involved in these children's lives. While we recognize that the ministry has invested in considerable resources to support these children since the death of Colby, we wonder where these children would be if, at many different points in their lives, resources had been provided to Violet, her mother, the great auntie and uncle, or even the caregivers.

Staci and Graham's three children were safety-planned into the care of the couple's former respite caregiver following Colby's fatal injury and remained with this caregiver until July 2023. This placement came despite multiple previous reports received by MCFD against the female respite caregiver of physical violence against children. In July 2021, RCMP reported to MCFD that there were video records of violence enacted by this caregiver on the children, but the ministry closed the file with no concerns. Staci and Graham's children were not moved from this home until after another report of physical abuse against the caregivers in July 2023.

In conversations with RCY, community leaders shared that this tragedy had a significant impact on families and communities as they grappled with how this could have happened, what was missed and who might have known something and shared something that would have made a difference to the trajectory of the story. Leaders also expressed concern about the issue of violence within their community and the need for healing to disrupt intergenerational cycles of violence.

Cultural support and ceremony were offered in the hospital when Colby was removed from life support. And in the weeks after the sentencing hearing, when new information came to light about what had happened, the community held a healing ceremony for all who were connected with the family.

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<sup>38</sup> RCY notes that the onus to create and sustain familial connection should not be on the family members alone. The Department and MCFD staff have important roles to play to create opportunities for familial connection.

MCFD has made some changes following Colby's death. In summer 2020, the Provincial Director of Child Welfare had started a yearly "real time" check to ensure all children and youth in care had been seen in the last 90 days as per policy.<sup>39</sup> RCY notes this did not occur for Colby. In summer 2023, this expanded to a "real time" check conducted every quarter. Additionally, as of Sept. 1, 2023, children and youth in EFP agreements and those in Interim or Temporary Out of Care orders must be seen in the home every 90 days. Previously, this only applied to children in the care of MCFD (i.e., placed in foster homes and group homes). It is noted that the ICFSAs AOPSI standards<sup>40</sup> have a 30-day policy requirement for children and youth in care to be seen, compared with the 90 days set out in MCFD policy. ICM upgrades in Oct. 2023 also include an applet to better track and record when children and youth are seen by their social workers.<sup>41</sup>

Questions continue to be on the minds of family, friends, community members and staff as well as the many professionals who were involved in Colby's life. Many shared with RCY that they wonder what more they could have and should have done. Hospital staff have asked themselves, "What more could I have done to get Colby to his appointments?"

Colby's school-based worker wonders what might have happened if, when she was dropping off Colby's schoolwork and Staci and Graham didn't answer the door, she had waited just a little longer before leaving.

We will never know for sure if one small action could have changed the trajectory of this boy's life – but there's no question that collective action could have done so.

Colby's story broke our hearts, but it built our conviction that caring for a child takes so much more than one person – one doctor, one social worker, one parent, one teacher. It takes a system to come together to truly "see" a child, to understand them, to love them and to ensure they thrive. Colby has taught us so much – but the learning is far from over.

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<sup>39</sup> During the administrative fairness process, the ministry indicated that they had been tracking CIC visits prior to 2020, however, RCY notes that had the tracking been effective in ensuring that children were regularly seen by social workers, the abuse that Colby and his sister were experiencing may have come to light.

<sup>40</sup> The Aboriginal Operational and Practice Standards and Indicators (AOPSI) are the policies and standards by which Indigenous Child and Family Service Agencies (ICFSAs – formerly known as Delegated Aboriginal Agencies or DAAs) provide services. Though the emphasis of some of these standards differ from those of MCFD, the safety and protection of children are always paramount. The AOPSI standards either meet or exceed those established by MCFD.

<sup>41</sup> During the administrative fairness process the ministry advised that as of December 2023, a Child Visit Report is now available in government's corporate data warehouse, allowing for real time, accurate and efficient data collection regarding child visits.

## What we learned through Colby's story

When a tragic incident occurs that takes the life of a child, it is tempting to point a finger – to identify one thing or one person responsible for the death. But in Colby's case, there was no one thing or one person wholly responsible for his death.

Instead, we see a litany of actions, inactions and missed opportunities. We ask ourselves a series of what-ifs:

- What if a more comprehensive approach to violence within the family had been taken?
- What if there had been sustained wraparound supports for the family's many struggles?
- What if there had been stronger and more responsive substance use services?
- What if the family had received enhanced income supports that would have allowed them to better care for a child with complex health needs?
- What if their housing precarity could have been alleviated?
- What if basic social work policy and practice had been adhered to and strongly overseen?
- What if there had been a clearer understanding of roles and responsibilities between a Nation and a government?

And there are so many more. To support reflection and learning, RCY has identified over 40 missed opportunities and child rights concerns, which will be shared and discussed with MCFD to support learning and change.

The Representative has concluded that this child's death was entirely preventable. There is no question that collectively we all failed this boy in so many aspects of his family's life. Across systems – on the school grounds, in the

health care system, in the housing and income sectors, in child welfare and in the Nations – it is clear that this family needed so much more. These systems needed to deeply understand the impacts of intergenerational trauma and the cycle of acceptance and indifference to violence and substance abuse that impacted this family and so many others.

We needed to come together to provide early help and interventions, to offer proper wrap around supports to both Colby's family and extended family care providers. We needed to do a much better job ensuring that due diligence, strong practice, clear roles and responsibilities and accountability existed among MCFD and staff of the Nation's Department tasked with providing family support services. We needed a better way for organizations to communicate with each other to make sure the needs of a family were met in a timely way. There is no room for hesitation or "squeamishness" when speaking about a child's safety and well-being. We heard the regrets of those who did not speak up when they had that "gut feeling". And finally, and importantly, we all needed to recognize and address the biases and assumptions we as a society had about this family and continue to have about so many families who are vulnerable.

As we have stated previously, the purpose of this report is not to blame, shame or point fingers. However, it is about identifying missed opportunities that might have prevented Colby's death and that could help prevent future abuse and deaths of children in B.C. As can be seen from the pages that follow, Colby's death is not an outlier. The patterns and themes that we will discuss in our systemic analysis are prevalent in too many cases that come to RCY and cut across race, age, income and family status. As we take a closer look at what we learned through Colby's story and the themes that emerged, it is clear: the time to act is now.

# Key Missed Opportunities

RCY identified dozens of missed opportunities from Colby's story that highlight lack of adherence to policy, inadequate responses or missed opportunities to provide support, safety and clarity. In some situations, policy at the time would have supported action, and in other situations there may not have been explicit policy, programs or services available. This small sample of missed opportunities are offered to inspire reflection and learning about what might have been done to change Colby's and his family's story – and therefore what could be done for children like Colby in the future.

## Responding to Violence

### Summer 2007:

The first documented incidence of intimate partner violence (IPV) came 15 months after the birth of the couple's first child, when police were called to their residence due to an altercation that resulted in both parents sustaining injuries. Violet and her daughter were "safety planned" by RCMP to the maternal grandmother's home as a temporary measure. MCFD relied on the RCMP's plan and did not conduct an assessment to understand the IPV and substance use risks to the child and did not reach out to the family, despite RCMP's concerns about the violence. MCFD finally met with Violet seven months after the report was made. A family service file was opened for the "monitoring and development of a positive support system for Violet and Colton."



### Missed opportunity to provide early help:

MCFD could have met with the young family at the time of the incident to not only assess risks to the child from the violence and reported substance use, but also begin to engage the family in determining what help they might need to ensure that they could safely parent their daughter. The family service file recordings the issue of violence in the home.

Note: The use of the term "monitoring" in the case file suggests surveillance and is no longer supported in policy.

## Family Supports

### Spring 2009:

Colby is born with complex medical and nutritional needs that would continue throughout his childhood necessitating specialized formula, supplies, supplements, frequent medical appointments, visits to hospital emergency rooms and clinics. Violet is taught appropriate formula preparation at the hospital, but inadequate funding was provided for Colby's specialized diet and his parents tried to extend the formula by watering it down during the first few months of his life. Family members reported they often helped to pay for the formula and supplies.



### Missed opportunity to provide early help:

As will be seen in the systemic review, information sharing, coordination and collaboration between systems is challenged by silos and barriers to information sharing. Had the health system, MCFD, social development and the Department come together following Colby's birth, they could have helped Colby get off to the strongest start possible by meeting his specialized nutritional and medical needs. Although medical professionals apprised the Nation's community health nurse and the MCFD social worker of their concerns, it's not clear whether supports were offered to the parents to help them ensure that their son received the care he required.

“She was supposed to receive supports for cleaning, for parenting. But she didn’t get the supports,” the relative said. “... I would take the kids when I could see the stress on her face. We knew that the best place for them was going to be with their mother, but she needed supports ...”

- Family member

## Gathering and Assessing Information

### Winter 2010:

A child protection report was made to MCFD concerning Violet’s partner Matt’s history, alleging that he poses a risk to children. The MCFD social worker did not assess the report and a subsequent review of Matt’s criminal charges and interactions with the criminal justice system included: assault, sexualized violence, property damage, and drug possession. It was further learned and documented that Matt had experienced time as a child in care, had a child where there was a no-contact order, and had experienced sexualized violence and used sexualized violence historically.



### Missed opportunity to gather and assess information to determine risks to the children and support planning:

MCFD’s policies at the time would have enabled the social worker to gather more information through the records and to meet with Violet and Matt to mitigate potential risks, learn more about the family’s challenges, and offer supports and services that might have kept Colby and his family safer. Lack of engagement and providing supports to men who use violence is a consistent theme in Colby’s and other children’s stories.

## Opportunities for Interconnection

### Spring to Summer 2019:

Local MCFD social workers received four reports from community service providers over a five-month that raised concerns about Violet’s care of the children, reliance upon her older daughter for child care, familial substance use and the cleanliness of the home, among other things. Instead of documenting and assessing each concern, they were rolled together in a single memo and follow-up action was not taken until four months after the first report.



### Missed opportunity for interconnection and engagement with other community supports:

Given that concerns were raised by colleagues in community and health services, MCFD’s lack of responsiveness conveyed a lack of professional respect and was a missed opportunity to engage those close to the family within community to offer relevant and timely supports. This lack of early intervention allowed for problems within the home to reach a crisis point, which is emblematic of a reactive system.