15-YEAR-OLD TONY

An Investigative Review

NOVEMBER 2014

ocya OFFICE OF THE CHILD AND YOUTH ADVOCATE ALBERTA

Under my authority and duty as set out in the *Child and Youth Advocate Act (CYA)*, I am providing the following Investigative Review concerning the passing of a 15-year-old First Nation youth who was, at the time, receiving services from the Government of Alberta. Consistent with section 15 of the *CYA*, the purpose of this report is to learn from this tragic event and recommend ways of improving Alberta's child intervention system.

While this is a public report, it contains detailed information about children and families. My office has taken great care to protect the privacy of the family members of the young person involved. The names used in this report are pseudonyms (false names) and, in accordance with the *CYA*, the report refrains from disclosing identifying information. Finding an appropriate pseudonym is difficult because a young person's name is part of who they are. However, it is a requirement that my office takes seriously and respectfully. In this situation, we have called the young person, Tony.

Following legislative changes made by the *Child, Youth and Family Enhancement Amendment Act*, 2014, the names of a deceased child or their parents may be published. However, family members who wish to prevent personal information respecting the deceased child or any relatives from being published by media sources must apply for a publication ban. The legislative changes do not alter the protection of privacy for the deceased child and their family members in the Child and Youth Advocate's Investigative Review. Accordingly, I would request that readers and interested parties, including the media, respect this privacy and not focus on identifying the individuals and locations involved in this matter.

Tony ended his life in 2012 when he was 15 years old. He was a young man who struggled to have a sense of belonging. Although attempts were made to keep Tony connected to his family, and his First Nation Community, it was not enough. He was found hanging outside of his group home.

I couldn't help but think back to a similar tragic event that occurred in 1984 when Richard Cardinal, a 17-year-old Métis youth, was found hanging outside of his foster home. The review of Richard's life led to significant child welfare reforms in Alberta. The purpose was to prevent similar tragedies from continuing to occur. Sadly, although much has changed over the past 30 years, the reforms have not led to a child intervention system where we can be confident that these tragic circumstances no longer happen.

Tony's experiences and his death by suicide, contains a clear and compelling message that the child intervention system must change. There are other young people like Tony. We must not wait any longer.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

CONTENTS

EXECUTIVE SUMMARY 5

INTRODUCTION 7

The Office of the Child and Youth Advocate 7

Investigative Reviews 7

ABOUT THIS REVIEW 9

BACKGROUND 10

About Tony 10

About Tony's Family 10

About Tony's Community 11

HISTORY OF INVOLVEMENT WITH CHILD INTERVENTION SERVICES 12

Tony from Birth to 9 Years Old 12

Tony from 10 to 11 Years Old 12

Tony from 12 to 13 Years Old 14

Tony at 14 Years Old 15

Tony at 15 Years Old 16

Tony's Last Days 17

After Tony's Death 17

DISCUSSION AND RECOMMENDATIONS 18

Ensuring Relationships for Aboriginal Children 19

Assessing Risk of Suicide 21

Sharing Information Between Caregivers 23

CLOSING REMARKS FROM THE ADVOCATE 25

APPENDICES 26

Appendix 1: Terms of Reference 26

Appendix 2: Committee Membership 28

Appendix 3: Genogram 30

Appendix 4: Timeline 31

Appendix 5: Bibliography 32

EXECUTIVE SUMMARY

Alberta's Office of the Child and Youth Advocate (the "Advocate") is an independent office reporting directly to the Legislature of Alberta, deriving its authority from the *Child and Youth Advocate Act (CYA)*. One role of the Advocate is to "investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

In the fall of 2012, Tony (not his real name),[1] a 15-year-old youth was found unresponsive, hanging in a playground beside his group home. He passed away in hospital two days later. At the time of his death, Tony was the subject of a Permanent Guardianship Order. In January 2014, the Advocate advised the Minister of Human Services that an Investigative Review would be conducted.

Tony was a First Nation youth who had sporadic child intervention involvement in his early years while in the care of his parents. He was brought into government care when he was 10 years old and remained in care until he passed away. During the five years Tony was in care, he moved 13 times and had eight caseworkers.

Caseworkers were challenged to find a home for Tony that could meet his behavioural needs and he ended up living far away from his home community. His relationships with those who mattered the most to him were weakened. It seems he lost touch with his sense of belonging and identity.

The information gathered through the investigative review process revealed three systemic issues related to the child intervention system:

1. Ensuring relationships for Aboriginal children

Caseworkers tried to keep Tony connected with his mother and grandfather. When these relationships were threatened, Tony had no one else to turn to. Caseworkers struggled to bridge the distance between Tony and his family. There were missed opportunities to enhance and strengthen Tony's relationships and identify relationships with other family members.

2. Assessing risk of suicide

Over the five years that Tony was in care, there were at least four times that he attempted to harm himself. Although there was time between attempts, a pattern emerged in which it was apparent that his intent was getting stronger.

1 All names used throughout this Investigative Review are pseudonyms. Section 15(3) of the *Child and Youth Advocate Act* states that a report must not disclose the name of, or any identifying information about, the child to whom an investigation relates or a parent or guardian of the child.

3. Sharing information between caregivers

Tony had numerous placements, often because caregivers were not equipped to deal with his behaviours. Routines and supports that worked well with Tony were not directly shared among day-to-day caregivers from one placement to the next.

To address these issues and to help improve the effectiveness of Alberta's services for young people, the Advocate makes **three recommendations**:

Recommendation #1

The Ministry of Human Services, with its service delivery partners should strengthen processes related to:

- The search for meaningful relationships in an Aboriginal child's life and ensure that the extended family of both parents is explored.
- The ability of placement facilities to provide Aboriginal children in care continuous and ongoing access to traditional knowledge and activities.

These processes should be documented and audited for compliance to ensure that Aboriginal children remain connected to their family, community and culture.

Recommendation #2

The Ministry of Human Services, with its service delivery partners, should require a suicide risk inventory be completed for all young people, who have been identified as at risk of suicide, on a regular and ongoing basis – not just at the time of crisis.

Recommendation #3

The Ministry of Human Services, with its service delivery partners, should review policy and practice in information sharing when a child transitions to a new placement. Emphasis must be placed on direct communication between day-to-day caregivers to support the continuity of successful treatment approaches. This means those caregivers who work directly with young people in their placements.

INTRODUCTION

The Office of the Child and Youth Advocate

Alberta's Office of the Child and Youth Advocate (the "Advocate") is an independent office reporting directly to the Legislature of Alberta. The Advocate derives its authority from the *Child and Youth Advocate Act*,[2] which came into effect on April 1, 2012.

The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act*[3] (the *Enhancement Act*), the *Protection of Sexually Exploited Children Act*[4] (*PSECA*), or from the Youth Justice System.

Investigative Reviews

Section 9(2)(d) of the *Child and Youth Advocate Act* provides the Advocate with the authority to conduct investigative reviews. The Advocate may investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Through the Investigative Review process, the services provided to the young person are examined; and, findings and recommendations are identified to help make systemic changes that will lead to better outcomes for children and youth. The final report is non-identifying and made public.

An Investigative Review does not assign legal responsibilities, nor does it supplant or abrogate other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an Investigative Review is not to find fault with specific individuals, but to identify key issues along with meaningful recommendations that are:

- *prepared in such a way that they address systemic issue(s); and,*
- *specific enough that progress made on recommendations can be evaluated; yet,*
- *not so prescriptive to direct the practice of Alberta government ministries.*

2 *Child and Youth Advocate Act*, S.A. 2011, c. C-11.5.

3 *Child, Youth and Family Enhancement Act*, RSA 2000, c. C-12.

4 *Protection of Sexually Exploited Children Act*, RSA, c. P-30.3.

The Child and Youth Advocate expects that ministries will take careful consideration of any recommendations, and plan and manage their implementation along with existing service responsibilities. The Advocate provides an external review and advocates for system improvements that will help enhance the overall safety and well-being of children who are receiving designated services. Fundamentally, an Investigative Review is about learning lessons, rather than assigning blame.

ABOUT THIS REVIEW

In 2012, the Advocate received a report of death regarding Tony (not his real name),[5] a 15-year-old First Nation youth. Tony was found hanging in a playground next to his group home. He was transported to the hospital, where he passed away two days later. The Office of the Chief Medical Examiner (OCME) found the cause of death to be asphyxia by hanging, and that the manner of death was suicide. At the time of his death, Tony was the subject of a Permanent Guardianship Order.[6]

The Advocate thoroughly reviewed file information provided by the Ministry of Human Services. A preliminary report was completed which identified potential systemic issues and the Advocate subsequently advised the Minister of Human Services that a full Investigative Review would be conducted.

Terms of Reference for the Investigative Review were established and are provided in Appendix 1. A team gathered information and conducted an analysis of Tony's circumstances through a review of relevant documentation, interviews and research. A number of individuals who knew Tony provided insight into his circumstances.

Tony's mother and members of his extended family met with the Investigative Review Team. They remembered Tony as a child who enjoyed life and had a special bond with his siblings. They spoke of the sadness of losing another young person from their family and their community to suicide. The Advocate also met with leadership from the Delegated First Nations Agency about the review process.

A preliminary report was completed and presented to a committee of subject matter experts whose purpose was to provide advice related to findings and recommendations. The list of committee members is provided in Appendix 2. Committee membership was determined on members' experience and expertise in child and youth care, clinical social work with Aboriginal communities and suicide. An Aboriginal Elder also provided guidance.

The systemic issues identified in this review were:

- Ensuring relationships for Aboriginal children;
- Suicide risk assessment; and,
- Sharing information between caregivers.

5 All names used throughout this Investigative Review are pseudonyms. Section 15(3) of the *Child and Youth Advocate Act* states that a report must not disclose the name of, or any identifying information about, the child to whom the investigation relates or a parent or guardian of the child.

6 Under a Permanent Guardianship Order, the court awards guardianship of the child to the Director on a permanent basis. The child is in the care of the Director and remains in an approved placement. The guardianship of any former guardian is terminated and the Director is the sole legal guardian of the child.

BACKGROUND

About Tony

Tony was of Cree and Nakota Sioux heritage. Many remembered him as a "cute kid" who was always smiling and joking. He loved sports, rap music, drawing and camping in the bush.

Tony was competitive and led his peers in sports and other activities. Although he had some academic delays and was diagnosed with Alcohol Related Neurodevelopmental Disorder (also known as Fetal Alcohol Spectrum Disorder), younger children looked up to him. He was president of the student council in junior high school.

In his first ten years, Tony lived primarily with his mother and his grandfather. Later, while in government care he moved through a number of placements. Caregivers often struggled to deal with his angry outbursts.

Through this review, what struck the Advocate the most was Tony's lack of a sense of belonging even though he always remained connected (on some level) to his family and community.

About Tony's Family

Tony was part of a large blended family. His parents, Rachel and Gabe, each had children from previous relationships. Rachel had five older children: Nancy, Michelle, Karen, Jody and Doris. Gabe had three older children: David, Andrew and Irene. Tony spent his early years with his maternal siblings. Later on, he lived with his grandfather, Roger, who also raised Tony's paternal siblings.[7] The family's genogram is provided in Appendix 3.

Rachel was Cree. During her childhood, Rachel's family resided in a remote wilderness area and lived a traditional way of life. They moved to their First Nation community when Rachel was a teenager. This was a difficult change for Rachel and she became involved in abusive relationships.

Gabe was of Nakota Sioux heritage. A non-Aboriginal family adopted him and his siblings when he was very young. The adoption broke down when he was a teenager. Searching for where he belonged, Gabe gravitated to a First Nation community where he met Roger. Roger became like a father to him and a grandfather to Gabe's children.

7 A genogram of Tony's family is contained in Appendix 3.

When Tony was two years old, Gabe left the family. All contact with him ended, but Roger remained a strong support to Tony and Rachel.

Tony's home community was his mother's Cree First Nation. Roger lived nearby.

After he came into government care, all Tony wanted was to live with his mother or grandfather. However, this became an unrealistic goal for reasons beyond his control.

About Tony's Community

Tony was born in a Cree community located close to other First Nations. People from the First Nations often experience racism, stereotypes and distrust in surrounding cities and towns. First Nation members still feel the impact of colonialism and the residential school system. The community has experienced difficult years due to poverty, unemployment, violence and poor housing. However, community members remain resilient by keeping true to their values, beliefs, culture and language.

The community has been working hard to create a healthier environment by strengthening social programs, youth initiatives and outreach services. Suicide among young people is a significant concern. Children are seen as special gifts and when they end their life by suicide, everyone is devastated.

HISTORY OF INVOLVEMENT WITH CHILD INTERVENTION SERVICES

Tony from Birth to 9 Years Old

There was sporadic child intervention involvement with Tony's family during his first six years. Concerns were related to domestic violence and parental alcohol and drug abuse. Before he was two years old, Tony was brought into government care for seven months and then returned home. He was brought back into care for three months when he was three years old, shortly after his teenage sister committed suicide. The family moved frequently and spent significant time outside of Alberta.

When Tony was six years old, he lived with Roger for almost three years. There was no child intervention involvement during this time.

Tony returned to his mother's care at her request when he was nine years old and they moved to a nearby city.

Tony from 10 to 11 Years Old

When Tony was 10 years old, Rachel called Child Intervention Services in the city asking for help with Tony. He was swearing at her and destroying property in the home. After her third call, he was brought into government care at her request.

Tony wanted to live with his grandfather, but Roger could not provide the care that Tony needed. As a result, he was placed with an experienced Aboriginal foster parent in the city where he did well. At school, Tony was described as cooperative, a good listener, respectful and popular with peers.

Rachel returned to her First Nation community and wanted Tony there. After five months in the foster home, Tony was moved to a provisional foster home[8] on the First Nation. His child intervention file was transferred to a Delegated First Nations Agency[9] (DFNA) caseworker.

While Rachel wanted to care for Tony, she doubted she could manage his behaviours. When the caseworker tried to arrange visits, Rachel was often unavailable. It was difficult to confirm if Rachel was addressing her addiction issues. The caseworker applied for a Permanent Guardianship Order and the long-term plan was for Tony to live with Roger.

8 Provisional foster homes have not completed all of the requirements (such as training) to be an approved foster home. Special concessions are made to start fostering on a conditional or probationary basis.

9 An agency that delivers On-Reserve child intervention services to a First Nations community. DFNA's operate under provincial legislation, policy and standards but are funded federally.

Tony struggled at his new school. He damaged property, fought with peers and was suspended for a month. On one occasion, police became involved when Tony assaulted school staff. Tony told his caseworker[10] that he had "blacked out" and had no recollection of the incident. His foster parent requested that he be moved because she was worried for her safety.

Tony was placed in a group home near his First Nation. Shortly after, he assaulted peers and staff members and threatened to harm himself. A psychiatrist prescribed Topamax[11] in an attempt to lessen Tony's outbursts. But, the incidents continued. He stayed at the group home for three weeks.

Tony subsequently moved to a Youth Assessment Centre (YAC),[12] which was intended to be a short-term placement for stabilization. Despite the increased structure and supervision, Tony continued to struggle. On one occasion, he climbed into a freezer and said he wanted to kill himself. Due to his unpredictable and violent behaviours, it was unsafe for Tony to ride in a car and family members had to visit him at the YAC. During the three months that he was there, Tony was taken to hospital three times for psychiatric risk assessments.

A neuropsychological assessment was completed and Tony was diagnosed with Alcohol Related Neurodevelopmental Disorder (ARND),[13] also known as Fetal Alcohol Spectrum Disorder. Tony had challenges in his intellectual ability and executive functioning, which made it difficult for Tony to respond to stress and control his emotions. The psychologist recommended an environment tailored to Tony's abilities so that he would not become overwhelmed.

Tony had an electroencephalography (EEG)[14] which identified "disturbances" or abnormalities in Tony's brain activity. The psychiatrist reviewed his medications and prescribed Celexa,[15] Seroquel,[16] and Zyprexa[17] in addition to Topamax.

10 Within seven months of Tony's return to the First Nation, he had four caseworkers. This caseworker worked with him for two years.

11 Also known as Topiramate - An anticonvulsant drug also used to treat bi-polar disorder and to counteract weight gain caused by other medications.

12 A staffed facility intended to stabilize youth who have behaviours that cannot be managed in foster care or staffed group homes in the community.

13 Brain damage caused by prenatal exposure to alcohol that results in behavioural and learning problems. (http://www.nofas.org/faqs/what-is-alcohol-related-neurodevelopmental-disorder-arnd/)

14 A medical diagnostic test that measures electrical activity in the brain.

15 Also known as Cilatropam - Used to treat depression and panic disorder.

16 Also known as Quetiapine - An anti-psychotic drug used to treat schizophrenia and bi-polar disorder.

17 Also known as Olanzepine - An antipsychotic drug used to treat schizophrenia, bi-polar disorder and anxiety.

Tony developed relationships with some of the youth workers at the YAC who calmly addressed situations, lessening the frequency and severity of his outbursts. Tony listened to and respected an Elder who spent time with residents at the YAC.

Because the YAC had only been intended as a short-term placement, Tony was moved to a group home. Within three weeks, Tony had to be moved again after he threatened a staff member.

A kinship home[18] was found for Tony on his First Nation. The placement ended after a week, when Tony assaulted one of the parents and then wrapped an extension cord around his neck. He said that nobody loved him and that it would be easier for everyone if he were dead.

Tony was moved to a residential facility outside of Alberta ("The Centre")[19] that specialized in treating children with mental health and trauma issues. It had on-site therapists, a specialized school program and access to a psychiatrist. Tony stayed there for almost two years.

Tony from 12 to 13 Years Old

In his initial months at The Centre, Tony's angry outbursts occurred up to twice a day. While Tony's behaviours were usually directed at others, once he threatened suicide and put a belt around his neck. Tony often told staff that he did not recall what happened during these episodes and he was apologetic afterwards. He said that he was worried about his family and where he would live.

For several months after he moved to The Centre, Tony phoned the YAC and connected with staff members whom he missed. This lessened as he formed relationships with some of the male workers at The Centre.

Tony's mischievous smile and joking personality gradually emerged. He found great enjoyment in crafts, camping and, most of all, sports. Tony's teacher discovered that when she tailored the curriculum to Tony's individual needs, he did very well.

Through sports, Tony demonstrated his highly competitive spirit and potential to be a leader. His peers elected him as the student representative, a role he took very seriously. Tony proudly wore a suit to student council meetings and visits with his caseworker.

18 Relatives or community members who are approved by Child Intervention Services to provide care for a child.

19 For the purposes of this report, this placement will be referred to as "The Centre".

After being at The Centre for about a year, the frequency of his outbursts lessened to approximately once a month. He transitioned to a community school and his teachers noted that his behaviour was exemplary. Tony worked hard in class[20] and spent his spare time playing sports. He sought help from staff when he needed to calm himself. His psychiatrist decreased his medications (Risperidone,[21] Cilatropan and Topiramate).

Rachel and Roger visited Tony at The Centre and Tony visited them on the First Nation. The long-term plan was for Tony to live with Roger because Rachel could not care for him. But, as Tony approached the end of his second year at The Centre, Roger became very ill. An alternate permanency plan needed to be established and a new caseworker[22] was assigned.

It was determined that it would be best for Tony to be closer to his home community so he could have more contact with his family. A group home was located closer to his First Nation and he was moved there. Within two weeks, he damaged property, left without permission and threatened staff. Tony was told that he would have to be moved if there were any further incidents. Subsequently, another incident resulted in Tony being charged with assault and mischief.

Within two months, Tony returned to The Centre. Staff members felt that he came back a different person, even though he had been gone only a short time.

Tony at 14 Years Old

Upon his return to The Centre, Tony was hesitant to resume sports and other activities in which he had previously participated. He told youth workers that they were "trying to take the Indian" out of him. There were no on-site resources to connect Tony to the traditional teachings of his First Nation. His opportunities to meet with Elders or participate in traditional activities were infrequent.

Tony showed interest in the gangs that were in his home community, which resulted in home visits being suspended. His family was encouraged to visit him at The Centre.

Approximately three months after his return to The Centre, Tony was found in his room with a plastic bag tied tightly around his head. He was upset about the limited contact with his family. Staff members determined that Tony was at moderate risk for suicide and monitored him closely.

Tony returned to the community school where he had experienced success the previous year. This time, he skipped classes and threatened peers. After two months, Tony returned to the on-site school at The Centre.

20 Tony was at a Grade 6 level academically and was enrolled in a Grade 8 modified program.

21 An antipsychotic drug used to treat schizophrenia and bi-polar disorder.

22 His caseworker of two years had assumed a new role as an assessor.

Roger was diagnosed with a terminal illness, which was extremely upsetting for Tony, and he started running away.

About four months later, a new caseworker was assigned and Tony was told that he would move to a group home in Alberta where he would be closer to his family and gradually gain skills to live on his own. His mother was not in a position to care for him.

Tony's psychiatrist continued to prescribe Citalopram, Risperidone and Topiramate. Concerta was also prescribed to treat symptoms of Attention Deficit Hyperactivity Disorder.

Tony at 15 Years Old

A week after his fifteenth birthday, Tony assaulted a staff member while on an outing. Police arrested Tony and he was held in custody overnight. Because of the severity of the incident and the impact it had on the other residents, Tony could not remain at The Centre.

He was moved to a group home for Aboriginal youth located near his home community. The group home had an Aboriginal Resource Worker who developed a rapport with Tony. Staff at the group home became concerned when Tony told them that he could see spirits. A therapist met with him to address this, but she was unaware of his mental health history.

Tony and his caseworker made a round trip to attend court outside of Alberta. Tony returned to the group home very early the next morning. When he was awakened a few hours later to attend school, he became very upset and agitated, damaging property and threatening staff. Police responded and Tony had to be moved again. Tony was placed in a kinship home on his First Nation for six weeks. It is unclear what took place during this placement.

Tony was then moved to a group home located on a First Nation somewhat distant from his home community. Over the three months that he was there, Tony was helpful, outgoing and showed his sense of humour. He was protective of younger residents and assumed a leadership role among the other youth. Tony occupied himself writing rap music and drawing. An Elder led healing circles with group home residents. Tony looked forward to building his own drum. He had no incidents of physical aggression or threatening behaviour.

Tony attended the local First Nation school and went to a boxing club. He had regular appointments with a psychologist and continued to take his medications.[23] His caseworker visited with him twice. He seemed happy, saying he liked the staff and was willing to stay at the group home.

23 There was no record to specify what prescriptions he was on. Two months prior, when his medications were reviewed, he was prescribed Topiramate, Risperidone, Citalopram, Trazadone and Ritalin which was replacing Concerta to treat symptoms of ADHD.

His caseworker arranged for a home visit. Tony was eager to see Roger who was in the hospital and very ill. After the visit, group home staff observed Tony to be sad and withdrawn.

Tony became romantically involved with a female resident at the group home. Staff tried unsuccessfully to discourage the relationship and as it progressed, Tony struggled with feelings of jealousy and rejection.

Tony's Last Days

Following an argument with his girlfriend, Tony was seen leaving the group home with a shoelace. Shortly afterward, two residents found him hanging in a nearby playground. Tony was airlifted to hospital where he passed away two days later.

During his last days, Tony was surrounded by his family, an Elder, DFNA staff and other community members.

After Tony's Death

The Office of the Chief Medical Examiner (OCME) determined Tony's cause of death was asphyxia by hanging; the manner of death was suicide.

After Tony passed away, group home staff found Tony's writings, which indicated that he had been having thoughts of anger and suicide.

Tony's death had a profound impact on his family. They had a difficult time understanding why this would happen to a boy who was eager to play sports, who had a wonderful sense of humour and who was very likeable. His family received support from the community and the DFNA. Tony's mother continues to struggle with his death.

Tony's caseworkers, who are either part of the First Nation or have a commitment to the community, also continue to wrestle with Tony's death. They expressed frustration and questioned whether the outcome might have been different if there were more preventative services and placement resources within Tony's First Nation. They wondered if Tony truly felt a connection to his family and community when he was placed outside of his community. Caseworkers find support from each other and their cultural beliefs.

Tony painted a mural at The Centre, which has been preserved in his memory.

DISCUSSION AND RECOMMENDATIONS

The investigative review identified the following systemic issues in the child intervention system:

- **Ensuring Relationships for Aboriginal Children**
- **Assessing Risk of Suicide**
- **Sharing Information Between Caregivers**

Each issue is discussed, along with recommendations designed to address these issues. The goal is to learn from these to prevent similar events from occurring elsewhere in the systems that serve our vulnerable children.

Ensuring Relationships for Aboriginal Children

Early in his life, Tony's exposure to domestic violence, substance abuse and many moves likely caused feelings of anxiety, uncertainty and mistrust. Most of Tony's siblings grew up in the care of parents or extended family. Tony might have wondered why he came into government care and not his siblings. His connections to his family and community were few and fragile. Tony was part of a large family but caseworkers mostly focused their efforts to maintain his relationships with his mother and grandfather. Because of Rachel's own struggles and Roger's poor health, neither could provide care for Tony and he came into care.

While in care, multiple placement moves weakened the relationships and connections he made. Tony had eight caseworkers[24] and he was moved even when he worked hard to control his behaviours and had done well in a placement. Between the ages of 10 and 15, Tony moved 13 times. Tony did better in placements that connected him to his culture and shared traditional teachings with him. Tony also did well at The Centre, but it was too far away from his family, community and culture. While there, he lacked consistent connections with Elders and traditional teachings to remind him of where he came from.

In previous Investigative Reviews, the Advocate identified the need for children to have strong connections with their community, family and others who are important to them. Healthy, meaningful relationships nurture a sense of belonging, identity and hope for the future. When young people know where they come from and who they are, they are stronger and more resilient. The importance of ensuring relationships is critical for Aboriginal children in care due to their unique history. Caseworkers must be aware of the present and historical societal impacts on the family and community and consider these when case planning with Aboriginal children, youth and families.

Ensuring relationships for a young person in care can be challenging. Local and community resources need to be engaged to reinforce the connections that the child and family have. Geographic distance between a child's placement and their home community can also be a barrier to maintaining important relationships. When there is no option but to place a young person far away from their home, additional resources need to be in place to help maintain relationships with the child's family, community and way of life.[25] Restoring relationships for Aboriginal children in care can profoundly strengthen them, their families and their communities.

Caseworkers may be unaware of extended family members who might be available to be involved in a child's life. Tony received services from the DFNA affiliated with his mother's First Nation. Tony's father, Gabe, and Gabe's extended family were from a different First Nation, outside of the caseworker's DFNA. Caseworkers did not approach

24 Tony changed caseworkers five times between the ages of 10 and 11 years.

25 Fraser, S.L., Vachon, M., Arauz, M.J., Rousseau, C., & Kirmayer, L.J. (2012)

Tony's paternal family to see how they could be involved in his life. Other than to notify Gabe of the Application for Permanent Guardianship regarding his son, there was no indication that caseworkers reached out to Tony's paternal family or community. Tony did not have the opportunity to form relationships with – not only his father – but an entire extended family.

Near the end of his life, Tony believed that Roger was dying and he had no other healthy relationships to anchor him. Tony felt alone, with no one to reach out to. Consequently, he identified with gangs[26] that were present in his community and focussed on his relationship with his girlfriend.

Recommendation #1

The Ministry of Human Services, with its service delivery partners, should strengthen processes related to:

- The search for meaningful relationships in an Aboriginal child's life and ensure that the extended family of both parents is explored.
- The ability of placement facilities to provide Aboriginal children in care continuous and ongoing access to traditional knowledge and activities.

These processes should be documented and audited for compliance to ensure that Aboriginal children remain connected to their family, community and culture.

26 Tony was never part of a gang but would often present himself as a gang member.

Assessing Risk of Suicide

Tony's suicide was not an isolated, impulsive event. During his last four years, he attempted suicide at least four times. Tony's caregivers informed caseworkers of his suicide attempts. Looking at these incidents together reveals a pattern of attempts following periods of stress and uncertainty.

An assessment of suicide risk must not be limited to times when young people are engaged in suicidal activities or dialogues. Child Intervention Policy Section 7.2.3, "Suicidal Child"[27] informs casework response to suicidal actions or statements by young people. The policy does not guide casework proactively, when a person is not outwardly suicidal. The periods between Tony's suicide attempts were opportunities to examine what was happening in his life and develop a longer-term plan to reduce his risk. Tony was happy with his situation at his group home, but a series of stressful events (i.e., Roger's illness; issues with his girlfriend) along with ongoing stressors (i.e., lack of stable relationships or ability to see the future) increased his risk. In the long term, Tony had no sense of where he would live and with whom.

Dr. Klonsky, an expert in the area of suicide, concluded that suicidal ideation arises from three factors being present in a person's life:

- A person comes to the resolve that ending their life is a solution when their daily life is characterized by psychological pain;
- They have no hope that their life will improve in the future and their suffering will end; and,
- They have no personal, cultural or spiritual connections in the world around them to help counteract the pain they experience.[28]

Caseworkers need support to reflect on the individual circumstances of the children they work with. There is ample research to help caseworkers assess if a child is predisposed to suicide and to develop a plan to reduce the risk. The assessment should be holistic, looking beyond suicidal behaviours and statements to consider disruptions in a young person's key relationships or recent losses. It is important that such an analysis occur on a regular basis, not just when the young person expresses suicidal ideation or self-harming behaviour. Caseworkers need the opportunity to review, reflect and consult with others when they are evaluating if a young person on their caseload is suicidal.

27 Alberta Human Services, 2011

28 Klonsky, D. E. (personal communication, June 8, 2014) Written letter to the Office of the Child and Youth Advocate following participation in the Investigative Review Committee.

Recommendation #2

The Ministry of Human Services, with its service delivery partners, should require a suicide risk inventory be completed for all young people, who have been identified as at risk of suicide, on a regular and ongoing basis – not just at the time of crisis.

Sharing Information Between Caregivers

Tony moved many times. He was often moved because caregivers were overwhelmed with his behaviours. Other times, Tony changed placements to be closer to his family and community. There was a lack of planned, purposeful moves for Tony and most placements were not prepared to care for him because they did not know him or how best to care for him.

When Tony was 11 years old, he was diagnosed with Alcohol Related Neurodevelopmental Disorder (ARND).[29] A common feature of ARND is the inability to link a consequence with an event or action.[30] Group home environments, which used a behaviour-modification approach, were challenged with Tony's behaviours. These environments used rewards and consequences to decrease problematic behaviours, assuming that Tony could learn from the consequences of his actions. A behaviour modification approach was not effective with Tony. In fact, it may have overwhelmed and agitated him further.

The Centre used a restorative, relationship-based model of care and Tony responded to it very well. There was a high tolerance for his behaviours and his treatment program was customized to his individual needs. Staff members connected and formed relationships with Tony, modelling better ways for him to behave.

The gains Tony made at The Centre could have continued if information was shared between care providers about what worked best for him. Information sharing should include historical information, completed assessments, mental health diagnoses, medical information, information regarding significant relationships, risk factors, strengths and the permanency plan. A direct dialogue between a child's previous and future caregivers would enable those who are going to care for a child to benefit from the insights and experiences of those familiar with the child.

Trauma-informed practice, which is based on establishing relationships, results in fewer placement changes and more stability.[31] In their research on Trauma Systems Therapy (TST), Brown et al. suggest caregivers should view 'bad' or 'problem' behaviours as responses that a youth has learned from distressing events in their past. The behaviours arising from a young person's distress are tolerated within the limits of what can present a danger to themselves or others. This approach requires a high level of interaction and supervision between a child and their caregivers. It also requires a high level of skill and training so that the caregiver can look beyond a child's behaviours and understand what is causing them.

29 Alcohol Related Neurodevelopmental Disorder (ARND) is brain damage caused by prenatal exposure to alcohol that results in behavioural and learning problems.

30 Provincial Outreach Program for Fetal Alcohol Spectrum Disorder, 2006

31 Brown, A.D., McCauley, K., Navalta, C.P., & Saxe, G.N. (2013)

Information sharing between placements would have assisted new caregivers to continue successful treatment approaches for Tony. The continuation of a trauma-informed model based on relationships might have resulted in a more positive outcome.

Recommendation #3

The Ministry of Human Services, with its service delivery partners, should review policy and practice in information sharing when a child transitions to a new placement. Emphasis must be placed on direct communication between day-to-day caregivers to support the continuity of successful treatment approaches. This means those caregivers who work directly with young people in their placements.

CLOSING REMARKS FROM THE ADVOCATE

A First Nations young person, whom we are calling Tony, died by suicide. He had a real name, a family, a community, and a First Nation who grieve his loss, some who will never fully recover from the tragedy of losing a loved one so young.

Tony cared deeply about his family and others in his life. People who knew him described him as a cute kid who was always smiling and joking with those around him. He was also a young person who carried a heavy burden of separation from those whom he felt closest to. His sense of belonging, relationships and his identity were affected by his experiences with the child intervention system.

Sadly, Tony's experience is far too often the situation for young people involved with the child intervention system. Although, the outcomes are different for many young people, the experience of displacement, of frequent moves, of losing relational connections to those most important, is the reality for many young people in the system. This is especially true for First Nations youth.

It is not surprising that First Nations children and youth are significantly over-represented in the child intervention system of today. The history of colonization, of residential schools, of the "60's scoop", and child welfare systems have had devastating impacts for First Nations people in Canada.

It is often the case where the complexity of these issues can overwhelm us. We can lose sight of what young people identify as most important to them. To know that they are loved by the people important to them, to know and understand who they are and where they come from, and to know where they belong are central needs for all young people. As a First Nations young person, Tony struggled with these areas of his life.

Throughout this review, it was very clear that this young man's family loved him dearly. I want to convey our sincere condolences to his family and let them know we are deeply saddened by the loss of their loved one. I also want to thank them for their participation and contribution to this report. As well, I would like to convey my appreciation to all of the others who knew this young man and contributed to this report.

My hope is that the Ministry of Human Services will take swift, decisive and meaningful action on the recommendations made in this report. It is the only way that change will happen.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

APPENDIX 1: TERMS OF REFERENCE

Incident

In 2012, 15-year-old Tony was found unresponsive in a playground beside his group home. He was transported to hospital where he passed away two days later. The Office of the Medical Examiner (OCME) found the cause of death to be Asphyxia by Hanging; the manner of death was suicide.

At the time of his death, Tony was the subject of a Permanent Guardianship Order.[32]

Authority

Alberta's Office of the Child and Youth Advocate is an independent office reporting directly to the Legislature of Alberta. The Child and Youth Advocate derives his authority from the *Child and Youth Advocate Act*. The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act*, the *Protection of Sexually Exploited Children Act* or from the Youth Justice System.

Section 9(2)(d) of the *Child and Youth Advocate Act* provides the Advocate with the authority to investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

The Child and Youth Advocate received a report of death regarding Tony. The decision to conduct an investigation was made by Del Graff, Child and Youth Advocate.

Objectives of the Investigative Review

1. To review and examine the supports and services provided to Tony specifically related to:
   - *Mental health needs.*
   - *Placements and relationships.*
   - *Permanency and transition planning.*
2. To comment upon relevant protocols, policies and procedures, standards and legislation.
3. To prepare and submit a report which includes findings and recommendations arising from the investigative review.

32 Under a Permanent Guardianship Order, the court awards guardianship of the child to the Director on a permanent basis. The child is in the care of the Director and remains in an approved placement. The guardianship of any former guardian is terminated and the Director is the sole legal guardian of the child.

Scope/Limitations

An Investigative Review does not assign legal responsibilities, nor does it supplant or abrogate other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an Investigative Review is not to find fault with specific individuals, but to identify and advocate for system improvements that will enhance the overall safety and well-being of children who are receiving designated services.

Methodology

The investigative process will include:

- Examination of critical issues;
- Review of documentation and reports;
- Review of Enhancement Act Policy and casework practice;
- Review of case history;
- Personal Interviews;
- Consultation with experts as required; and,
- Other factors that may arise for consideration during the investigation process.

Investigative Team

Lead investigator: Office of the Child and Youth Advocate

Secondary investigator: To be determined

Investigative Review Committee

The membership of the committee will be determined by the Advocate and the OCYA Director of Investigations. The purpose of convening this committee is to review the preliminary investigative review report and to provide advice regarding findings and recommendations.

Chair: Del Graff, Child and Youth Advocate

Members: To be determined but may include:

- An Aboriginal Elder;
- An expert in the area of adolescent mental health; and,
- A specialist in the area of child welfare best practices.

Reporting Requirement

The Child and Youth Advocate will release a report when the Investigative Review has been completed.

APPENDIX 2: COMMITTEE MEMBERSHIP

Del Graff, MSW, RSW (Committee Chair)

Del is the Child and Youth Advocate for the Province of Alberta. He has worked in a variety of social work, supervisory and management capacities in communities in B.C. and Alberta. He brings experience in residential care, family support, child welfare, youth and family services, community development, addictions treatment and prevention services. He has demonstrated leadership in moving forward organizational development initiatives to improve service results for children, youth and families.

Gilman Cardinal, Elder

Elder Gilman Cardinal was raised in the community of Calling Lake north of Edmonton. He came from a family that practiced a traditional way of life, relying on the land and one another for sustenance and healing. In his adult life, Gilman worked extensively with the development of social and employment programs in northern communities. Through this work he has received the Premier's Award of Excellence in 1998 and was presented with the honourary key to the Town of Slave Lake. He became a husband, father and grandfather to seven grandchildren. For the last several years, Gilman has dedicated his time to volunteering and giving back to the community. Through the teachings and healing he received from Elders, he began his own journey of eldership. Gilman is a source of traditional knowledge and spiritual guidance for many in his ever-growing community.

Betty Bastien, PhD, RSW

A member of Piikani First Nation, Dr. Betty Bastien has dedicated her life to Indigenous studies and social work. After teaching at the University of Lethbridge, Mount Royal College and Red Crow Community College, she became a member of the University of Calgary's Faculty of Social Work in 1999. Her traditional knowledge is located in the Brave Dog Society and Thunder Pipe Bundle. Publications and research include indigenous ways of knowing, intergenerational trauma and indigenous child welfare. Betty is a resource to First Nation and rural communities who want to support their own members to become helping professionals for their people. Internationally, she is sought after to present her knowledge at conferences. Dr. Bastien received the Women of Distinction award in 2004 from the YWCA Lethbridge and District. In 2007 she received an Esquao award from the Edmonton Institute for the Advancement of Aboriginal Women. She was chosen by the Alberta College of Social Workers to receive the John Hutton Memorial Award in 2013.

Ralph Bodor, PhD, RSW

Ralph Bodor is an Associate Professor with the Faculty of Social Work at the University of Calgary. He is devoted to social work education, research and delivery with rural, remote and First Nation communities. For the past 16 years, Ralph participated in the creation and ongoing development of a culturally relevant social work program at Blue Quills First Nations College. Ralph has subsequently helped to research and develop similar programs elsewhere in Alberta. His published work has included the long-term impact of residential schools, the reunification of children in care with their First Nation communities, and best practices for indigenous children in care. Ralph has dedicated himself to learning the Cree language, ceremonies and cultural protocols. His contributions have led to him being honoured with a Cree name. He also received the Killam Award for Innovative Teaching from the University of Calgary in 2010.

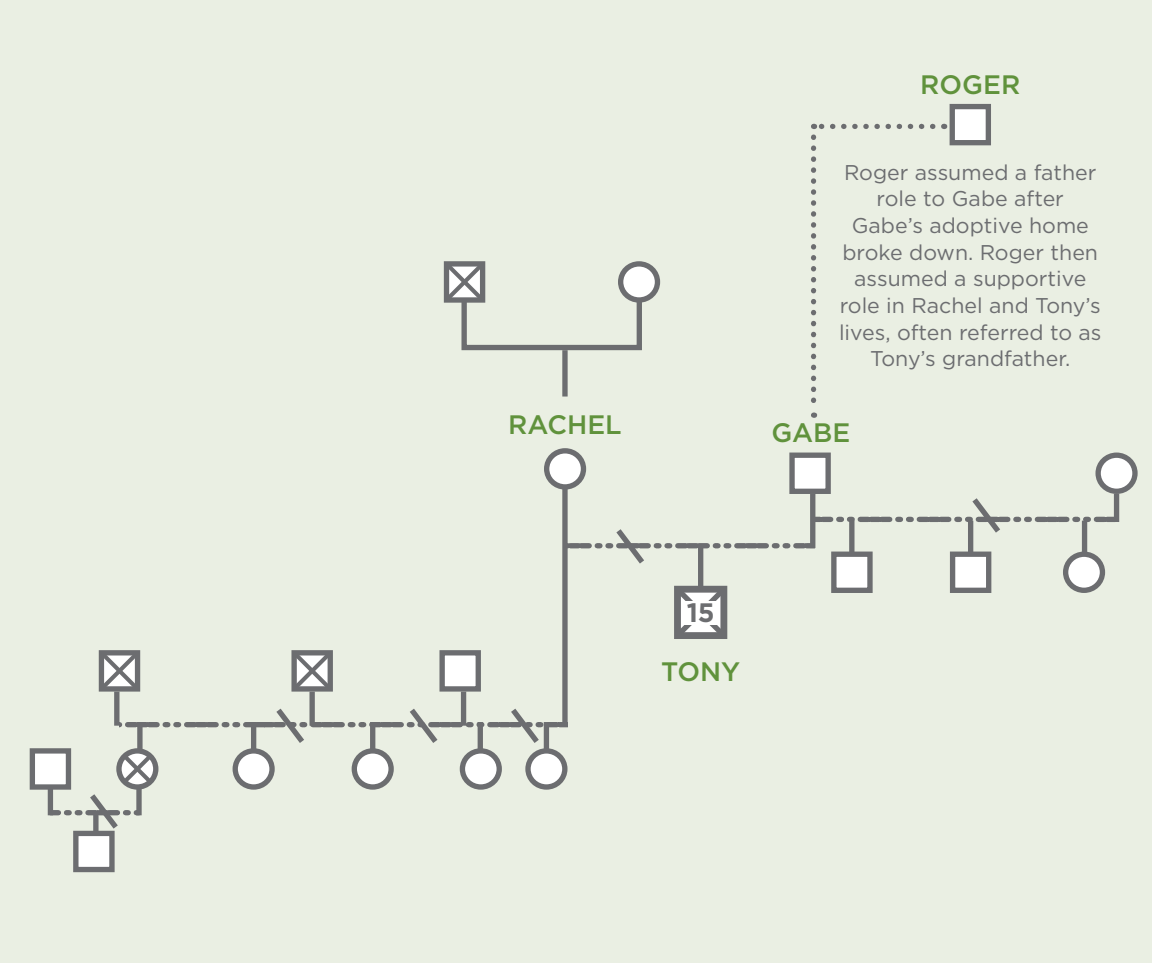
Jack Phelan, Bachelor of Child and Youth Care MS (Long Island University), CCYC

Jack started his career in Child and Youth Care in New York City in the late 1960's. He obtained his Masters degree and contributed to the creation of a professional association for Child and Youth Care workers on a local and national level in the United States. About 30 years ago, Jack met his wife which brought him to Edmonton. He has been teaching at Grant MacEwan College for more than 25 years. Jack strives to promote change that will support consistent, quality service in the complex field of Child and Youth Care. He has shared his knowledge with educational institutes nationally and internationally. Jack is very active as a presenter at countless conferences and workshops. The Child and Youth Care Association of Alberta honoured Jack with their Visionary of the Year award in 2013.

E. David Klonsky, PhD

Dr. Klonsky is an Associate Professor in the Department of Psychology at the University of British Columbia. His research interests include suicide, non-suicidal self-injury, emotion dysregulation, and personality disorder. Klonsky is Associate Editor of the Journal of Suicide and Life-Threatening Behaviour, author of the book *Non-Suicidal Self-Injury* (along with Drs. J. Muehlenkamp, S. Lewis and B. Walsh). His research has been recognized by several organizations including the Society of Clinical Psychology, American Psychological Foundation, and the Association for Psychological Science. Dr. Klonsky is the President of the International Society for the Study of Self-Injury.

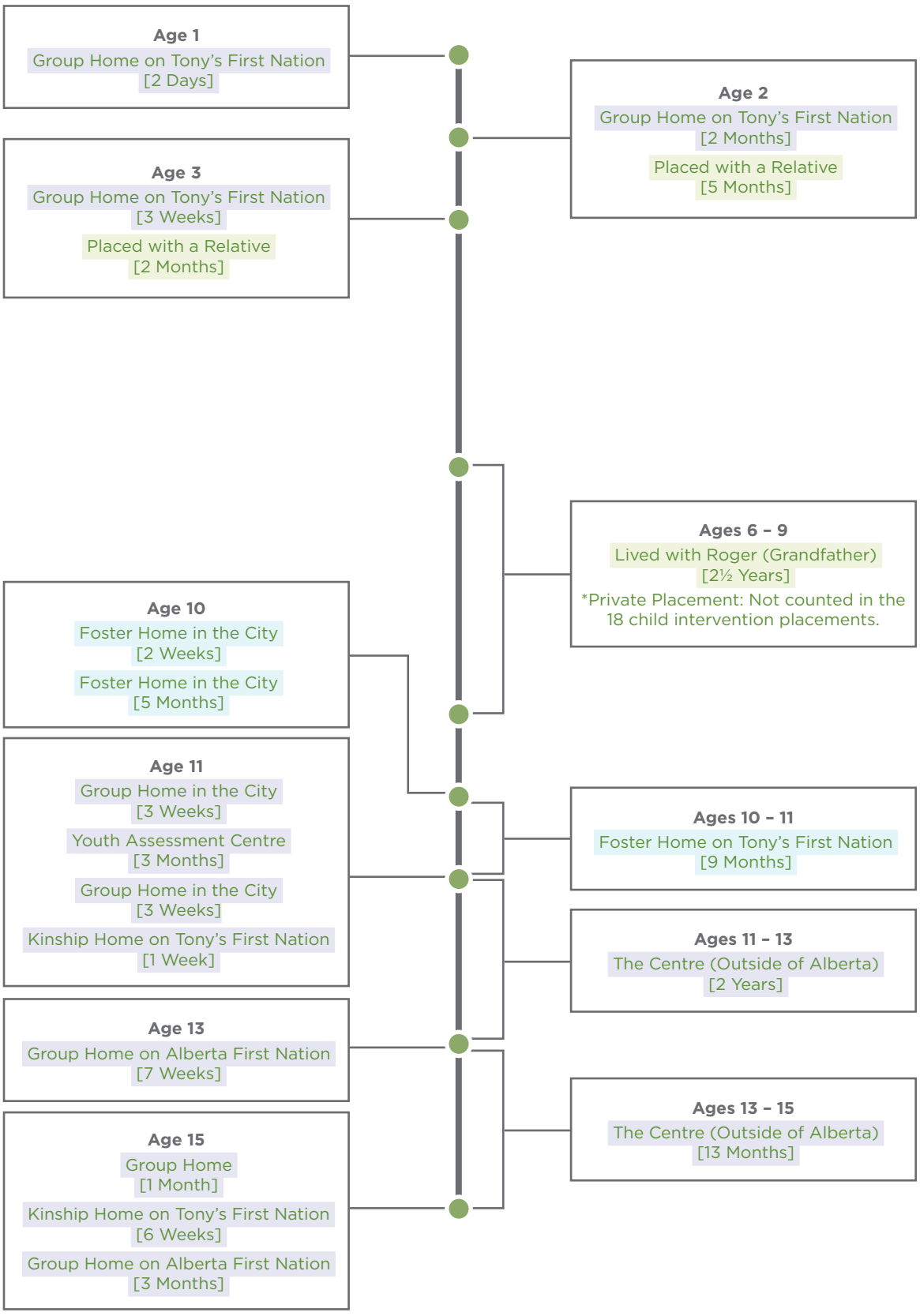
APPENDIX 3: GENOGRAM



Legend

Male Female Death Cohabitation & separation

APPENDIX 4: TIMELINE



APPENDIX 5: BIBLIOGRAPHY

Alberta Human Services (2011). *Enhancement Policy Manual*, Intervention Section, Chapter 7: Responsibilities, 7.2.3 Suicidal Child Safety, pg. 403-404.

Brown, A.D., McCauley, K., Navalta, C.P. & Saxe, G.N. (2013). Trauma systems therapy in residential settings: Improving emotional regulation and the social environment of traumatized children and youth in congregate care. *Journal of Family Violence*, 28: 693-703. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3782637/

Fraser, S.L., Vachon, M., Arauz, M.J., Rousseau, C. & Kirmayer, L.J. (2012). Inuit youth transitioning out of residential care: Obstacles to re-integration and challenges to wellness. *First Peoples Child and Family Review*, 7(1), 52-75. Retrieved from http://journals.sfu.ca/fpcfr/index.php/FPCFR/article/view/118/183

Provincial Outreach Program for Fetal Alcohol Spectrum Disorder (2006, November 30). Cause and Effect/Impulsivity - eLearning video. Prince George, BC: POPFASD. Retrieved from http://www.fasdoutreach.ca/elearning/teaching-strengths-and-needs/cause-and-effect-impulsivity

15-YEAR-OLD TONY

AN INVESTIGATIVE REVIEW

NORTH OFFICE

#600, 9925 109 Street NW
Edmonton AB T5K 2J8

SOUTH OFFICE

#406, 301 14 Street NW
Calgary AB T2N 2A1

www.ocya.alberta.ca
1 800 661 3446