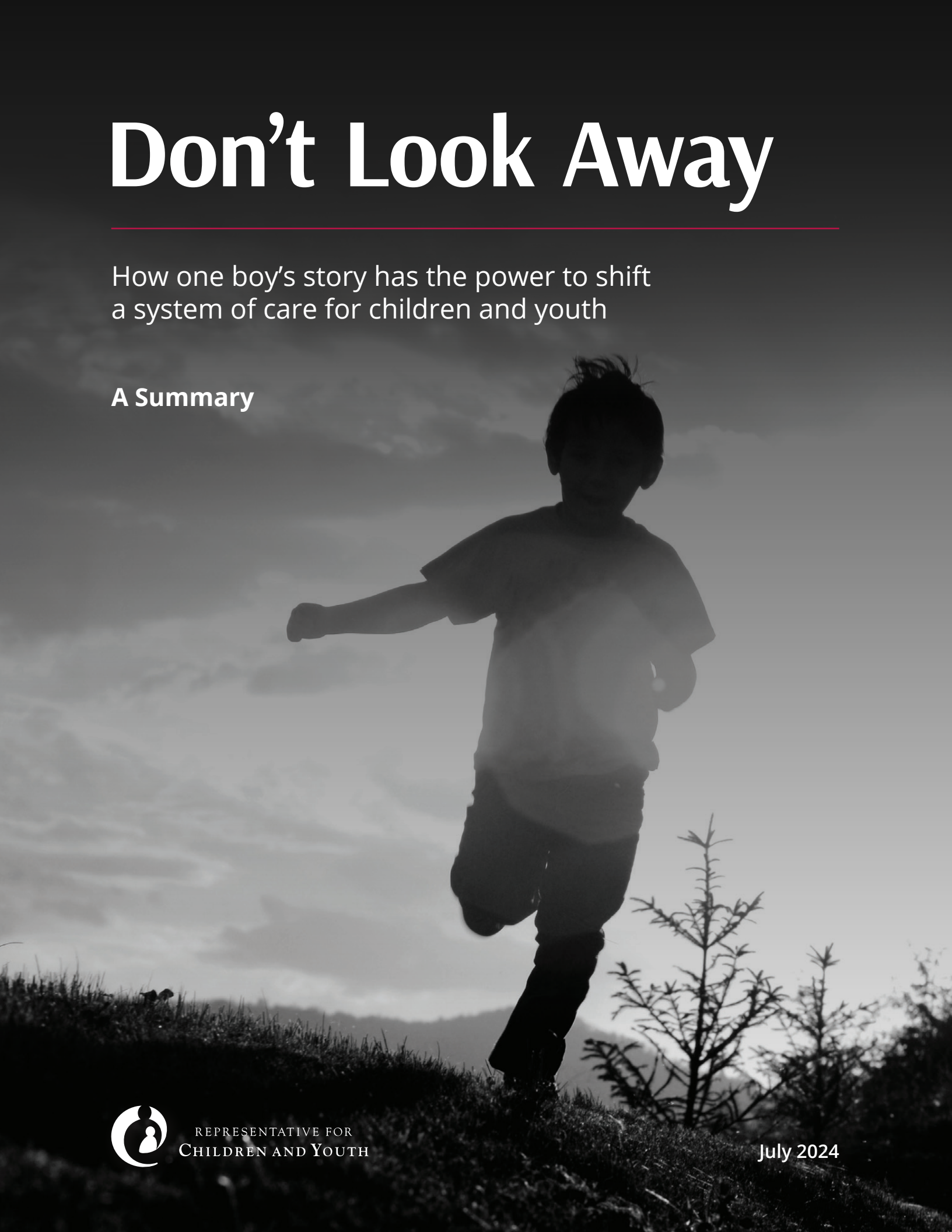
Don’t Look Away

How one boy’s story has the power to shift a system of care for children and youth

A Summary



REPRESENTATIVE FOR
CHILDREN AND YOUTH

July 2024

The Representative and staff, working throughout the province, would like to acknowledge that we are living and working with gratitude and respect on the traditional territories of the First Nations peoples of British Columbia.

We specifically acknowledge and express our gratitude to the keepers of the lands on the traditional territories of the Lheidli T'enneh peoples (Prince George) and the Lekwungen (place to smoke herring) people of the Songhees and Esquimalt Nations (Victoria) where our offices are located. We also acknowledge our Métis and Inuit partners and friends living in these beautiful territories.

Starting in a good way – The Spirit of Colby's Family

The Sacred Teachings from our Cultural Advisors have been our guides throughout this sacred story investigation, systemic review and engagement. 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. We honour the relationships they tried so hard to sustain, and highlight the ways this family was bound together by love, laughter and hope.

One of the threads that ran through this story – and the stories of most children and families involved in the systems 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.

These themes are true for Colby and his family. Their sacred story reveals much shadow and darkness. But it is critical that we enter into this story with dignity for the family by remembering that they also have light and goodness.

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

Colby was loved by his parents. He 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 – be it 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 middle 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 shows the children with matching shirts and braided hair, squeezed together on a picnic blanket at the park, holding one another. Their five smiles are reflections of their parents' smiles. The sparkle in their eyes reminds us of their spirit, promise, connection and belonging.

We have been here before

Over more than three decades, dozens of reports about child and family services in British Columbia have been written and released by various organizations, including by this Office. Hundreds of recommendations have been made and millions of dollars have been invested by the government in an attempt to address those recommendations.

And yet here we are again – reviewing the death of an innocent young child and asking the same questions that have been asked for years: How did the systems that are intended to help children and families in this province let this boy and his family down so badly? What will it take for us not to return to this very place in another few years? And we are not shying away from asking ourselves the tough questions: How effective are we really in bringing about change? What are we missing and how could we better inform, influence and advocate for the deeper transformation that is so clearly needed now?

The Representative for Children and Youth's (RCY) report *Don't Look Away – How one boy's story has the power to shift a system of care for children and youth* addresses these questions and calls us all into action.

We begin by telling the heart-wrenching story of what happened to Colby,[1] an 11-year-old boy who was killed after enduring months of torture and abuse at the hands of extended family caregivers who were recommended and approved by the Nation's child and family service department (the Department) and the Ministry of Children and Family Development (MCFD). It shows how different pieces of the child- and family-serving systems in B.C. failed him and his family. It shows how a young family living in deep poverty and caring for a child with complex health needs was not supported from the very start; how this family's struggles with intergenerational trauma and the resultant violence and substance use were not well considered or addressed. And it shows how basic policy and practice were not adhered to due, at least in part, to a beleaguered workforce at MCFD that has long struggled to meet its mandate.

When RCY first learned details about the horrific abuse suffered by Colby and his middle sister, it struck us to our core. Details of the violence that these children endured were excruciating to hear. The story demanded an urgent effort from our Office to learn more about how and why Colby's life was taken from his family, the many people who cared about him and his community.

There was outrage and despair and many needed to understand how the abuse had gone undetected for so long. This is understandable and it is our hope that we have brought forward information in this report that will both honour Colby's beautiful spirit and provide some answers.

But Colby's true legacy is a much larger call to action. His story – and that of his family – teaches all of us about how our current systems work, where they are strong, but also where they are weak. The themes of Colby's story help uncover what could be done in the future to prevent such tragedies, and how we might collectively ensure that children throughout B.C., in all types of communities and families, are cared for, safe, connected and thriving. This is not just a call to action for MCFD and other ministries and health authorities, but also for Indigenous

[1] "Colby" is a pseudonym. RCY is not identifying the child or his family by name, nor the community they are from.

governments, leaders and service providers. It is a calling in to all of us to care about what is happening for children. We must, collectively, expect better and do better for all children in our province.

Although Colby came to widespread public attention following the sentencing of the caregivers who killed him, his story is, unfortunately, not an outlier. In fact, the ways in which the systems of care let his family down have been experienced by many other children and families in B.C. and across Canada. RCY sees such stories every day in its work as direct advocates for children, youth and young adults involved with these systems as well as in its role reviewing and analyzing hundreds of injuries and deaths of children in B.C. every month.

The fact that Colby's story is not an outlier was a major reason RCY chose to investigate what happened to him. Rather than a standard investigation, RCY decided to tell Colby's story as part of a much larger initiative – one unlike any this Office has produced since its inception in 2006.

In 2023/24, RCY staff received **6,437** reports of injuries and deaths of children in government care or receiving reviewable services, of which 2,908 were determined to be in RCY's mandate for further review as a *critical* injury or death.

In addition to the full investigation of his story, we have conducted a Systemic Review of many areas in the child- and family-serving systems that factored in Colby's story and in hundreds of other children's stories. The stories of 14 other children in eight families have been selected for inclusion in this project because they too shed light on how the systems work – and how they don't – and what we can all do differently.

> "I was a child in *care* in the child *protection* system; I didn't get either care or protection."
>
> – Member of the Circle of Advisors

RCY's Systemic Review examines in detail the areas of: family and intimate partner violence; family supports, early years and early help; kinship care; inter-agency communication and coordination; accountability and quality improvement; workforce capacity in MCFD; and child welfare reform, including the in-process resumption of jurisdiction by B.C. Nations over their own children's well-being. In addition to learning through the stories of children and families, RCY commissioned 13 research papers that examined the current state in B.C. in each of these areas and how other jurisdictions have experienced and tackled similar issues, as well as promising practices and approaches that could work in B.C.

It was very important to RCY to gather input from those experiencing the child- and family-serving systems in B.C. as well as those working in them. Through working sessions, webinars, focus groups, interviews and online surveys, RCY engaged with close to 2,000 people who care about children and their well-being. This included Indigenous leadership, government and health authority leadership and direct service staff, community sector agencies and workers, as well as family and kinship carers, many of whom have received services and supports from the child- and family-serving systems. Their feedback ensured that we had both a strong sense of the current state of child and family systems as well as new ideas for how to improve care and support for children and their families.

Who is this for?

This is not an Indigenous-specific report. The lessons we have learned apply generally to all children and families who find themselves involved with B.C.'s child- and family-serving systems. The lessons apply to children and families whether they are requiring supportive services from MCFD, an Indigenous Child and Family Service Agency, the health care system, social assistance, or their public school, or facing the removal of their child(ren) due to a child protection concern.

However, Colby was an Indigenous child. And the fact remains that MCFD is disproportionately over-involved in the lives of Indigenous children and families, especially when it comes to child protection. An Indigenous child is 18 times more likely to come into government care in B.C. than a non-Indigenous child. Indigenous children comprise more than 67 per cent of the children in care in this province, despite representing less than 10 per cent of B.C.'s total child population. Through this project, the RCY set out to consider the reasons *why* these disproportionate and troubling numbers have persisted over the years.

Therefore, RCY approached this work with an Indigenous lens. Our over-arching intent was to do no further harm to Colby's family and community. Rather, our intent was to challenge the implicit colonial and racist mindsets that underpin current systems and that influenced the way he and his family were treated by the systems of care.

To do that, we worked with the close guidance of three Indigenous Cultural Advisors who are respected Matriarchs and a Hereditary Chief. They are all cultural knowledge holders who have extensive experience provincially and nationally regarding child welfare issues.

> "The work that we're doing is sacred. And it's not just us here.... One of the first things we learn in our long house is the fire represents truth. And if you're going to be in the long house or speak, that you speak the truth. We cannot change what we don't acknowledge. And I know that some have said it brings harm to have to hear this over and over again. Oh, we need to hear this over and over and over again until change is achieved."
>
> – Member of the Circle of Advisors

The Cultural Advisors wove their knowledge together to present RCY with Sacred Teachings that have been applied to our day-to-day work on *Don't Look Away – How one boy's story has the power to shift a system of care for children and youth* and the accompanying engagement processes. These teachings encompassed the values of relationship, respect, relevance, responsibility, reciprocity and repair.[2] All values are grounded in the knowledge that we are stronger when we are paddling *together*, we are more relevant and responsible when we know where we are going, and we are wiser when we follow the Sacred Teachings.

2 Informed in part by Kirkness, Verna J., and Ray Barnhardt. "First Nations and higher education: The four R's—Respect, relevance, reciprocity, responsibility." *Journal of American Indian Education* (1991): 1-15.

RCY then worked to integrate learnings from the three elements of the project together (i.e., sacred story investigation, systemic review and engagement). We sought guidance from a Circle of Advisors (experts in the areas of child well-being including early childhood development, public health, pediatrics, education, child welfare, anti-violence, justice, social psychology, grief and loss and advocacy) who encouraged us to be bold, courageous truth-tellers. The resulting full report is available online at rcybc.ca. We encourage you to read the full report as it provides the depth and context necessary to fully understand what happened to Colby and the lessons that we can learn about the entire child caring and family support system. The report also offers recommendations and observations about how all of us can take this learning and make meaningful change.

The following section of this Summary Report provides an abbreviated version of Colby's Story. A warning to readers, it includes details that may be disturbing to some. If you require supports, please reach out to one of the resources listed at the end of this Summary Report.

A Boy's Sacred Story

It's important to know that Colby grew up in a small community that has, and is still, experiencing deep and lasting harms. The ongoing legacy and trauma of settler colonialism and racism 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 hide them in order to keep them safe and bonded with their families, were told to us as a reminder of where so much of the trauma began.

The community Colby was part of is on a healing journey that is unique to them but, in many ways, similar histories and experiences are also seen in the journeys of other Indigenous communities across Canada. In telling 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. Deeply held cultural values and practices varied between families and sometimes became a source of disconnection and tension between the families in the community. As we continued our work learning about this child's sacred story, we saw the light and shadow not only that this family experienced, but that all families and communities have – the themes of imperfection, unpredictability and struggle are the common ground to us all.

About Colby

Colby was like so many other 11-year-old boys. His tousled dark hair framed his sparkling brown eyes that were always looking for fun. Whether on the soccer field, immersed in Minecraft, reading *Archie* comics, or marvelling in 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. Whenever Colby saw his middle sister in the hallway at school, he would give her a hug. She remembered feeling safe whenever they held hands, lacing their fingers together.

Colby was born with significant health issues which easily could have crushed his spirit. But many people with whom RCY spoke described Colby as someone who approached his challenges with courage and a remarkable, positive spirit.

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 (nine years younger). He also shared his father with three other siblings born to a different mother.

Colby's 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, so that he could 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.

About Colby's mom

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

In her own upbringing, Violet worked hard to be a good older sister. She volunteered with the homeless and stayed connected to her culture. She was smart and graduated from her community's high school. As one community member told RCY, "She showed a great deal of tenderness towards the people

around her – gently braiding the hair of young girls taking part in cultural dances who looked up to her."

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

At 19, she began dating Colton, who was six years older than her. A year later, they had their first child, a daughter. Violet's desire to provide a better life than what she had known herself growing up – both for this child and for those to come – was sadly not to be fulfilled.

Colton and Violet's relationship was marked by poverty, instances of violence by both partners, housing insecurity, and substance use, as well as involvement with both police and the child protection system.

The resilience of a beautiful child

Less than three years after their daughter was born, Violet gave birth to Colby in 2009 by emergency caesarian section at BC Women's Hospital. The surviving sibling of a twin pregnancy, Violet referred to him lovingly as her "miracle baby". Following his birth, Colby was admitted to the neonatal intensive care unit at BC Children's Hospital due to his complex health needs. He required life-saving procedures within four days of his birth and subsequent surgeries and medical interventions for his heart, kidneys and lungs. Both Violet and Colton helped to care for the tiny boy while he grew strong enough for them to take him home.

Colby's various conditions required ongoing medical care from pediatricians, urologists, and cardiologists in addition to careful attention from his parents and caregivers who needed to make sure they were keeping track of the medications and providing the supplies Colby needed. His health needs would have been incredibly challenging for any parent, but a lack of support, poverty, and communication issues would make things even more difficult for Colby's mother, father and other caregivers.

> "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

Struggling to parent in a difficult environment

These parents loved their children deeply. But taking care of Colby's significant health requirements was difficult for a struggling family living in deep poverty and facing the continuing effects of intergenerational trauma without the supports that might have helped them to cope and thrive. RCY's investigation shows that the couple weren't provided early supports to help them deal with the immediate health issues nor were they given enough support to help them consistently accommodate Colby's complex medical needs.

Less than a year after Colby was born, Colton and Violet split up and she met another partner. This new relationship would continue on-and-off for the next seven years and would also be marked by poverty, substance use and violence. One of Violet's relatives recalled that this partner was probably the most prominent father figure for Colby, 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."

In addition to the heavy demands of caring for a child with complex health needs, Violet's mental health challenges intensified as a result of the inconsistent housing, multiple moves, problematic substance use and relationships characterized by violence. These mental health challenges became so severe that, on several occasions over the course of Colby's young life, she would require hospitalization and treatment, including for post-partum depression.

Although Violet had three additional children after Colby, she was never sufficiently supported to be able to create enough stability for Colby and his siblings. As a result, on a number of occasions, family members stepped up to care for one or more of the children either informally or through arrangements with MCFD.

It was during one of those situations – with her mother caring for Violet's three eldest children – that the children were first removed from Violet's care. Following an incident that resulted in both Violet and her mother being unable to care for the children, the children were removed and placed with their great aunt and uncle.

The children thrived when they were living with the great aunt and uncle for nine months. But Violet wanted to care for them again, and the discovery of a very small amount of marijuana in the great aunt's vehicle began a chain of events which eventually led to the children being returned to their mother's care.

Set up to fail

Despite Violet continuing to struggle with substance use and mental health issues, the children were returned to her care. RCY investigators learned that some professionals felt that returning the children to Violet was setting her and the children up to fail, but their concerns were left unaddressed. Although her desire to parent the children was strong, Violet needed extensive wraparound supports, yet little support was provided.

Within a period of only four months, Colby and his three siblings were returned to Violet's care and she gave birth to her fifth child. Violet

went from having no children to look after to caring for five children – including Colby with his complex health needs. All of this was as a single mother with mental health and substance use challenges. Some supports were provided to her by the Department and MCFD, but they weren't enough nor were these supports focused on the actual needs of Violet and her family.

The result was predictable. Reports from community and RCMP to MCFD detailed concerns about the children's well-being with their mother. Just over a year after being returned, the children were taken out of Violet's care again for the final time.

Confusion over roles and responsibilities

Before moving on to examine what happened to Colby and his siblings after they were removed from Violet's care and placed with an extended family member, it is important to provide some additional context.

This placement decision was made against an historic 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. It was a time of transition marked by confusion and a blurring of roles and responsibilities as MCFD and the Nation navigated toward jurisdiction. In interviews with MCFD senior staff who were involved with this transition period, one theme became clear to RCY: Maintaining good relationships with the Nation was imperative to ensuring a smooth handover. While strong relationships, trust, and respect are essential to support the complex higher level jurisdictional planning, negotiations and transitions, RCY learned that there was a lack of clarity about *what* was expected of workers day-to-day and *how* they were to practice during this time of transition. This translated into confusion around decision points and accountability for direct-service MCFD workers. Although the ministry still had legal authority and responsibility, RCY investigators were told by several interviewees that MCFD social workers and team leaders were often instructed to take the Department lead when it came to decision-making as they best knew the children and families in their communities.

The Memorandum of Understanding 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 systemic and structural barriers that impact the well-being of children, families, and the [Nation] community."*

The confusing working environment described above would play a role in the placement decision for Colby. According to records and interviews, when the Department suggested that Violet's cousin Staci and her partner could become caregivers for the children, MCFD agreed despite not having done due diligence as per ministry policy. RCY investigators learned that members of the Department held knowledge about Staci's past abuse of her own child but this may not have been shared during the joint decision-making process for the placement.

The placement decision was also made without consultation with Colby's family, including his mother, the children's fathers and the maternal and paternal grandmothers, some of whom were willing to care for the children. Colby's maternal grandmother told investigators that, while the cousin was technically family, she, Violet and the children didn't know the cousin well.

The fateful placement

Colby and his older sister were moved into the home of Staci, who lived with her partner Graham on a nearby reserve. Within a couple of months, Colby's middle sister was also placed there. Including the couple's own three children, Staci and Graham now suddenly had six children to care for, including a boy with complex medical needs.

As noted earlier, placing the children with their mother's cousin was a joint decision by the Department and MCFD. However, the ministry still had legal responsibility for the children and, despite this, it became clear to RCY investigators that there was neither due diligence nor adherence to policy during the placement.

The ministry did not complete basic checks on this couple, including checking for prior contact with MCFD as well as any past criminal offences. Neither did MCFD conduct a safety visit of the home before the children were moved there. Moreover, none of these steps were completed retroactively once the children were living in the home.

This clear lack of communication, due diligence and process would prove to be a massive error. Staci had prior involvement with the ministry regarding physical abuse of her first child and there were documented concerns about Graham's conduct with children.

Colby and his middle sister would go on to face horrific abuse and torture at the hands of their new caregivers in this home. RCY is not sharing details in this summary, but a description is included in the Office's full report. The Representative notes that the abuse was strikingly similar in nature to the horrors inflicted on many Indigenous children who attended residential schools.

The isolation and killing of Colby

The abuse and torture that Colby and his sister experienced was enabled by the fact that they were essentially isolated. They had little to no contact with anybody outside of the home during the final months of the boy's life. Colby's MCFD social worker didn't see him in-person during the final seven months despite a ministry policy requirement that children in care should be seen every 90 days. There is no record of the Department ever visiting the family or children. Staci also isolated Colby from his health care team, many of whom placed urgent but often unaddressed requests to both MCFD and Staci to see Colby. These requests noted the dire risks to Colby's health and well-being with continued delays to care. After mid-September of 2020, neither child attended much school as Staci kept them home, citing Colby's health and concerns about COVID-19 as the reasons for their absences. After mid-October, the two children didn't attend school at all. Education professionals also raised concerns about the children's well-being.

Meanwhile, the children were also being prevented by Staci from participating in cultural and community activities and from seeing their family. Colby's aunt and two grandmothers each told RCY about trying to arrange visits with the children through contact with the MCFD social worker and, at times, directly with Staci. These visits didn't happen. Colby's father last saw his son in December 2019 and his requests for further visits went unanswered.

This lack of "eyes on" the children enabled the abuse and torture of Colby and his middle sister to continue undetected. It escalated during the final three months of Colby's life when a video camera installed in the couple's duplex caught hundreds of hours of evidence that would lead to the eventual conviction of both Staci and Graham on charges of manslaughter and aggravated assault. Each was sentenced in June 2023 to 10 years for the manslaughter conviction and six years for the aggravated assault conviction, to be served concurrently.

The specific incident believed to have caused Colby's death occurred on Feb. 26, 2021, when he was beaten repeatedly by Staci over a nine-minute period caught on camera. He became unresponsive, and 40 minutes later, Staci finally called 911. Medical personnel and police attended, and 11-year-old Colby was airlifted to BC Children's Hospital. Doctors couldn't save him and he was declared brain dead on Feb. 28. Later he was removed from life support and died.

Aftermath of a tragedy

Colby's mom was heartbroken by his death. Upon learning of it, she walked several hours alone in the winter rain to be with her own mother as no one would give her a ride. But the pain of losing her son was too great and, just 20 months after Colby died, Violet also passed away from a toxic drug poisoning.

The excruciating abuse and death of Colby was – and still is – felt by the rest of his family, his community, and all by those who were touched by his gentle and resilient spirit.

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 could have made a difference. Leaders also expressed concern about the issues of violence within their community and the need for healing to disrupt intergenerational cycles of violence.

The communities where Colby lived have been reeling since his death. Cultural support and ceremony was offered in the hospital, and, in the following days, Colby's home community held a healing ceremony for all who were connected to this family. This ceremony was just the beginning of a long healing journey ahead.

A preventable death

Questions remain for the family, friends, and the professionals who were involved in Colby's life. Many of these people have shared with RCY that they wonder what more they could have and should have done. Medical staff have asked themselves, "What more could I have done to get Colby to his appointments?" A school staff worker wonders what might have happened if she had waited just a little longer on the doorstep when nobody answered as she was dropping off his schoolwork.

> We will never know for sure if one small action could have changed the trajectory of Colby's life. But there's no question that collective action could have.

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

When a tragic incident takes the life of a child in care, it is tempting to point a finger, to identify one thing or one person responsible for this death. In fact, in the days and weeks that followed the June 2023 sentencing hearing for Colby's abusers, MCFD offered a response to what happened. Their statement was that the *workers* failed; basic social work practice simply wasn't followed by the individuals involved. The implication was that the problem could be fixed if the "bad apples" were let go, if individual workers were reminded to follow policy, and if oversight of policy compliance was ramped up. End of story.

But that was, and is, far too simplistic. In Colby's story, there was no one thing or one person who could be held wholly responsible. Instead, we see a web of actions and inactions and dozens of missed opportunities across an entire system.

We have asked ourselves a series of what-ifs. What if a more comprehensive approach to violence within the family had been taken early on? What if there had been sustained wraparound supports for the family as they navigated the many struggles of poverty and complex health needs? 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 needs? What if their housing precarity could have been alleviated? What if basic social work policy and practice had been delivered and supervised? What if the tensions and fears about sharing information had been addressed so that communications could have been more honest and fulsome? What if there had been a clearer understanding of roles and responsibilities between a Nation and a government?

And there are so many more.

> "A system built on risk and liability [management] can't raise children; a system built on care and love and respect is one that can raise children."
>
> – Member of the Circle of Advisors

Not an Outlier

RCY has come to the conclusion that Colby's death was entirely preventable. There is no question that the lack of collective and connected care for Colby and his family – practised in the community, by the Nations, in schools and health care, in housing and income security, and in child welfare – contributed to Colby's tragic death. The aim now is to understand what contributed to this tragedy so that we can make different decisions and take different actions.

It is critical to note that Colby's story is not an outlier. Rather, it is emblematic of *systemic* issues within the systems serving and supporting children and families. To better understand these systemic patterns we examined the stories of 14 other children from eight other families. These children – Hillary, Annabella, Julia, Freddy, Tanya, Riley, Dahlia, Tyson, Aliah, Jessica, Madelyn, Dereck, Presley and Chantele[3] – and their families also experienced light and shadow. Three of the children died. None of the families received timely or appropriate supports. Thirteen of the children experienced violence. Poverty, housing precarity, substance use and mental health concerns were challenges that many of the families faced. There was minimal oversight and "eyes on" for many of the children, especially those in kinship care arrangements.

[3] Names of the children have been changed for privacy and their stories within the report are anonymized out of respect for the children and their siblings who survived.

Systemic Review

Colby's story – and those of many others we have seen and shared – point to patterns and recurring themes that must be addressed if we are going to create systems of care that enable child and family well-being.

The Systemic Review focuses on a collection of nine themes: (1) family and intimate partner violence; (2) family support, early years and early help; (3) kinship care; (4) inter-agency communication and coordination; (5) accountability and quality improvement; (6) workforce capacity; (7) loss, grief and belonging; and (8) jurisdiction and (9) reform. The first four themes are summarized here, and the first five themes are elaborated on in individual chapters in the main report. The sixth theme of workforce capacity in MCFD is lightly touched upon within the main report, but will be addressed fulsomely in a two-part report, the first of which will be released on July 23, 2024. The themes of loss, belonging, jurisdiction and reform are addressed in the final chapter of the main report prior to recommendations. Each of the Systemic Review chapters also explores the extent of bias and discrimination, often seen as assumptions or beliefs about the child, their family, and their community, that are built into our current colonial system. The existing mental models or mindsets, grounded in colonial worldviews, must be disrupted and replaced so as not to repeat the same stories of harm and violence again in a few years.

Family and Intimate Partner Violence

As we reflected on the many learnings from the *Don't Look Away – How one boy's story has the power to shift a system of care for children and youth,* we kept coming back to violence. No matter what other changes are made to B.C.'s child-, youth- and family-serving systems, if we do not address violence in families and communities the impact of all the other efforts will be minimized. And if we do not support healing from intergenerational and colonial violence, the impact of any other changes will ultimately be incomplete. This must be an all-in priority for compassionate action to get at the root causes and perpetuating conditions for intimate partner and family violence.

Four key observations are addressed within the main report including:

- Families' fears of protective services' involvement and the possible removal of their children contributes to violence being concealed and under-reported. These same fears sometimes lead violence to be "accepted" and "normalized" within families and communities. The secrecy and concealment of violence results in workers having gaps in their understanding of what is going on within the families they serve.

- Social workers, health care workers, educators, police and community agency workers are still too often not attuned to family and intimate partner violence even when there is clear direction in their respective policies and guidelines. This is likely due to a confluence of factors,

We have to recognize: Children who are exposed to violence are *experiencing* violence.

> This [silencing] is not who we are as Indigenous people, but it is who we have become because of what has happened to us. We can reclaim our ways of caring and respect.
>
> – First Nations Leader

including the combinations of: (1) lack of knowledge and understanding about violence; (2) a lack of confidence or capacity in assessing and inquiring into violence with family members; (3) assumptions about the role of police or health care professionals in assessing the risks; (4) fear of bringing up such a difficult issue with family members; and (5) assumptions and beliefs about the role of "protective parent."[4]

- Intimate partner and family violence is rarely a one-time event. To understand patterns and consider possible interventions and stronger practices, we also need to understand intergenerational contexts. An important question to consider is: What are the lived experiences of those who are enacting violence? Many have had violence enacted on them as children and youth, and the cycle continues.

- Fathers and father figures – despite being the most frequent perpetrators of violence on their partners, former partners and children – are often invisible in safety and response planning. Their partners or former partners are often expected to "manage" their behaviour by ensuring that they do not violate the terms of any Safety Plan or order. The consequences for any violation are more often felt by the mothers who may be deemed as non-protective and whose children may be removed from their care. Moreover, often because of assumptions and bias about caregiving roles, those fathers who do want to address the violence, take responsibility and do healing work, have very few options available to them.

> Mom said they wanted the violence to stop, not the marriage. We worked with extended family, Nations and elders. We gathered the circle. We weren't afraid to take a chance. And it worked.
>
> – Participant in engagement session

[4] "Protective parent" is a term used to describe the parent who is expected to ensure that the children are not exposed to or at risk of violence perpetrated by the other parent, in situations of intimate partner and/or family violence. This often means that the protective parent has to ensure that the other parent has no access to the children.

Family support, the early years and early help

Both Indigenous and Western knowledge and research point to the importance of supporting families and ensuring that children, especially in their early years, receive nurturance, love and care. So why are many of our systems and programs *waiting* to intervene once vulnerability is more entrenched and developmental damage has already been done? If we know that we can shift a child's trajectory by focusing on the wraparound well-being of their family and community, why would we wait to act?

Many of the people with whom RCY engaged spoke about the interconnections between child, family and community: "a healthy community supports a healthy family, a healthy family supports a healthy child". Participants in the engagement also noted reciprocity: healthy children become the bedrock for healthy communities. This synergy has been known amongst Indigenous peoples for time immemorial. It is one of the reasons that the intentional destruction of these bonds through the forcible removal of children from Indigenous families and communities has had such a profound and lasting impact.

Four key observations are addressed within the main report including:

- The families described in the report, and those that the RCY has come to learn about in the course of our daily work, face many challenges that are outside of the scope of the child protection system and child welfare system more generally. Child protection/child welfare does not have a mandate or capacity to address poverty, or housing precarity, or health care, or violence. And yet, these are exactly the conditions that often contribute to the need for child protection involvement in the first place.

> "And most people will say that it takes a community to raise a child, but our people say it takes a child to raise the community. We name our children when they're born after the community. And it just speaks to the idea that our children are going to be our village. They are the faces of the village as they become adults. And so we invest in them, we nurture them and we support them. And that's one of the things we need to return back to."
>
> – Cultural Advisor

> "We ask child protection to step into spaces where society has essentially failed to provide prevention and support services and then we say, oh, you're meant to fix it. But the tools available to fix it in the child intervention system are limited by law... they don't have a legal mandate to solve the issues that cause children to eventually be in place [of harm] to begin with... We look to the wrong system to solve the problem."
>
> – Member of the Circle of Advisors

- At best, the current child welfare system refers or points families to other systems that have a role to play but these, too, are constrained and siloed. The lack of wider attention to the broader social determinants of health and how families are affected, and the disconnection between systems limits the opportunities to make fundamental changes and improvements in child well-being.

- Our current systems and practices pay limited attention to upstream opportunities to bolster a family's capacity to safely care for and nurture their children. There are two key opportunities: during a child's early years (0-6) and when concerns first arise. Neither early childhood development nor early help are current priorities. All the children would have benefited from greater supports in their early years at a time when the brain is rapidly developing and when family stressors and violence can have a particularly significant outcome on their development. All the families whose stories we share in this report would have benefited tremendously from early help – more intensive wraparound services when the small cracks in their capacity to parent and their own well-being first began to appear.

> "We need to ask, 'What are the circumstances for your family? What does mom need? What does the family need to help mom? What does the Nation need to help the family and mom?"
>
> – Participant in engagement session

- Current child welfare systems are neither strengths-based nor relational despite pronouncements that they are. Instead, they are crisis- and compliance-oriented. We rarely see robust, longer-term, co-created family plans that identify strengths and assets to reinforce and build upon, or that mobilize the services and supports that could enable a family to be successful.

Kinship care

Similar to other jurisdictions, B.C. has put increased emphasis on kinship care in recent years. The number of children in kinship/out-of-care arrangements has more than tripled since 2008, while at the same time those in government care have reduced by half. Colby's story illustrates the tremendous strengths, challenges, and risks of kinship care. As Violet struggled, her extended family often stepped in to help both informally and formally and there were both positive and negative outcomes.

Kinship care has the potential to create better outcomes for children, but it must be well-supported, sufficiently resourced, culturally appropriate and routinely monitored. When parents are not able to care for their children, the children should be placed with their family members whenever possible, in accordance with federal and provincial law. But the work and resources necessary to support a successful placement is of paramount importance. When kinship care is viewed by the child welfare system primarily as a mechanism for reducing the number of children in care or as a means of saving money, the health of the child and the caregiver are both at increased risk.

Four key observations are addressed within the main report including:

- Family engagement in planning for any kinship care arrangement is essential. This requirement is already set out in MCFD policy, but RCY has observed in this story and many others that such policy is inconsistently upheld. There are various reasons for this, including: (1) it takes time that workers feel they don't have; (2) there is a sense of urgency to take a 'less intrusive measure' and workers therefore move quickly to solutions without family inclusion; (3) it may be difficult to find, connect with, and engage family members; (4) there may be tension between family members due to the sensitivity of the circumstances giving rise to the safety and protection concerns; (5) workers may feel ill-prepared to navigate these tensions with families; (6) workers may assume that they know what the family wants and decide to establish an arrangement in accordance with what they think will work; and (7) sometimes workers accept the Nation's guidance as sufficient and fail to include the family in decisions. RCY has also noted that outreach to fathers is hit-and-miss.

- Clear communication is essential for all parties. In particular, communication between child welfare, education, health, police, Nations, and community agencies is needed about: (1) checks and assessments; (2) expectations for action; (3) roles and responsibilities; (4) parental and child rights; (5) children's needs; (5) timeframes for response; (6) availability of financial and other supports; (7) consequences if expectations and requirements are not met; and (8) access to social workers. In the absence of clear and consistent communication, there is a greater likelihood of misunderstanding, confusion and frustration that compromise the adult relationships and may have a negative consequence for the child.

- Checks and assessments are essential. Each type of kinship care has different expectations for assessment and there are good reasons for the policies and practice guidelines that are already in place. If children are going to be removed from their parents' care, there needs to be some assurance that they will be safe, supported and nurtured in another home. The kinship carer also needs to know what they are taking on, what will be expected of them, and how they will be supported. The current assessment processes are far from perfect, but they can still be an opportunity for the kinship placement to be explored and better understood. RCY noted various reasons that the necessary checks and assessments are not completed, including several repeated themes, such as: (1) it takes time that workers feel they don't have; (2) there is a sense of urgency to make the placement; (3) people who the workers trust or feel accountable to have 'vouched for' the kinship carer; (4) the worker is concerned that the assessments are potentially triggering or culturally unsafe; (5) the kinship carer is reluctant or resistant to the checks and assessments; and (6) workers may feel ill-prepared to navigate this resistance or awkwardness if concerns are revealed.

- Most kinship carers and the children in their care will need supports and services either continuously or episodically. Many of these are similar to the services and supports that were discussed for family support, such as practical and tangible supports and access to specialized supports for the child. Another facet of support is through broader family engagement – for the child to thrive, their kinship carers also need to thrive. Regular check-ins with both the caregiver and the child are a core part of good relational practice and, while some kinship carers are reluctant or unwilling to engage with MCFD due to negative past experiences or fears, this can be done well with partnership from community-based organizations.

Inter-agency communication and coordination

Colby's story illustrates the care and commitment that many different professionals brought into their relationship with him. Many of these interviewees recalled specific interactions with Colby even years after those interactions occurred. They also noticed when he was not present at school or when his medical appointments were missed. On many occasions, their concerns for his well-being were brought forward to administrators, his MCFD social worker and his caregivers, in the hopes that there would be some action to ensure that he was seen and connected back to school, community and health care.

Unfortunately, Colby's story and other children's stories also reveal that silos persist between Nations, ministries, mandates, programs and services. There remains a lack of inter-agency, inter-sectoral, inter-disciplinary and inter-ministerial information-sharing, coordination and collaboration (referred to as inter-connection) across child and family-serving systems.

Four key observations are addressed within the main report including:

- Silos remain despite many reports over many years highlighting how these silos are detrimental to the well-being of children. Each organization and discipline (including ministries, other public bodies and community agencies) can work earnestly within its sphere of expertise and influence. Yet the strong boundaries created by mandates, policies, resources, time limitations, histories, assumptions and beliefs continue to limit the potential for meaningful engagement between disciplines and organizations. As a result, the various parts of the systems that serve children and youth do not share information to build the bigger picture of the child/family. Quite simply: the system does not plan as a system to mobilize the diverse resources to improve the lives of children. While the RCY found examples of inspiring collaborative work going on throughout B.C., with many professionals working very hard to break down these silos, the *system* as it stands today does not enable this work.

> "We have to move away from child protection. For somebody that was in care before, that system didn't protect me. It was far from protecting me, and so I think it's a fallacy to suggest that child welfare is about protection. We need to focus more on prevention. And we need to make sure that all sectors are working with each other."
>
> – Member of the Circle of Advisors

- There remains a lack of understanding about roles and responsibilities especially when there are multiple disciplines and organizations involved. Who is responsible for coordinating/managing the care of a child who is being served by upwards of 10 professionals across five different sectors? An assumption is often made that it is the parent's responsibility to coordinate care. Thus, if a child is in care, it becomes MCFD's or the ICFSA's responsibility. But is this the best model or even a realistic one? What if the child's needs are primarily in a domain that MCFD has little expertise in, such as health care? In situations where there is significant violence within a family, who is responsible to ensure not only

that the immediate risks and harms are addressed, but also that the underlying concerns are addressed in the longer term? Where do the responsibilities of police or first responders end and other parties pick up? Confusion about roles and responsibilities are especially poignant as Indigenous Governing Bodies/Nations transition towards self-determination and resume jurisdiction.

- There appears to be a lack of "professional generosity" within the system and particularly in MCFD staff's interactions with other professionals. We learned about the necessity of establishing an *ethic of care and respect* between the professionals who are involved. A lack of care and respect is demonstrated when calls are not returned, information is not considered, meetings are not attended, or contributions are not made. The concept of professional generosity lines up with the Sacred Teachings that were offered by RCY's Cultural Advisors – relationships, respect, responsiveness, responsibility, reciprocity and restoration/repair, as needed. This work is complex and hard to do at the best of times; RCY learned through research and heard through many engagements that the work becomes more fulfilling when there is a sense of respect and a "we are in this together" approach amongst allied professionals. In contrast, the work becomes so much harder when silos become impenetrable and respect is lost between professionals.

- While mechanisms intended to support inter-connection often exist – integrated case management meetings, complex care case management tables, situation tables, coordination tables, high-risk action tables, inter-agency planning groups, and more – these mechanisms may no longer serve the purpose for which they were intended. Indeed, in some cases, the reason for creating a mechanism of inter-connection may no longer be relevant. How many of us have dutifully showed up at meetings wondering what the purpose was, or simply stopped showing up? In other words, in some situations, we have mechanisms that have no meaning.

Where Do We Go From Here?

The sacred story investigation, systemic review and engagements have clearly shown that these are not just MCFD issues. We need an "all-in" approach from across government. We need, for example, to be able to gather the necessary data to systematically track and take steps to improve the social determinants of health and well-being for children and families. Nations need targeted support based on unique characteristics to continue to heal and they need sufficient resourcing as they resume jurisdiction over their own children's well-being.

Through the work that has been done thus far, the RCY hopes that the provincial government, Nations, and organizations will see the necessity of, and the value in, reimagining the ways that supports for and services to children and families are provided in B.C.

As one of this project's Cultural Advisors declared, "The system has been designed to "protect" our children from their families, community and culture; but our children need to be protected from the system that continues to cause them harm." The safety of children and protecting them from immediate abuse and harm is, of course, still vitally important. But so too is *preventing* abuse and neglect and *restoring* family, cultural and community well-being.

There is widespread agreement that, despite good intentions and significant investments, the colonial structures and approaches in place now have caused harm. There is also agreement that the current approaches are unable to meet the contemporary challenges faced by many children and families.

In the words of Indigenous leaders: "Healthy children need healthy families; healthy families need healthy communities – they are all interconnected."

The most common call to action from the engagement sessions in this project was a call to shift the mental model – from child protection/child welfare to child *well-being*. This shift is from thinking about an action for now (to protect) to imagining a desired outcome over time (well-being). It is more congruent and aligned with Indigenous ways of knowing and being that reflect circle over hierarchy. It reflects holism and shared responsibility for the well-being of the young ones rather than separation and silos. The mental model acknowledges the many different contributors to well-being and brings in more opportunities to provide help and support to children and families. It recognizes that it is not just the job of MCFD to protect, but the responsibility of all to uphold the rights of children to thrive. A model of well-being brings in wisdom and experience from other sectors and fosters new approaches that may not have been possible to envision within an exclusively child protection mindset.

Such shifts don't happen easily or quickly. However, concrete actions can be taken that will stimulate and incentivize a shift toward practice that is focused on child well-being.

It is unrealistic to expect MCFD to work at all these levels by itself. It cannot and should not

try to do this sacred work alone. Currently, we have a divided and siloed system that is not serving children and families well or within the spirit of the Sacred Teachings that have guided RCY's work. We will never be able to prevent all tragedies, but we can collectively better address inequalities and inequities and improve child outcomes so that many more children are safe, connected and thriving.

RCY believes that, within B.C., we have all the ingredients to achieve this transformation. Areas of practice such as early years and public health have known about and advocated for a more holistic approach for years. Indigenous communities have understood the inter-relatedness of all things for time immemorial. There are good policies, practices and approaches to build upon, some of which are identified in the full report. However, older mental models and mindsets pull us back into the familiar status quo so that the cycle of tragedy and mistrust continues. In the space of complexity that characterizes child and family well-being, there are no simple solutions or quick fixes. There is nothing that is easy about this. But the themes uncovered through this review mean that we now know better and, in response, we can resolve to do better.

The most important place to begin is to commit to lean in, expand the circle, listen, be humble, build compassion, try things, learn by doing, act differently and sustain the drive towards transformation.

RCY (and many others) have issued hundreds of recommendations over many years. While some have been acted upon and some have improved the experiences and outcomes of young people, we have not seen the significant changes that many have hoped for.

The Representative has chosen to take a different approach for this report. The following high-level recommendations will help set the "North Star" and get the journey underway. These recommendations have been informed by Cultural Advisors, the Circle of Advisors, First Nations and Métis leadership and thousands of people in engagement sessions who have direct experience with the current system.

Participants in the engagement sessions were clear that we need to: (1) "invite government into their responsibility to be leaders of change" and (2) "create and illuminate a pathway forward for government, but also communities and Indigenous leadership." More specific opportunities for change identified through the Systemic Review are touched upon below and offered in our full report.

In addition to this project summary and the full report, RCY will continue to release and share learnings related to this project. Within the coming days and months, we will be releasing two key reports focusing on MCFD's workforce capacity, posting resource "bundles" including key research and learnings and developing issue briefs in each of the Systemic Review's areas of focus. RCY also commits to convening and hosting hard conversations about change, surfacing community-based solutions and monitoring and reporting out on progress.

Summary of Recommendations*

* This summary is a sampling of the North Star recommendations: the comprehensive list is in the full report.

TO THE GOVERNMENT OF BRITISH COLUMBIA

- Establish guiding principles and priorities for a Child and Youth Well-being Action Plan, in collaboration with First Nations, Métis and community leadership. Bring this Action Plan forward to the Legislative Assembly for endorsement to ensure a sustained non-partisan approach to the well-being of children and youth.

- Establish a Child and Youth Well-being Action Plan that reflects a whole-of-government approach and recognizes and addresses the ongoing harms of colonization and racism on Indigenous children and families, particularly within the child welfare system. The Action Plan should provide funding and support for community healing, address substantive equality issues, and support Nations' transition to resume jurisdiction over their own child welfare.

- Require that all Cabinet and Treasury Board submissions include an assessment of the impact of proposals on child rights and well-being.

- Establish Cabinet and Deputy Minister committees on child and youth well-being to guide the development of the Action Plan, support ongoing interministerial work, fulfill government-specific commitments under the Action Plan and prepare an annual accountability report for public release.

- Ensure that the Action Plan acknowledges the many acts of resistance and resilience demonstrated by First Nations, Métis and Inuit children, youth, families, communities, leadership, knowledge carriers, elders, and matriarchs, and the many efforts that have been made over decades to achieve a transformative approach to Indigenous child well-being, and commits to sustained and meaningful legislative, policy, practice and financial support for the following:
  - Community-based healing
  - Substantive equality
  - Supported transition to greater self-determination and jurisdiction over child welfare, to the extent that the Nations desire.

> "We're talking about creating a child well-being system. That's why everybody in this circle and their perspective matters. That's a fundamental mind shift."
>
> – Member of the Circle of Advisors

TO THE MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT

- Address immediate measures as set out in the *No Time To Wait – MCFD Workforce Capacity Report* to begin mitigating factors contributing to unsustainable and unhealthy conditions for MCFD staff across service lines, with particular attention to those working in child protection and family service.

TO ALL SOCIAL DEVELOPMENT MINISTRIES WORKING WITH CHILDREN, YOUTH AND FAMILIES

- Undertake shared anti-racism learning and development work to illuminate, disrupt and dismantle the pervasive colonial systems, mental models and assumptions that sustain bias in public services.

TO MINISTRIES AND PUBLIC BODIES WORKING WITH AND FOR CHILDREN, YOUTH AND FAMILIES

- Ensure that there is a shared baseline of "current state" data and information about how children and youth are faring across the domains of social-emotional well-being, health, education, inclusion and belonging (at minimum). These data and information can be compared over time to identify trends and changes.

- Identify key indicators and measures of child well-being that are shared across and used by multiple ministries, health authorities and other public bodies to inform their collection and assessment of data to determine what is improving and what needs further attention and intention.

TO PUBLIC BODIES FOR WHOM RCY IS MONITORING RECOMMENDATIONS

- Enter into discussions with RCY to identify which of the outstanding recommendations will best support child well-being and progress toward the intentions of the Action Plan. Revise expectations and timelines for other recommendations to ensure that the public bodies are directing attention and resources to those changes that will have the greatest short-, medium- and long-term impact.

> "If you are First Nations, you know what racism looks like. You know what it feels like. You know what it sounds like. And it's still there."
>
> – Member of the Circle of Advisors

Sampling of short-term actions directed to MCFD

Violence

1. Embed risk factor template into Integrated Case Management system to prompt to workers to look for B-SAFER risk factors.

   Rationale: ICM changes could prompt workers to inquire into and assess risks associated with violence in the family. File documentation also needs to capture the perpetrator's use of violence.

2. Support team leader/senior staff participation in local Violence Against Women in Relationships/Violence in Relationships (VAWIR/VIR) Committees and related community tables to ensure that child well-being and the impact of intimate partner and family violence on children is being considered and addressed across sectors at the local level.

   Rationale: RCY learned that participation of MCFD staff in local action tables is inconsistent; MCFD staff are under the impression that this is not a priority for their time. MCFD's absence from community tables limits both information sharing and collaborative problem solving to address violence at all levels – individual, family, community – that affects child well-being.

> "We will need a significant shift in the mental models and mindsets, so we will need to be bold and aspirational. But there are steps that could be taken right now that would be in the service of moving towards the fundamental changes. It's a both/and."
>
> – Member of the Circle of Advisors

Family support

3. MCFD to ensure that every family has a Family Plan as per policy that is co-created with family members and all members of the circle in an inclusive and culturally attuned way. Team leaders and Directors of Operation to support and monitor development of inclusive Family Plans and identify and address barriers and enablers to meeting policy requirements.

4. With wraparound supports as the overall aim, ensure that there is also capacity to provide practical assistance to alleviate unforeseen issues that will have a direct impact on child and family well-being, with expedited approval processes.

   Rationale: Intention here is to enable the family to address smaller issues or issues when they are small, e.g., assistance to prevent hydro or water getting turned off, $ for specialized diet or equipment for child, respite.

Kinship care

5. Review practice and evidence informed assessments for caregivers to develop a toolbox of assessment approaches to ensure that they are culturally attuned and aligned with the responsibilities that the kinship carers will be assuming (e.g., duration of time, complexity of children's needs, etc.).

   Rationale: Assessment is important however current approaches are not in alignment with needs and cultural approaches. There is an opportunity to revise the basic assessment for temporary kinship arrangements to be more comprehensive, with a focus on identifying which supports are needed to help the arrangement to be successful.

6. Provide dedicated support to kinship carers and enhance the array of options available to kinship carers to access – without judgment – counselling supports, respite, training, timely provision, helpful 'resource' worker/navigator.

   Rationale: Kinship carers are asked to take on a significant responsibility for their kin's well-being and it is not easy. Whereas foster caregivers have access to a social worker, training, resources and respite, kinship carers do not and are often reluctant to ask for help due to fear of judgment and consequences such as removal of the children.

> "We've got so many beautiful practices and programs to build on and learn from and great work that's being done in other sectors and we can ask what could be woven together that could allow us to move forward."
>
> – Participant in engagement session

> "We have talked about [the need for change] in the other conversations.... Young people have said this before, families have said [this] before, ...decision makers [too].... Now we're having a 'what are we going to do about it' conversation, right? This conversation right now is actually as, or more important as, the ones we've had already."
>
> – Member of the Circle of Advisors

Inter-agency communication and coordination

7. Emphasize duty to report AND duty to respond especially when callers should have 'eyes on' the children, e.g., medical, health, educational and police callers, and when there has been a pattern of missed school, appointments, key actions.

   Rationale: Too often professionals with knowledge of children who may be vulnerable report that their calls and requests to MCFD go unanswered and they are unsure whether action is taken and what their role could be. In the absence of communication, opportunities for collective understanding, care and action are missed and silos are reinforced.

Emotional Trigger Warning

This report discusses topics that are very challenging and may trigger strong feelings of loss or grief, or memories of personal or familial experiences related to child and family services. If you require emotional support, the following resources are available:

Kid's Help Phone (1-800-668-6868, or text CONNECT to 686868) is available 24 hours a day, seven days a week to Canadians ages five to 29 who want confidential and anonymous care from a counsellor.

KUU-US Crisis Line (1-800-588-8717) is available to support Indigenous people in B.C., 24 hours a day, seven days a week.

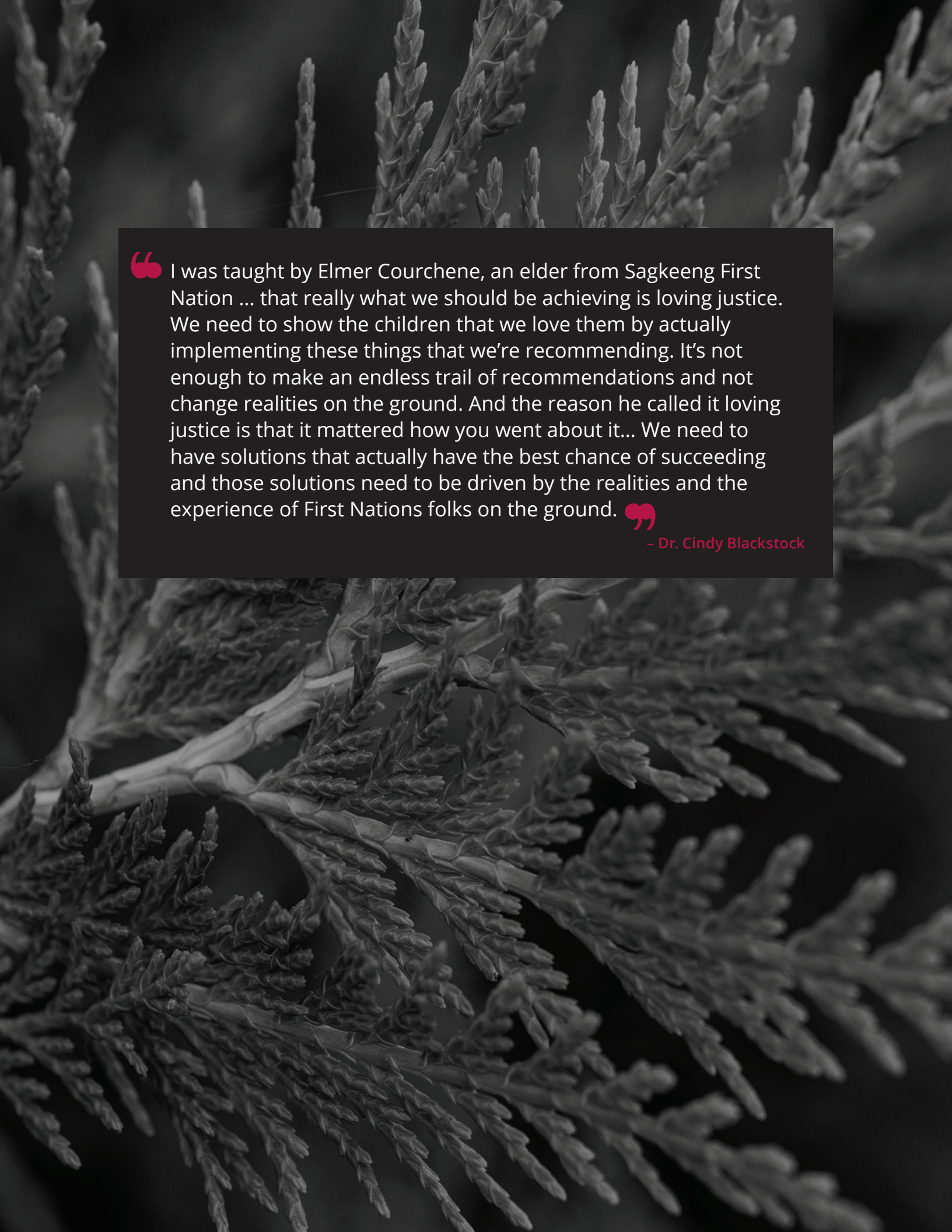
The Métis Crisis Line (1-833-638-4722) is available 24 hours a day, seven days a week.

Youth in BC (https://youthinbc.com) Online chat is available from noon to 1 a.m. in B.C.

Mental Health Support Line (310-6789 – no area code) will connect you to your local B.C. crisis line without a wait or busy signal, 24 hours a day. Crisis line workers are there to listen and support you as well as refer you to community resources.

Missing and Murdered Indigenous Women and Girls Crisis Line (1-844-413-6649) is available to individuals impacted by missing and murdered Indigenous women, girls and 2SLGBTQQIA+ people, 24 hours a day, seven days a week.

The National Indian Residential School Crisis Line (1-866-925-4419) provides 24-hour crisis support to former Indian Residential School students and their families.



> I was taught by Elmer Courchene, an elder from Sagkeeng First Nation … that really what we should be achieving is loving justice. We need to show the children that we love them by actually implementing these things that we're recommending. It's not enough to make an endless trail of recommendations and not change realities on the ground. And the reason he called it loving justice is that it mattered how you went about it… We need to have solutions that actually have the best chance of succeeding and those solutions need to be driven by the realities and the experience of First Nations folks on the ground.
>
> – Dr. Cindy Blackstock

Contact Information

Phone
In Victoria: 250-356-6710
Elsewhere in B.C.: 1-800-476-3933

Text (children and youth)
1-778-404-7161

Chat (children and youth)
rcybc.ca/get-help-now/chat

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Rep4Youth

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REPRESENTATIVE FOR
CHILDREN AND YOUTH