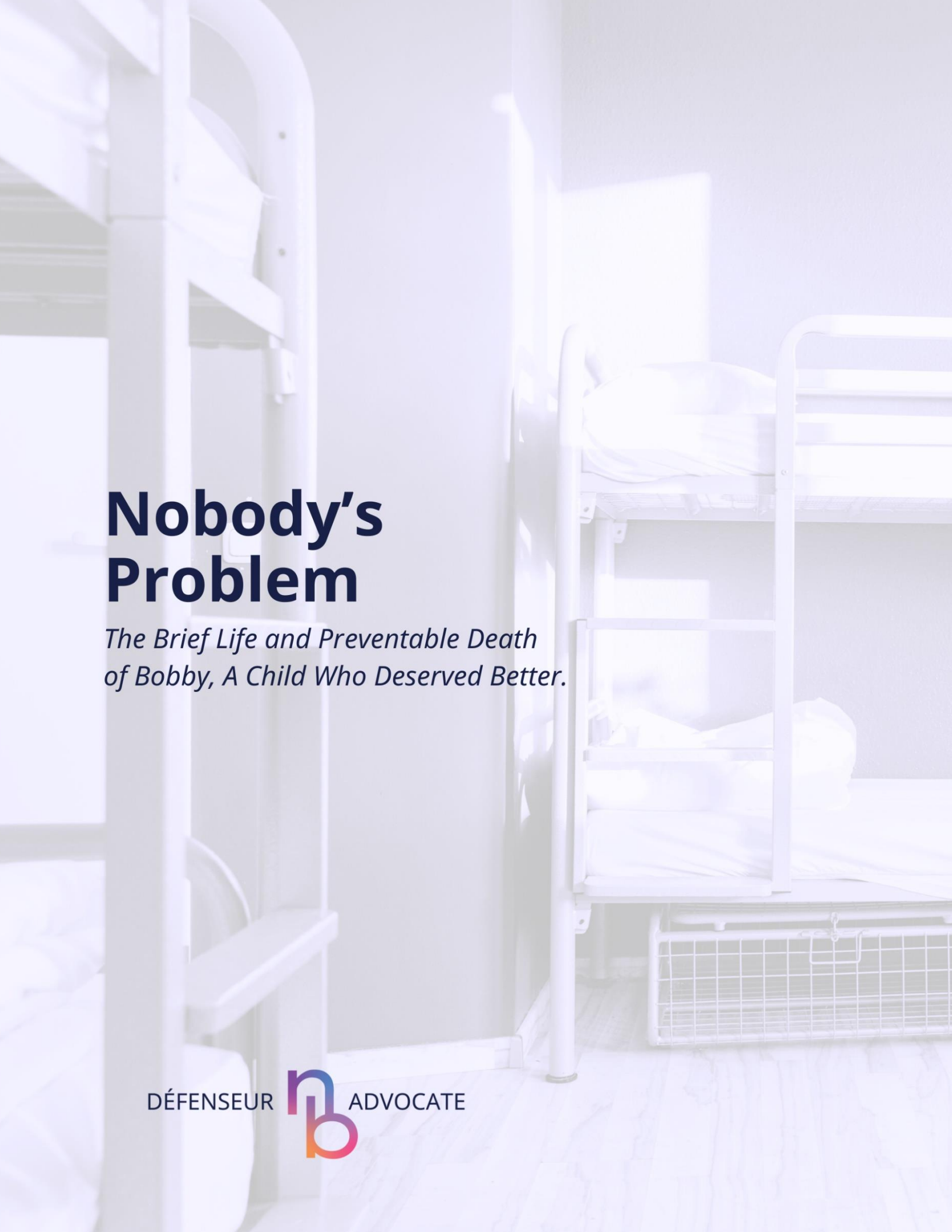

Nobody's Problem

The Brief Life and Preventable Death of Bobby, A Child Who Deserved Better.

DÉFENSEUR ADVOCATE

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ADVOCATE'S FOREWORD

I usually write long forewords, to tell people what they are about to read.

This one won't be long.

A child died.

He died alone and unnoticed.

He died preventably.

He died after asking for help.

He died in the same damn way he almost died a few months earlier.

He died waiting for some adult to help.

I don't have words to put here that inspire hope or soften the story in this report.

I didn't want to write this or pick up the file again after I read it the first time.

Because a child died, and in the last year of his life fifteen calls got screened out and twelve different people in the system turned away.

So don't turn away. Read the story.

I became a dad again, for the fourth time, not long ago. I think a lot about the power of babies. How they take over a room, dominate it. How adults can't look away because they are so compelling with their wonder and innocence and endless potential.

How did Bobby, the child whose brief life is described herein, become unnoticeable so soon? How did no one see him in those final days?

You can see him now.

You can see the next child who will cry out for help.

I'm asking you to see and hear Bobby now, so that the next time, the ending is different.

DISCLAIMER

This report has been prepared using de-identified information to protect the privacy of individuals. Names, locations, and other potentially identifying details have been altered, generalized, or omitted where necessary to reduce the risk of identification. No material facts have been changed. The events described, the sequence of those events, and the substantive issues remain accurate.

BOBBY'S STORY

In Bobby's first days alive, he went through withdrawal. One of the first things he experienced, before he could even fully understand what it was to be alive, was the pain and disorientation of his tiny body craving narcotics. The first 45 days of his life were spent in the hospital where he was born, being weaned off a poison someone else chose for him.

At the heart of the concept of community is that children deserve love and protection. They deserve adults in their lives who make decisions where they cannot, who put their well-being first. They deserve to be seen and valued. They deserve to know that around them, people believe that they matter.

Children deserve all of that in the first instance from their parents. Happily, most children's early experiences are bonding with their parents and gaining the certainty and trust in the adults around them that lets them greet the rest of the world with confidence and hope.

For the minority of children who do not have parents who can keep them safe, their future depends upon other adults seeing them and stepping up and showing them a world worthy of their trust. The common value that children deserve the kindness of strangers is one of our core values.

For the first forty-five days of Bobby's life, doctors and nurses and other first responders filled that void. They worked to get him clear of the addiction and pain foisted upon him like an unwelcome birthright. They delivered, as much as a health care system can fill the gap between what a baby deserves and the hand Bobby was dealt. A system can never replace parents. Bobby was seen and held by adults who still aspired to fill that void.

When little Bobby left the hospital, he was taken into care. When a child is taken into care by the Department of Social Development, or by "the Minister" as the legal phrase goes, the law intends that the child is to be cared for as they would be by a loving and conscientious parent who puts the best interests of the child above all else. The government, acting in our collective

name and guided by our collective values, is held to that standard. Everyone the government pays to care for that child is to aspire to that standard every time they make a decision.

In Bobby's final days alive, he was again addicted to drugs. By now, he was neither seen nor held by people with care and concern for him. He died alone in a house where the only adults were those too broken themselves to see others. These broken adults would come in and out, paying a few dollars for a place to get high to someone exploiting their suffering. Children often take a place of prominence in any room they enter. They hold our gaze. In Bobby's last days, no one saw him.

No one even called an ambulance when the overdose began squeezing the life from him.

This is the story of what happened in between. It is the story of how the system that was supposed to protect Bobby lost sight of him and why. It is not the story of the parents who might have, in a better world, met their duty to him. Perhaps they had their own demons, their own story, and they are not in this story for exoneration or condemnation. They are here simply as a fact, as people who could not meet their duty to their child. Beyond that fact, the Advocate is not here to judge them.

There is a system that we, as a society and through our democratic actions, have charged with stepping up and giving Bobby a fighting chance at a different outcome, at avoiding a last breath with tragic echoes of his first one. Ensuring that this system is available, relevant, effective, and responsive is the mandate of the Advocate.

There may be much to say and learn from what happened in between Bobby's troubled birth and lonely death. First, the facts must be established.

Bobby's Early Childhood

When Bobby was born, his mother had entered a methadone program after a period of hard drug use and a number of arrests and police interactions. His father was in prison. Because of concerns about his well-being, he was taken into protection and the Minister of Social Development was granted custody. Baby Bobby had a relatively uneventful few months in foster care.

When Bobby was eight months old, the decision was made to reunite him with his mother. A case plan was put in place. There would be some supports in place and some milestones for Bobby's mother to meet. There would be a parent aide in place for a few months and a home support worker to assist the family. A pediatric team from the hospital would work with Bobby

and monitor his development and recovery from his difficult early days. The mother would agree to random drug screening and participate in counselling.

Two months after this, calls of concern began. The family doctor made two referrals to child protection, with concern that the mother had begun seeking to overfill prescriptions for Ritalin, and the doctor believed that there was either abuse or trafficking involved. There was an anonymous referral made to child protection that a boarder living with the mother may have been abusing Bobby. Eight months later, the mother had stopped attending her drug counselling appointments and the doctor had made three more referrals – two for continued Ritalin seeking behaviour and one report of observing powder in the mother's nose and throat consistent with drug use.

At two years of age, Bobby's situation was assessed by child protection. Since he had been returned to his mother, there had been four referrals for concerns about drug use by Bobby's mother. There had been an unsubstantiated call about possible abuse. And the mother had stopped attending drug counselling appointments. The pediatrics team advised that Bobby's development had been on track at his 12-month assessment, but the mother had failed to attend for his 18-month assessment and at 24 months Bobby was again showing developmental delays.

Child protection officials deemed Bobby's case to be "low risk" and, while noting opposition from the pediatrics team, recommended closing the child protection file. While that recommendation was being considered, other worrying signs appeared.

Ten days after the "low risk" designation, an announced check-in found an eviction note on the family's door, citing unpaid rent and the growing of marijuana plants as the issues. The family doctor advised that the mother had received a Ritalin prescription from an emergency room in Moncton and may be trafficking. The Department still proceeded to close the child protection file, but put in place monitoring by the pediatrics team's Early Intervention services and the family doctor (who supported closing the file with these conditions in place).

In the next few months referrals from the former support worker, who continued to babysit Bobby and who showed remarkable care for him, would raise new concerns. The pediatrics team had reported four straight missed appointments, and the family had been evicted and moved to a smaller community an hour away. The decision was made to not re-open a child protection file but to upgrade the risk designation to "moderate". Arrangements were made for the former care worker to take Bobby to his appointments and to report that this was done, in addition to the other monitoring in place. At this point, Bobby was four months shy of his third birthday. Comments from frontline workers reflect that Bobby's mother loved him very much, although struggled to manage some parts of his care.

For a couple of years, it can be said that there was no red flag raised by the monitoring in place and no record of any adverse calls. The next time the system would encounter Bobby would be when he started Kindergarten.

Bobby Starts School

By the time Bobby started school, he was living with both parents. His teachers' comments describe a "pleasant little boy" with a "big heart" who "loves being at school". While he struggled with focus and got some extra help with reading, his infectious personality was something teacher after teacher noticed. "Bobby works hard at being a model student", one teacher wrote. What comes through is a little boy who wanted to do well and wanted to connect with the grown-ups around him.

And, for a while, Bobby was doing better. His learning in math showed promise, and by grade four he had caught up to his grade level in reading. The education file suggests that the return of some stability in his home life had predicted school success. Bobby missed only 5 days of school in grade one, and 15 in grades two through four. However, at the end of fourth grade there were some warning signs – over thirty days when Bobby came to school late suggested that the fragile stability of his home life was beginning to fray. His father was back in prison and his mother was now losing her battle with drug addiction.

By fifth grade, Bobby missed over 60 days altogether and was noticeably late nearly 50 more. The school made one child protection referral that didn't get followed up on, and then at the start of his sixth grade year another child protection referral was sent when Bobby was late or absent every day for two weeks.

More worryingly, child protection found that Bobby was backsliding rapidly in self-care and hygiene. He was frequently left to fend for himself while his mother, now back using cocaine, was high. He would often play video games and not eat, sleep or take care of himself.

Something was clearly disintegrating in Bobby's life. The notes of the child protection worker reflect that the Department of Social Development learned on the second referral follow-up that Bobby had been completely absent the last seven weeks of his fifth grade year, and now the first two weeks of his sixth grade year. The Integrated Services Team and Child Protection both became involved. By the last week of October, Integrated Services advised that their calls to Bobby's parents had been unreturned for three weeks. Child protection asked them to keep the file open and put a safety plan in place.

Bobby changed schools because the safety plan involved he and his mother moving back in with the care worker who had stayed in his life since Bobby was little. This appeared to stabilize the

situation briefly. Bobby's mother again entered methadone treatment. Bobby's self-care improved and his school attendance did as well. He was back on a Personalized Learning Plan because he had fallen behind in school, but he was again getting to school.

However, things reached a critical point soon afterwards. Bobby's mother was backsliding and using hard drugs, vanishing for stretches due to drug use. The lack of parental care for Bobby caused tension between the caregiver and mother, and now Bobby's mother began to propose erratic and sudden shifts in plans. At times there was talk of moving to Ontario, or other cities in New Brunswick. By Christmas of Bobby's sixth grade year, the parental drug use, school absences and housing instability created so much risk that Bobby was placed in a group home on a four-month custody order.

Life In Care: Some Hope, Then A Crash

Notes show that initially, Bobby showed some improvement. His attendance at school stabilized and his report card for this period reflects near perfect attendance at school and marks that are above average. The group home reported that Bobby did not show much interest in contact with his mother, but his interest in school was still as strong as it was when he was younger. When he was delivered to school, Bobby succeeded.

However, Social Development continued to work to place Bobby back with his mother. His mother suggested moving to Quebec to live with a relative, and Social Development began assessing the feasibility of that move. Even as Social Development began planning for reunification, Bobby's mother tested positive again for cocaine.

Three months in, as the reunification date grew near, Bobby began to show signs of a mental health crisis. He began threatening to kill himself, wrapping cords around his neck and threatening suicide. The health care system screened Bobby out as not at immediate risk, and child protection workers entrusted group home staff to keep Bobby under 24-hour suicide watch.

Three weeks after Bobby was placed on 24-hour suicide watch, he was returned to his mother's care, as she had secured housing. There is no record of Bobby's preferences being sought or of any mental health care being arranged. Within six weeks of Bobby's mother regaining custody, the safety plan was terminated and the Family Group Conferences were cancelled. It appeared that Social Development was again moving Bobby off its radar.

The quiet did not last long. One week after the referrals for Family Group Conferencing were closed, there was a new intake report on Bobby's file. The social worker found that the mother was again using cocaine, Ritalin and crystal meth, and Bobby was staying up late and missing

school. The Integrated Services Team reported that within weeks of Bobby's return to his mother's care they had to close the file because the mother was not responding. This would have cut Bobby off from school-based mental health services and any hope of mental health or support services over the summer months. A couple of weeks before Bobby was to return to school, the Integrated Services Team finally reached the mother, but she refused to let them speak with Bobby. This was referred to child protection for follow-up but there is no record that follow-up occurred.

By now, Bobby's school was expressing deep concern. The school's team took on Bobby's file and used a wide range of school-based supports, including a behaviour mentor, 1:1 educational assistant support, guidance appointments, and even rewards for attendance. Nevertheless, by November, the school advised that Bobby was missing over half of the time from school and that his mental health was deteriorating.

Two weeks after receiving the report of Bobby's low attendance and high mental health needs, Social Development closed his file altogether, declaring that "all issues have been resolved".

The Rest of Middle School – School Pleads for Help That Never Comes

The second half of Bobby's grade seven year saw the school begin January by frantically referring concerns to Social Development. The notes with their referral show that Bobby was punching himself, was becoming angry and frustrated easily, and had withdrawn from making friends. His self-esteem was plummeting and his mother was not responding to any school communication.

The response of Social Development to the school guidance counsellor's referral containing this information was contained in an email from the responding social worker to the supervisor in the zone:

> *"It is my recommendation that this intake SCREEN OUT as the information does not meet the SDM criteria for abuse or neglect at this time."*

The school tried again five weeks later, making another referral based on the facts that Bobby had attended only 10 days in the first two months of school, that his mother remained incommunicative, and that there were signs and reports of extensive parental drug use.

Social Development again let the matter drop. The social worker refused to do a home visit, stating:

> *"My recommendation is to SCREEN OUT the reported concerns as they do not meet the SDM criteria – (referral source) had no details regarding the reported concerns and information came from an anonymous caller to the school."*

Bobby missed over 50 days of school in grade seven and the school allowed him to repeat some courses. Another referral to Social Development arrived and this time the report was that Bobby's mother had been evicted and was using drugs, and Bobby's father had again gotten out of prison and was living with them. This led to one home visit by child protection services where Bobby's mother was interviewed at home, the father refused to speak to child protection workers, and Bobby was interviewed at school.

Due to the eviction, Bobby now attended another middle school – his third – and his winter report card in eighth grade reflected 66 missed days in that calendar year. Over the summer, another referral came in from a neighbour about yelling from the family home into the night and open drug use. It was again screened out.

Another neighbour call came in as Bobby began high school, noting that they saw smoke residue in Bobby's house on walls and fans, and that Bobby was wearing the same clothes day after day. The intake was closed after a social worker spoke to Bobby at school, and even as the social worker noted that Bobby had 41 unexcused absences in his last term of middle school, they wrote:

> *"It is my recommendation that this intake close as unsubstantiated for emotional abuse. (Bobby's mother) is adamant that she is maintaining her sobriety and (Bobby) made no disclosures concerning drug use in the home."*

Bobby's Last Year – The Warning Signs Spiral

The next time Social Development would get a referral would be five months later. It would come from Bobby's mother herself. Five months after being adamant that she was sober and that there were no issues, Bobby's mother made a call saying that they were about to be evicted, that they had been without power for some time and that they had nowhere to go.

After several calls to the mother went unanswered, efforts were discontinued.

A few weeks later, a family friend called Social Development to advise that Bobby and his mother were homeless and crashing in motels or with friends as they could.

Two months later, the child protection file was closed without contact. The reason stated in the file is that they could not find the mother or Bobby, but that the efforts to find transitional housing by couch surfing showed enough parental care that the file could be closed again.

This proved to be important, because while Social Development was closing the file because they could not find the family for three months and Bobby had stopped attending school, he also turned sixteen and could refuse child protection.

No one knew it then, but now Bobby had eight months left to live. The warning signs came quickly.

After that, Bobby was often found in trouble, but Social Development found more reasons to refuse to act.

An acquaintance of Bobby's called Social Development to report that Bobby was staying with them and reported that he was not safe at home. Bobby and his mother were both using drugs heavily. Before any action was taken by child protection, the acquaintance called back to report that Bobby's mother had picked him up and did not appear visibly intoxicated. The call was screened out. The social worker explained:

> *" […] this intake will SCREEN OUT because it does not meet the criteria for abuse or neglect. There is a lack of information […] no information about who is using drugs tonight. We also don't have any information that (Bobby) is not welcome home[…] (Bobby) is 16 years old and can refuse help."*

Two weeks later the police called Social Development to report that they were called to a motel where an altercation had broken out between Bobby and his mother. A week later, police called Social Development again. They had been called back to the motel to assist with removing the mother, and she had resisted and been arrested, leaving Bobby with nowhere to go. Social Development closed the child protection intake when the mother was released and picked Bobby up, although they had nowhere to stay.

The next day, a social worker at the hospital called in a referral to Social Development because the mother had presented there with injuries after an altercation with Bobby and reported that they were both homeless. A child protection worker called Bobby's school to see if he was there, but of course he had stopped attending months ago. This child protection referral was closed along with others from police, an acquaintance of Bobby, and Bobby himself.

Two days later, Bobby's aunt called Social Development to report that Bobby and his mother were couch surfing and that Bobby was using drugs and spiraling out of control, becoming violent. A second call came in from a family friend reporting that Bobby had been given crack by his mother and while high had a violent altercation with a man renting a room in the same place Bobby and his mother were crashing.

There were no notes reporting on any follow-up by Social Development.

Eleven days later, two calls came in to Social Development from a hospital an hour from Bobby's last known address. A doctor and a hospital social worker reported that Bobby had suffered an overdose and his system showed the presence of fentanyl, crack and meth. His sister brought Bobby to the hospital. While recovering, Bobby reported that they were homeless and living with a friend of his mother's who uses intravenous drugs. He agreed to be released to the care of a local non-profit that works with teens in crisis.

That non-profit worker tried feverishly to get the system to respond, without success.

The non-profit worker and a nurse at the hospital called child protection asking them to intervene. The response from Social Development was that since they could not find Bobby's parents, they had no proof that the parents were unable to take care of him. The fact that Bobby was alone in a hospital after overdosing and the parents were unfindable was not, apparently, acceptable proof that they were not taking care of him.

At the urging of the non-profit worker, Bobby agreed to speak to a child protection worker about getting services through Social Development's Youth Engagement Services (YES) program, which is designed to connect teens who have aged out of care with mental health services, addiction counselling, and housing. The social worker notes reflect that she told Bobby that because he was homeless and his mother could not be reached, he could not qualify for the YES program because they could not assess his home life. No further action was taken by Social Development, and Bobby never received Youth Engagement Services. Bobby left the hospital, lied about his age, and got into a men's shelter. The non-profit worker was back early the next morning, trying to find some way to get Social Development to respond.

They approached the regional (zone) office of Social Development, but the response was that since Bobby's file was in his previous city, he would have to get in touch with his original social worker in that zone, and they could not tell him who that was. He left with a number for the switchboard to call and ask them who his social worker was.

Then the Social Development regional office from the original city called to say that as they had no information that Bobby was unwelcome to return to his mother's care, he should go back to couch surfing with her and wait for his social worker to call. Bobby spent another night in the shelter.

Two days later, Bobby's social worker called the non-profit worker. By now, Bobby had expressed an interest in going to Portage, an addictions rehabilitation facility, but he would have to go through detox first. The non-profit worker advised Social Development that there was a doctor at the Saint John hospital willing to co-ordinate Bobby's entry into detox. The Social Development social worker advised that they would only help with this if Bobby came into government care, and this could only be done once his file was transferred to the region where

the hospital was. The Social Development social worker said that they could only make the referral and wait.

Two days later, after four nights at the shelter and no offer of help from Social Development, Bobby advised his non-profit worker that he no longer wanted to go to detox or Portage. Ten days later, the non-profit worker still had not heard back from Social Development, so she contacted the original social worker to advise that by now Bobby was likely back in the original city. The non-profit worker urged the Social Development social worker to try to locate Bobby and get him stable housing at a group home so that they could try again to co-ordinate a rehab plan.

There is no record that Social Development did anything with that call.

Four weeks later is the next time Social Development notes reflect any attention to Bobby's file. An Integrated Service Delivery professional at Bobby's school called Social Development and noted that it was two months into the school year, and there had been no sign of Bobby. The ISD professional had last seen him at the end of the school year, when she delivered food to him because he was couch surfing and homeless. The ISD professional was concerned.

The call provoked no follow-up. It is not clear that any of the information from the overdose incident had even made it back to the regional Social Development office, because the social worker wrote:

> *"My recommendation is to SCREEN OUT the reported concerns for the following reasons: The information reported is for 16-year old (Bobby's) school attendance; there is limited information known about the family's living situation or whereabouts, or any other details; Concerns for attendance alone is insufficient for a child protection response."*

It is unclear if the absence of information about where Bobby was or the reports of disappearing after being hungry and homeless were considered "concerns for attendance alone" by the social worker.

The next Social Development notation was two months later, as the regional office finally responded to the transfer that was started while Bobby was lying in hospital after his overdose. Apparently, due to a clerical error the file went unnoticed for two months. The notation from the social worker reads:

> *This intake was sent to the (region) inbox at the end of September however I forgot to change the region on the intake and it went unnoticed for a couple of months. The intake will be updated and sent back to (the region) for follow up.*

The new social worker called the non-profit worker trying to start work on the file and was told that Bobby had already headed back to the original region, and that this had been reported two months ago.

So, the new social worker who finally got on the file after two months stopped looking, but now new calls were coming back in to the region that had just taken two months to refer Bobby's "urgent" file to another region.

A call came in from a recovery centre noting that Bobby and his mother were living in their car, sharing fentanyl and meth. The recovery centre noted concerns for Bobby's lack of nutrition and hygiene. The Social Development social worker screened it out.

> *"The information provided doesn't meet the SDM criteria for an investigation of neglect. The information is provided by a third party. No information on how long the family would be residing in a car…unknown how that person would know that the mother is providing (Bobby) with drugs."*

Before any action was taken to answer the questions of how a recovery centre would know that the mother and Bobby were sharing drugs, another referral came in from the police stating that Bobby and his mother had been in a physical altercation after he smoked her supply of fentanyl. The mother reported that Bobby was violent and needed to go to a group home, Bobby reported that his mother was often violent with him.

Twenty-two days later, a Social Development social worker spoke to Bobby by phone and reminded him that he had a right to refuse child protection services because he was sixteen years old. Bobby refused. The social worker left contact details and after a few weeks passed, closed the file.

The Last Chance to Help

At this point, there had been fifteen cases of Social Development getting referrals about Bobby and closing them. Eleven different social workers had made the decision that Bobby did not meet the criteria for intervention.

Now, one final call came in from a nurse at a methadone clinic. She advised Social Development that Bobby's mother disclosed that she shares fentanyl with her teenage son and that they are homeless and couch surfing. The nurse urged Social Development to go check on Bobby.

On the other side of town, the director of a public housing organization sent a fifth letter to a tenant trying to get them to vacate the unit. This tenant had been making money off of their unit by renting cots to the addicted and indigent, to crash for a night, to use drugs, or both. The

housing organization was trying to get the Tenant and Landlord Relations Office to help end the tenancy because police were constantly being called but they could not get the tenant to leave.

Around the time the housing organization tried, for the fifth time, to get the tenant out and end the use of their property as a flophouse, someone found a teenage boy unresponsive inside this home.

After fifteen warnings, Social Development would not get a sixteenth. The "pleasant little boy with a big heart" from seven years ago was now another grim statistic.

Bobby was dead from an overdose. He died alone among those too broken to see him. No one had even noticed in time to call an ambulance.

Two days later, Social Development screened that last call, the one that came in three days before Bobby's fatal overdose. For the fifteenth time, the twelfth different social worker screened the call out as insufficient to raise alarms:

> *"This intake will SCREEN OUT as the reported concerns do not meet the SDM criteria for the following reasons. CP intake dated (Three months prior) included concerns of drug use and unstable housing – (Bobby) declined CP services […]there was very little information regarding the current concerns and no indication of the family's whereabouts […] it is reasonable to assume that both (Bobby) and (his mother) know how to contact the Department given previous involvement."*

Then, a final additional comment:

> *"(Bobby) has been confirmed to be deceased as of (two days ago)."*

It was a devastatingly, tragically fitting final note in the file. First, the call was screened out because no one knew how long Bobby would be homeless. The next one was screened out because after Bobby's first fourteen calls led to no help, he didn't ask for help the fifteenth time. And then, the call was screened out because no one knew where he was, and given how long Social Development had been hearing that he's homeless and using fentanyl, Social Development felt Bobby must surely know how to find them if he really wanted to ask for help a fifteenth time; so the onus was placed upon Bobby, and not upon any of the adults who had the power and resources to help him.

Besides all that, Bobby was now dead.

And that, apparently, was just one more reason why Bobby was still nobody's problem.

Reflections on Bobby's Story

We cannot change the ending of Bobby's story. We can dedicate ourselves to learn from it. We can grant Bobby the life and dignity he was deprived of by letting his story live in how we change the stories of others.

There are many lessons that can be taken from this sad story. While the list is likely inexhaustible, these are some important things that can be learned.

Lesson #1: Child protection files cannot stay unresolved for years.

The *Child and Youth Well-Being Act* brought in a cap on how long a child can be in the care of the Minister before some resolution must be brought to the file. In the Advocate's *Through Their Eyes* report, it was noted that too often efforts were made for years to work with birth parents but at the cost of children reaching adolescence having never been free of crisis and chaos. The Legislative Assembly agreed and adopted a law that states that after a child has been in care for two years, there must be steps taken to provide a home with some permanence.

The early decisions to provide some time for Bobby's mother to seek help and meet the standards needed to keep Bobby safe might have been defensible, if one musters as much charity as possible. The hindsight available when writing this report should not blind us to what people working on the file could have reasonably seen in real time, and family unity is often a good starting point when a parent is flawed but loving.

However, when the same patterns emerged again when Bobby was in elementary school, the system did not act with urgency. Bobby aged into a troubled adolescence faster than the system responded, with disastrous consequences. The window of opportunity for change when children are between ages 6 and 12 is incredibly small. Protocols need to reflect that.

The important thing for child protection officials and workers is to understand the principle behind the two-year limit and apply it to cases that may not perfectly fit the standard. When Bobby's mother fell back into dangerous patterns, Bobby had technically not been in care for two years. However, he had been living without security and permanence for ten years, and that began manifesting itself in foreseeable ways. It appeared that when Bobby was older, Social Development staff fell back to seeking reasons to minimize involvement rather than responding with urgency. Bobby needed a permanent and stable home quickly, and the system failed him.

Lesson #2: The Structured Decision-Making (SDM) criteria cannot be applied mechanically.

Structured Decision-Making is a framework that child protection agencies use to provide an orderly framework for decision-making in child welfare services. The Department of Social Development's Structured Decision-Making tool for child protection intake decisions was developed by an American nonprofit organization.

Widely seen as a best practice, it provides a framework of considerations that people on the front lines can use when determining when to initialize a child protection response. Like any decision-making framework, if it is applied mechanically or in a logically disjointed way, it can do harm.

The tool is a standard one across the U.S. and Canada, but the New Brunswick version is differentiated slightly by including a short blurb on guiding principles of practice:

> Balancing professional judgement and the use of SDM assessment tools is critical in the decision-making process. Keep in mind the following principles.
>
> - Abuse or neglect (as described in Section 34 of the Child and Youth Well-Being Act) does not need to have occurred in order to allow for assessment, investigation, or intervention to take place.
> - The Minister can respond based on suspicion that the child/youth's well-being may be in danger, even in the absence of evidence.
> - Proof of whether or how the child/youth is impacted by the possible abuse or neglect is not required.
> - Consider the likelihood of the impact on the child/youth if there is no intervention. Proof of the impact is not required.
> - Keep the child/youth centred in the work, and utilize their perspective when decision making.

In Social Development's files on Bobby, it is painful to see the constant references to the SDM criteria to justify bad decisions. In fact, it seems at times that the SDM criteria allowed frontline responders to simply emphasize any one principle that justified walking away from Bobby. At various times, the SDM framework was used to turn away from a teenager living in a car because there was no length of time known, to turn away from a child who had simply stopped coming to school because attendance alone is not sufficient to justify a response, to turn away from a child couch surfing because the call didn't contain a claim that the home was unsafe, to take parental non-responsiveness as a reason to give up instead of a reason to grow more

concerned, and to ignore a call days before a child died in a flophouse because the call didn't tell Social Development where he was.

Needless to say, this was not "Structured Decision Making," it was *ad hoc* excuse manufacturing. At times, what Social Development didn't know became an excuse to ignore the clearly troubling things that they did know. It seemed that what is supposed to be a holistic approach to assessing risk became a checklist where the emphasis landed on whatever criteria might excuse inaction.

Lesson #3: Referrals and warnings cannot be assessed in isolation.

Looking at the entire sad story that led to Bobby's death, it is hard not to have a sense of growing frustration that every warning – and there were many – was viewed in isolation. Calls about attendance were screened out because they were only about attendance, but there were other alarming signs of homelessness, drug use and poor mental health that would have made the urgent context clear. Concerns about homelessness were screened out because a search for housing might be underway, but a look at the long period of repeated transient living would have revealed an alarming trend. Some referrals were screened out because the caller did not know everything about Bobby's life but the missing information did not seem to inspire a review of the file to fit the new piece of the puzzle with the others.

The biggest failing in this category was that every call that offered another sighting of the mother's downward spiral seemed to be treated as if it was the only call, where a look at the volume and commonalities of all the calls would have told a clear story.

The heartbreaking end to Bobby's story was not surprising when one reads the file from start to finish. Yet the full story was available to each actor at Social Development every time a new referral came in. No one bothered to look at the story. It was like watching a police investigation where each clue was immediately discarded before the next one was discovered, ending with everyone sitting around unable to see the big picture.

Lesson #4: The system has no way to deal with urgency, or to escalate when a child is in danger.

There are moments in Bobby's story when some urgency might have saved his life. The reader can see the moments when the peril escalates, and the system does not escalate its response.

- Bobby's school attendance drops dramatically from the last months of grade 4 to the start of grade 6. There are clear referrals suggesting new addiction issues for his mother, a lack of self-care including a reversion of toileting, a spike in missed days and late

arrivals, and a loss of academic progress. This all happens in the last days of childhood – that critical period when the days to help a child still open to bonding with adults are dwindling. This would have been a period to intensify efforts for foster placements and educational supports. The system kept sleepwalking.

- Bobby's time at the group home correlates with near-perfect school attendance and some academic improvement. His four-month placement starts with him showing limited interest in contacting his mother and managing the transition, but as the return to his mother edges closer his mental health deteriorates and he threatens self-harm. After he returns home, his mental health bottoms out and he is completely withdrawn at school. This is a sharp change in under three years from the bright and pleasant boy of his elementary school report cards. There is no sign that Social Development sought to help group home staff with access to assessment or trained personnel, consulted mental health professionals regarding Bobby's deterioration, or even sought a high-level assessment.

- The saddest failure here is that a child was hospitalized with an overdose and the system did next to nothing between that warning shot and the fatal overdose that followed. The moment where Bobby asks to get into the YES program and is turned down because he is homeless is stunning in the cruelty and indifference of that response. The system could not move nimbly during that time when Bobby expressed openness to treatment, and then collectively shrugged when, after being left to sit in a men's shelter for three days, he lost interest and returned to the streets. Vital time was lost with social workers mishandling a bureaucratic file transfer instead of actually helping a homeless, drug-addicted young person who was recovering from an overdose in a shelter.

Lesson #5: The Department of Social Development, when we study their actions and not their words, does not see transitions to adulthood as a serious need.

A society that was serious about stopping homelessness, addiction and unemployment among young people would be aggressively trying to get every child who had been in care into a program like Youth Engagement Services (YES), which connects young people to stable adult mentors and a pipeline to education, training, counselling and mental health support. Instead, we have seen cases of frontline social workers treating YES like a treasure they are to guard and keep away from teenagers. Social Development places multiple roadblocks in front of YES applications before then claiming that, for some unknown reason, older teens in trouble don't seem to opt into services very much.

It seems that the date when a child turns 16 and can refuse services is not seen by Social Development's staff as a deadline that should inspire urgency, but a finish line at which they can give up. It was heartbreaking to see a referral made days before Bobby died screened out because, after all, Bobby obviously knew how to contact Social Development since there had been so many previous calls. The issue should not have been whether Bobby knew how to call Social Development. The question Social Development should have reflected upon and acted on was – after being denied help because he was homeless and left in a shelter for days after asking for addiction treatment – why the hell would anyone expect him to ever call Social Development again? After fifteen cries for help were screened out, what child would see any reason to make a sixteenth?

Children in crisis do not move at the speed of a bureaucratic committee. That lesson keeps getting tragically spelled out, and yet the processes live on while the broken and lost children pile up.

Lesson #6: Non-profit and community groups with limited resources, and caring teachers, moved more nimbly than government.

A community teen worker managed to respond by getting in touch with Portage and doctors, and lining up a treatment plan, and then Social Development put it on hold because a file needed to transfer between regions. A treatment facility connected the dots between a mother's behaviour and the homeless peril Bobby was in. A teacher was bringing Bobby food at a motel out of concern while Social Development said her call didn't provide enough information for them to investigate. Group home staff, some of the lowest paid and least-empowered people in Bobby's story, kept up a 24-hour suicide watch while Social Development couldn't even escalate mental health treatment.

It all tells a story – that most of the resources government provides to help troubled kids are now with the people and structures least able to deploy them in a way that matches how human beings normally respond to suffering.

The most important lesson of all: Social Development, under current conditions, cannot implement the Child and Youth Well-Being Act in the way they told the Legislative Assembly it would work.

The *Child and Youth Well-Being Act* (CYWBA) was hailed as a vast improvement over the old *Family Services Act*, and not without reason. It greatly expanded the number of tools available to frontline workers and created more opportunities for the Minister of Social Development to

create programs that filled gaps in the system, like transitions to adulthood, safe and supportive care for teens at risk, and family supports that might head off removals.

Yet when the Advocate's Office asked how often some of these important new powers were actually being used, like requiring integrated case planning or providing in-home supports or removing dangerous adults from homes, they were barely used at all.

Kin care – the practice of looking for relatives who can step up and keep a child in their family structure – is a good practice and an important tool. We see signs, however, that kin care is now being used as an end unto itself, sometimes allowing other options to atrophy and becoming a default used as reflexively as removal was used before. The goal is not simply to increase the use of kin care at all costs. It is to get every child somewhere stable where they are loved, safe and successful.

If the new law is applied as bureaucratically and slowly as the old law, the words won't matter at all. So far, they haven't mattered.

Bobby grew up under the old *Family Services Act*. The last year of his life the new *Child and Youth Well-Being Act* was in place, and the same bureaucratic failings defeated almost every promise it made to the Bobbys of the world.

Ideally, the management structure at Social Development would use the new legal mandates for outcomes and consideration of children's best interests to create a Department able to meet its charge to act as a caring and conscientious parent. Head office would set measurements for those on the frontline tied to actual outcomes for kids and respond quickly when regions fall behind. Frontline workers would be empowered to meet those goals by assessing a child's best interests and surveying all the new tools to choose the best one. The new model would provide help where it is needed quickly and create processes and incentives that would escalate when there was a mismatch between the child's need and the system's response.

This new law was in place when Bobby landed in the hospital, homeless and almost dead from the three hard drugs in his system. He asked for help. One social worker told him that he should find a place to live and then try again. A second said they couldn't help until he drove back to another city and found the right social worker. A third lost his file and didn't notice for two months.

A loving and conscientious parent? The Department was the kind of parent Bobby needed to be protected from.

Social Development officials have been proclaiming the glorious theory of the new law while ignoring the governance problems that will defeat its implementation. Ministers and senior officials keep urging the right steps but don't get proper information. Frontline social workers

are mechanically filling out forms and running program screens without the training or mandate to assess problems and escalate crises. Middle management is preaching compliance over compassion.

And no one can seem to follow a file in a linear way. If a child overdosing sixty miles from where their file is kept can paralyze the response for weeks, the governance model almost certainly is useless.

The next Bobby is out there. Someone is calling child protection about them now. Will we insist on doing better, even if it means that adults have to be more accountable and a little less comfortable with their routine?

Or are cases like Bobby's just the price we pay for avoiding uncomfortable changes?

Recommendations

The Advocate makes the following recommendations to the Department of Social Development, or when specified the Department named in the recommendation.

1. Every child who has been in the care of the Minister of Social Development should automatically qualify for transition to adulthood programs such as YES, and those who have not been in care should have their applications expedited without bureaucratic obstacles. Stop treating the YES program like some prize to be guarded by strict criteria. Start with the presumption that teenagers qualify unless there's a justifiable reason otherwise based on documented evidence that not accessing YES is in the youth's best interests. Rethink tying YES services to child protection standards. It discourages young people from asking for help and leads frontline staff to the wrong questions. Many teenagers may not be in imminent danger at home today but still desperately need support and mentorship to avoid disaster. External appeals or screening by community groups with experience knowing when a child's safety and development will benefit from YES services should be considered.

2. Get an independent review of and advice on the training of frontline staff, and look at a new model that addresses some of these glaring deficiencies:

    - How do we help social workers survey all the available powers in the *Child and Youth Well-Being Act* and develop a plan to help, instead of just going down eligibility checklists for a few programs?

- How do social workers interact with school officials and participate in case planning and advocacy when Personalized Learning Plans are being developed for children with whom Social Development is involved?
- How do you know when it's time to escalate, and how can you avoid walking away from a situation that leaves a child at risk?
- How can we ensure that referrals and calls of concern are read in the context of the full file, and that someone is noting negative trends or patterns of multiple calls before there's a disaster?
- How do we deal with parental regressions or patterns of behaviour by escalating files to ensure safety and stability?

3. Develop a mechanism of tracking the full list of the tools and powers contained in the new *Child and Youth Well-Being Act* and track how often each is used. If there are tools that are under-utilized, have a continuous improvement process that finds out what the barriers are and addresses them in training.

4. Fix the regional governance structure. There is no legal, statutory or governance principle that makes regions self-governing units beyond correction. They should be accountable for outcomes, responsive to need, and able to empower someone to follow a file out of zone when urgency dictates. Right now, there are too many people with too little information between the directions at the top and the execution on the front lines.

5. Look at the non-profit sector. Every day, non-profits with a fraction of the resources that government has, through people paid far less, are managing to navigate problems and serve vulnerable people with more speed and compassion than government. Often, as in this story, they are building solutions while the government officials are navigating checklists. It's time to provide resources to non-profits that aren't tied to conditions that make them more like government. Use them to make government more like non-profits. Explore partnerships and funding arrangements that empower community groups to lead on files.

6. Fix the accountability structure. There should be outcome-based measurements at each level of the Department such as how quickly children get into permanent, stable families, reducing repeat files, and increasing the number of children who have been in care who graduate, attend post-secondary education, and avoid homelessness and justice system involvement. These should be applied to all regions, and regions whose numbers trend in the wrong direction or are deviant from other regions should be subject to automatic head office review.

7. Develop a protocol for children aged 8-12 who come into contact or return to contact with the system. Insist upon rapid response. The years before the distrust and independence of adolescence are often the last chance to make a difference. Accelerate service, intervention, and permanency planning through a protocol that recognizes that the clock is ticking.

8. Get some support and resources to help group home staff. Right now, there is a lot of effort being put into standardizing administrative expenses. Respectfully, that is not your biggest problem. You have some of the lowest paid, least senior people dealing with the biggest crises. That is not a knock on those team members, who often do more with less than one would think possible. Expecting people making under $20 an hour to help a teen in crisis is like leaving the orderlies at a hospital to treat a stroke. They are good people doing honourable work, but they need to have a doctor to consult. Create a centralized place for mental health and health care advice. Give them resources to provide stabilization services and family supports while children can still be in their own home.

9. Have a fast-track procedure for addiction services for teenagers. Those windows when people ask for help are really precious. Teenagers who have not had a lot of help from adults don't easily ask for help and may become quickly discouraged when adults appear to be ineffective. There should be a way to start the treatment and let the paperwork, like zone transfers, come later.

10. The Department of Social Development and the Office of the Attorney-General should collaborate on protocols for teenagers who have aged out of care and are suffering from addictions. There are existing tools and capacity standards in both the *Child and Youth Well-Being Act* and the *Mental Health Act*. What is not there is a consistent approach, staff trained in when to use these tools, resources to review and approve applications, and sufficient services to offer if those tools are used.

11. An important fact to know is that I only found out about this case because a non-profit leader told me I should take a closer look. Other provinces have laws that require government to advise their Child and Youth Advocate of deaths that occur in certain situations, like when a child has been in care or when the death occurs in a place government controls, funds or regulates. The Department of Justice and Public Safety and the Office of the Attorney-General should be tasked by Executive Council Office to develop options for similar amendments here. Presently the Coroner's Act requires the

Chief Coroner to provide a copy of every report of the Child Death Review Committee to the Advocate, but it has been a year since Bobby died, and no report has yet been produced. The Department of Justice and Public Safety should institute a review of Child Death Review Committee structure and processes, to ensure timely examination of deaths.

12. The Departments of Social Development, Education and Early Childhood Development, Health, and Justice & Public Safety, and the Office of the Attorney General should collaborate on an *Integrated Services Act*, for which oversight and responsibility rests with the Executive Council Office. This statute should include:

    - Clauses based upon the multidisciplinary planning provisions of Section 42 of the *Child and Youth Well-Being Act*, which allow one department, through delegated ministerial power, to initiate and require participation of any Department, District Education Councils, Regional Health Authorities, and any other body responsible to the Province, to participate in shared planning and service delivery,
    - Mandatory measurements for outcomes across all four social departments,
    - Automatic triggers for integrated service delivery, such as justice system involvement, being taken into care, or being placed upon a partial day school plan, and
    - A protocol based upon Jordan's Principle wherein the office or department closest to the child delivers the needed service, and the mechanism for determining which budget is charged is activated through a central administrative process later.

These recommendations have been drafted using simple, plain language because they are not new or complicated. They are a question of will and common sense.

A NOTE FOR THE SAKE OF TRANSPARENCY

As I reviewed this file, I noted that an early period of Bobby's life overlaps with the period during which I served as Minister of Social Development. It was a period when Bobby lived with his family and, while some departmental monitoring occurred, there was no issue or decision which would have resulted in ministerial notification or involvement. To the best I can discern, the Minister of Social Development did not have custody of Bobby while I held that office. Nevertheless, I owe the reader transparency.

A FINAL CALL FOR DISRUPTORS

Four years into this job, I am struck by how many files I see where vulnerable people get left without help in ways that defy common sense.

How did we build a system where people on the frontlines have to escalate a file to management if they bend a rule or stretch a budget, but they feel they have to walk away from a moral absurdity without alerting anyone?

Bobby's story involves a lot of people who had to know that something did not add up. They applied the rules, even when it was clear that the rules were not going to help.

We see a lot of files where the obvious solution, in the absence of a perfect system, would be for someone to escalate the case. To point out the shortcomings. To see where the situation was going.

I read something a while ago about a leader of a community where there was a lot of poverty. The leader explained to other people that, when a child was born into that place, it was like being placed upon a train bound for a certain destination. That some of us are born on a train already pointing towards success. For others, the most likely destination is hardship.

In the files I have seen of young people born into tough situations, the variable that changes their outcome is whether or not they meet a system disruptor.

A disruptor is that one person who takes an interest and goes beyond following the crowd. They don't follow the tracks to where they have always gone. They tear up the tracks and demand a new destination.

When a child in need meets an adult willing to be a disruptor, we change the story.

Bobby, like a lot of children who encounter the child protection system, was born on a train moving towards hardship. He was born addicted to drugs, into a home where one parent was in prison and the other wrestling with addiction. If everyone did what the system has always done, the outcome would be predictable.

Government runs on predictability. We fill out the forms. We apply the eligibility criteria. We follow the rules. We move the paper.

Yet, when you're a child facing some situations, predictability can be harmful. It can even be deadly, as it was for Bobby. Because predictability means getting to where you are most likely bound to wind up.

We see a lot of children who surrender to what usually is and never get a look at what they could be. It's too much to ask a child who just wants to be safe and loved, who is in survival mode, to imagine what else could be besides what is right in front of them.

They need one adult to disrupt. To see them. To demand the unpredictable.

That's where you, the people on the frontlines, come in. I can write all the recommendations in the world. The only way systems really help the tough cases is when someone on the frontlines tells the folks at the top that what we've always done is not good enough.

When you fill out the form, file the report, screen the call, read the personalized learning plan, verify the information, dole out the resources, do you ask where this is heading? If the status quo is working? If the ordinary plan will meet the extraordinary need?

There is tremendous power in writing that one note that can't be ignored. In sending that one email that says we need to do more. In putting a note on the file that you told them to look again.

There is power in seeing what is needed before we just inventory what we have.

There is power in seeing the child in need, and not just the file to move along.

I know many of you try, and many of you feel overwhelmed. I know some of you wrestle with a system that is not always grateful to those who point out the shortcomings. But the system only works if people take risks at every level to bend it towards what children need.

Mr. Rogers told children to look for the helpers. Dr. Seuss wrote that "unless someone like you cares a whole awful lot, nothing is going to get better… it's not." The people who professionally turn their minds to the development of children and their needs know that it is the tiny acts of compassion and the determined disruptors that change stories.

I'm asking you to be a disruptor. Not to sabotage the system, but to lovingly, carefully and passionately point out when it is falling short.

It has been hard to learn of Bobby's story. Writing this feels inadequate to the crushing knowledge of how badly we failed him. I try to be an optimist who always believes that things can improve. Yet, in Bobby's case, the failing was final.

We cannot bring Bobby back to life. I'm hoping that he'll live on through his story shaping the lives of others. Where there is action born of caring and compassion, Bobby still lives.

Bobby lives in the tiny acts of disruption that his story inspires. I'm asking everyone who works in this system – this imperfect system that is still the only one we have – to be a disruptor.