Ministry of Justice
Coroners Service
Province of British Columbia

File No. :2014:07010:0008

VERDICT AT CORONERS INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST PURSUANT TO SECTION 38 OF THE CORONERS ACT, [SBC 2007] C 15, INTO THE DEATH OF

ROBINSON	**Angie Elsie**
SURNAME	GIVEN NAMES

An Inquest was held at Prince Rupert Supreme Court, in the municipality of Prince Rupert

in the Province of British Columbia, on the following dates September 28 to October 3, 2015

before: Michael Egilson, Presiding Coroner.

into the death of Robinson (Last Name) Angie (First Name) Elsie (Middle Name) 39 (Age) ☐ Male X Female

The following findings were made:

Date and Time of Death: April 3, 2014 9:00 am

Place of Death: Private Residence (Location) Prince Rupert (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Lack of oxygen to the brain - anoxia

Due to or as a consequence of

Antecedent Cause if any: b) Hanging

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) Other Significant Conditions Contributing to Death:

Classification of Death: ☐ Accidental ☐ Homicide ☐ Natural X Suicide ☐ Undetermined

The above verdict certified by the Jury on the 3rd day of October AD, 2015

Michael Egilson
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Michael Egilson
Inquest Counsel:	Bryant Mackey
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	The Ministry of Children and Family Development represented by Mr. Rolf Warburton and Mr. Richard Meyer; Dr. Jeffery Simons represented by Mr. David Pilley

The Sheriff took charge of the jury and recorded 2 exhibits. 26 witnesses were duly sworn and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. The following summary of the evidence as presented at the inquest is to assist the reader to more fully understand the Findings and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's Findings and Recommendations.

An RCMP constable testified that at 5:25pm on April 3, 2014, family members contacted the RCMP with concerns about the well-being of Angie Robinson. They had last spoken with Ms. Robinson in the afternoon of April 2, 2014 and believed her to be depressed. Two RCMP members attended the home where they found the blinds drawn and Ms. Robinson's vehicle parked. There was no answer at the residence which was locked. The RCMP forced entry into the residence through the garage for the purpose of determining the well-being of Angie Robinson.

As the constables entered the home they found Ms. Robinson's son Robert Robinson lying on a bed with his arm over this chest. Robert had no pulse and was not breathing. The officers called Emergency Health Services and then located Ms. Robinson hanging in the kitchen. The two officers cut the rope to see if they could revive Ms. Robinson. The Emergency Health Services paramedics arrived on scene at 5:40 pm. Based on their observations of rigor mortis and clear signs of death the paramedics did not engage in any resuscitation interventions. The RCMP noted the home was orderly and clean with some prescription medication (pills) and over the counter medication near the sink.

The RCMP secured the premises and formulated an investigation plan. The coroner was called and arrived just after 6 pm on April 3, 2014. At approximately 7 pm the coroner accompanied an RCMP investigator and went through the home. At this time a note was found expressing Ms. Robinson's despair and hopelessness with her ability to care for her son Robert and the lack of options she had for his future, with apologies for her actions. The coroner then waited until the RCMP identification unit arrived prior to examining the bodies of Angie and Robert Robertson.

After examining the body of Ms. Robinson the coroner found some bruising on her lower legs and ligature markings around her neck and determined the cause of death to be a result of hanging. The coroner estimated that the two deaths would have occurred at least 10 hours earlier. Based on the fact that the residence was locked, the note left by Ms. Robinson and the state of the residence the police and the coroner determined that Ms. Robinson's death was the result of a self-inflicted hanging.

Ms. Robinson was the mother of Robert, a large 16 year old non-verbal autistic young man with significant intellectual disabilities. At the time of her death Ms. Robinson lived with her son Robert in Prince Rupert where the family had moved when Robert was 5 years old to be closer to extended family. Ms. Robinson was described by witnesses as a gentle soul who cared deeply for her son.

School personnel testified that Robert enjoyed walking outdoors and tearing paper. Robert attended school in a lifeskills program and was given an early admittance to high school because of his size and programming needs. Robert had an individualized education plan (IEP) that was supported through the District Learning Services Program. As a result of his autism Robert had little capacity to interpret social cues and respond in appropriate ways. Robert's pediatrician explained to the jury that Robert would become very agitated whenever he had to interact with the health care system. Robert had been prescribed a number of medications for seizures, aggressive behaviour and Attention Deficit and Hyperactivity Disorder. Lorazepam was prescribed to address acute situations of aggression. Robert's pediatrician testified that because of Robert's aversion to medical practitioners he had regular phone contact with Angie with respect to adjusting Robert's medication. Robert's pediatrician noted that an increase in medication was required as a result of his growth and an increase in aggressive behaviours as he reached puberty.

A Ministry of Children and Family Development (MCDF or the Ministry) social worker provided evidence that a number of support programs were available to Ms. Robinson, for Robert, through the Ministry. The Autism Funding Program provided up to $6,000 per year that Ms. Robinson could access to obtain support for Robert. She would use this money to hire a one to one worker for Robert through a private contract. The autism funding did not cover the cost of hiring a one to one worker throughout the year and the worker often provided services at a reduced fee to continue working with Robert.

Robert was also eligible for respite services through the MCFD, Child and Youth with Special Needs Program (CYSN). Robert was assessed as being eligible for up to 14 days per month of respite services. As there was no available respite service for Robert in Prince Rupert, Ms. Robinson was responsible for transporting him to the resource in Terrace approximately 150

kilometers away. Sometimes this required Ms. Robinson to accompany Robert to Terrace by bus.

The Ministry also offered Ms. Robinson access to the Parent Support Program and the Provincial Networking Group. A Ministry social worker testified that Ms. Robinson declined both programs. An RCMP member told the jury that he wondered if accessing appropriate child care for Robert may have been an impediment to Ms. Robinson being able to access support programs for herself.

An RCMP corporal described for the jury that between July 2009 and March 2014 the RCMP had fifteen contacts with the family related to domestic disputes between Ms. Robinson and Robert's father, with a number of these contacts involving charges or no contact orders being issued. Victim services were offered to Ms. Robinson although the extent to which those services were accessed is unclear. A lack of capacity on the part of support services to accommodate Robert's special needs may have been a barrier to Ms. Robinson being able to access the offered support services. Additionally, the RCMP were contacted twice in 2014 with respect to Robert's behaviour. RCMP's domestic violence policy requires that where there are children, MCFD must be notified with a summary of the incident along with any child safety considerations.

The Ministry testified that it was involved with the Ms. Robinson and her son Robert through two program areas, the Child and Youth with Special Needs Program (CYSN) and through nine Child Protection Services reports. The CYSN program is a voluntary program and the CYSN social workers are not responsible for any child protection services. Ms. Robinson's initial contact with the Ministry was with respect to autism services and funding prior to her move back to Prince Rupert.

A Ministry social worker provided evidence that in 2009, Ms. Robinson had expressed concerns about her ability to care for Robert. That information was reported to MCFD and the child protection concern was dealt with under the CYSN program in terms of respite services. On February 14, 2011, Ms. Robinson was admitted to hospital as a result of an attempted suicide. This was her second hospitalization for an attempted suicide. Robert's father was not able to care for him so a special needs agreement was signed with Ms. Robinson bringing Robert into the Ministry's care on a voluntary basis. Robert was transported to his respite placement in Terrace by the CYSN social worker. On February 17, 2011, Ms. Robinson was discharged from the hospital and Robert was returned to her care.

A respite care worker told the jury that Ms. Robinson did not always utilize Robert's full respite allotment. Medical appointments, Robert's behaviour, weather and transportation issues

impacted upon Ms. Robinson's ability to utilize respite services 150 km away. Between 2009 and 2012 the CYSN program was administered through the Terrace office and dealing with families in Prince Rupert was challenging as a result of the distance. The Robinson file was transferred to the Prince Rupert office late in 2012, but the transferring summary was not completed until May 2013. The new CYSN social worker in Prince Rupert made contact with Ms. Robinson in February 2014.

A CYSN social worker explained to the jury that Robert's respite placement was suspended in June of 2013 due to health and safety concerns for other residents and staff. A staff member at the group home testified that Robert would break windows as a result of his head banging. He was very large and would push past staff and other children. Robert would leave doors and windows open and his head banging and shrieking became continuous at the respite home. An alternate respite plan for Robert was not developed.

On July 5, 2013, the RCMP reported to MCFD its third case of domestic violence involving Ms. Robinson that year. The RCMP also noted that there were unsecured guns in the home which they removed and that Robert was present at the time. The incident occurred on June 30, 2013 which resulted in an arrest and charges of assault and forcible confinement. A no contact order was also made to protect Ms. Robinson. On July 8, 2013, the no contact order was varied to require the subject of the order to leave at Ms. Robinson's request.

A Ministry child protection social worker provided evidence to the jury of being assigned the intake reported by the RCMP and attempted to meet with Ms. Robinson at her home. The investigation consisted of a phone call to Ms. Robinson after several unsuccessful home visit attempts. The worker reported Ms. Robinson down played the incident and felt embarrassed it had happened. The social worker told the jury that Ms. Robinson stated that the rifles the police removed had nothing to do with the incident and that she wanted the rifles back. There was a safety plan in place whereby Ms. Robinson would contact the police if needed. MCFD was unaware of the no contact order and does not get updates of orders being varied. The need for respite services was passed on to the CYSN team leader. The child protection team leader testified that the unit was understaffed and a decision was made to close the file between December 2013 and January 2014. The decision to close the file was based on not having received any new reports on the family and on an assumption that services were being provided by the CYSN program and the school. Around this same time Ms. Robinson had contacted child protection services looking for support. This information was provided to the CYSN worker.

On January 29, 2014, Robert was out for a walk with his one to one worker. Robert darted onto the street and was almost hit by a taxi. Robert was upset by the incident and head butted the

taxi's windshield, breaking it. The RCMP testified that this incident was reported to them by the taxi driver.

Robert's pediatrician provided evidence to the jury that on March 21, 2014, Ms. Robinson contacted him because Robert had a respiratory infection. The pediatrician arranged to meet Ms. Robinson and Robert at the hospital emergency department as Robert would become very agitated in the pediatrician's office. The pediatrician told the jury that as he attempted the examination Robert began throwing himself around the room and was a danger to himself. The RCMP were called and the pediatrician reported it took four officers to subdue Robert. Robert was given 16mg of Lorazepam over a one hour period before the officers could release him. The first officer on scene testified that he would not have been able to bring Robert under control by himself without hurting Robert.

A ministry social worker told the jury that on March 24, 2014, Ms. Robinson made contact with MCFD and was visibly upset. She was looking for a long-term placement for Robert as she was unable to provide the care he required. MCFD completed a priority service tool assessment which identifies a score of above 75 as a high priority. Robert's score was 104. MCFD explored options with Ms. Robinson, recognizing that it was unlikely a home would be available for Robert in Prince Rupert. The Ministry proposed providing two child care workers in the home of Ms. Robinson in the short term until a longer term placement could be secured. The Ministry left Ms. Robinson a voice mail March 31, 2014, regarding the details of the child care worker plan. Robert's previous one to one worker was to be one of the child care workers but he was not available until early April. Ms. Robinson left a voicemail for the Ministry worker April 1, 2014, stating that she was unable to meet that day because Robert had been up all night and had made a number of holes in the walls. She would wait until Robert's previous worker was available to begin service.

A number of agencies provided information on their mandates and the types of services they could provide to severely developmentally disabled children and youth. A Quality Assurance Director for Community Living British Columbia (CLBC) outlined the CLBC mandate and identified that CLBC works with MCFD regarding transition planning for youth after the age of 16 but noted that CLBC only provides services to persons over 19 in accordance with its legislation. Examples were provided where CLBC and MCFD had worked jointly in establishing residential resources that transferred to CLBC upon the young person turning 19. CLBC reported no contact with the Robinsons or with MCFD regarding Robert.

The Chief Medical Officer of the First Nations Health Authority (FNHA) explained the mandate of the FNHA to the jury and how they could assist First Nations persons with complex chronic care needs. Testimony was provided that both individual medical professionals and provincial

health authorities are not always clear when and how to involve the FNHA when providing services to First Nations patients. The FNHA is familiar with dealing with high needs, low demand clients and often sees First Nations clients facing barriers to service as a result of geographic and social access. The importance of involving Aboriginal and First Nations communities in planning and supporting families was also raised.

The Executive Director of Inclusion BC (formally known as the BC Association for Community Living) described for the jury Inclusion BC's role in helping families navigate government services for their developmentally disabled children. The importance of outreach was discussed in terms of families not being able to access services they do not know about.

MCFD staff told the jury that the Ministry had completed an internal review of its involvement with the Robinsons and a number of practice changes have resulted from that review. Domestic violence training and considering domestic violence in assessing child safety and protection has been instituted. Collaborative practice guidelines between CYSN and Child Protective Services have also been instituted.

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Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

JURY RECOMMENDATIONS:

To: Prince Rupert RCMP

1. Ensure all domestic violence cases are brought to the attention of the Integrated Case Assessment Team for review.

Presiding Coroner Comment:

The jury heard evidence of the Integrated Case Assessment Team discussing safety planning for those cases of domestic violence brought forward. Bringing forward all cases of domestic violence would ensure the Integrated Case Assessment Team was aware of safety concerns whenever the RCMP respond to a case of domestic violence.

2. Ensure peace bonds and/or no contact orders, including variances, are to be reported to Child Protection Services immediately.

Presiding Coroner Comment:

The jury heard evidence of the need to consider domestic violence when assessing child safety. Knowing of the existence or variance of peace bonds and/or no contact orders is critical in assessing child safety where domestic violence is present.

3. Ensure members receive First Nations cultural sensitivity training.

Presiding Coroner Comment:

The jury heard evidence that a comprehensive understanding of First Nations issues is important in working effectively with First Nations individuals in building trust and assessing safety concerns.

To: BC Society of Transition Houses

4. Review barriers to accessing suitable shelter such as the Transition House where children and youth with special needs cannot be accommodated.

Presiding Coroner Comment:

The jury heard evidence that Transition House services were suggested as a safety option and that there may have been a perceived or actual barrier to utilizing those services based on the need to also accommodate a special needs youth with challenging behaviours.

To: The Minister of Children and Family Development

5. Ensure transportation issues are addressed separately from autism and other special needs funding for families in rural and remote communities where travel is required to access services.

Presiding Coroner Comment:

The jury heard evidence that travel costs create service inequities for families in rural and remote communities when travel costs have to be absorbed within the family's autism funding

6. Ensure transportation costs and availability are part of respite planning for children and youth with special needs when respite services are outside of their home community.

Presiding Coroner Comment:

The jury heard evidence that transportation availability and costs create barriers to accessing respite services where families have to access those services outside of their home communities.

7. Ensure families of children and youth with special needs are aware of advocacy services such as the Representative for Children and Youth, and Inclusion BC.

Presiding Coroner Comment:

The jury heard evidence that parents do not always know what special needs services are available to them or how to access services. Proactively informing families of advocacy services can assist families to navigate the service system and reduce stress for families who may be overwhelmed.

8. Ensure Child and Youth Special Needs Social Workers establish client lists to update caregivers with information and training on an ongoing basis.

Presiding Coroner Comment:

The jury heard evidence that regular communication with families around autism training and autism information is important in helping families support their special needs children and youth.

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9. Ensure Child and Youth Special Needs Social Workers provide assistance to caregivers in accessing funding and completing necessary paperwork.

Presiding Coroner Comment:

The jury heard evidence that it is important to assess families' abilities to complete funding and service applications to ensure the application process does not create a barrier to accessing funding and or services.

10. Ensure caregivers of special needs children, living with conditions such as mental health issues or domestic violence, are assessed to determine appropriate support needs.

Presiding Coroner Comment:

The jury heard evidence that conditions such as mental health issues and domestic violence create additional stressors to caring for a special needs child. Where additional stressors exist for caregivers it is crucial to assess their need for support and collaborate between CYSN and Child Protection Services to ensure the safety needs of the child are also being met.