BRITISH COLUMBIA

Ministry of Justice
Coroners Service
Province of British Columbia

File No. :2014:07010:0009

# 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** | **Robert Victor Able** |
|---|---|
| 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) Robert (First Name) Victor Able (Middle Name) 16 (Age) X Male ☐ 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) Respiratory Failure

Due to or as a consequence of

*Antecedent Cause if any:* b) an overdose of Lorazepam

Due to or as a consequence of

*Giving rise to the immediate cause (a) above, stating underlying cause last.* c) his mother's encouragement to unwittingly take the overdose

*(2) Other Significant Conditions Contributing to Death:*

Classification of Death: ☐ Accidental X Homicide ☐ Natural ☐ 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 Robert's mother, 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 Robert's mother, Angie Robinson.

As the constables entered the home they found 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

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RCMP identification unit arrived prior to examining the bodies of Angie and Robert Robertson. The coroner estimated that the deaths would have occurred at least 10 hours earlier.
A pathologist and a toxicologist explained to the jury the results of an autopsy and toxicology screening that were performed on Robert. Robert was found to have lethal blood levels of Lorazepam and no other injuries or illnesses which would account for his death. Robert had been prescribed Lorazepam which was found in the residence.

The jury heard from Robert's pediatrician that Robert was a large 16 year old non-verbal autistic young man with significant intellectual disabilities. As a result of his autism Robert had little capacity to interpret social cues and respond in appropriate ways. The pediatrician further testified that Robert would not have initiated taking medications on his own. The 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. The 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.

At the time of his death Robert lived with his mother, Ms. Robinson, in Prince Rupert where the family had moved when Robert was 5 years old to be closer to extended family. Robert enjoyed walking outdoors and tearing paper. He attended school in a lifeskills program and was given an early admittance to high school because of his size and programming needs. The school Vice-Principal told the jury that Robert had an individualized education plan (IEP) that was supported through the District Learning Services Program.

A Ministry of Children and Family Development (MCDF or the Ministry) social worker provided evidence that a number of support programs were available for Robert through the Ministry for Children and Family Development. 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. The 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 for Children and Family Development was involved with 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.

A CYSN social worker testified that 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.

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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. Robert's pediatrician provided Ms. Robinson with a one month prescription of Lorazepam.

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: The Minister of Children and Family Development

1. Ensure ongoing training with regards to *Collaborative Practice between Child and Youth with Special Needs (CYSN) and Child Welfare Workers.*

**Presiding Coroner Comment:**
*The inquest heard collaborative practice training has now been implemented. The jury noted the importance of the training be ongoing given the turnover rate in social workers in the north and the need to ensure that the role of child protection is clearly understood by CYSN social workers*

2. Provide child safety training to Child and Youth with Special Needs social workers to identify when to involve Child Protection Services.

**Presiding Coroner Comment:**

*The jury heard evidence that CYSN social workers do not receive training in child protection because the CYSN program is for voluntary services. As CYSN social workers provide services to vulnerable children and youth it is essential that they are able to recognize child safety issues and know when to consult and collaborate with Child Protection Services.*

3. Provide Child and Youth with Special Needs social workers with adequate training in special needs education policy and practice, and cultural sensitivity.

**Presiding Coroner Comment:**

*The jury heard evidence that training in these areas for CYSN social workers is important in order to better meet the needs of families.*

4. Ensure the status of peace bonds and no contact orders are known and considered in safety planning for children

**Presiding Coroner Comment:**

*The jury heard evidence that the Ministry was unaware that a no contact order had been varied and that information was not included in a child protection assessment. Knowing the status of a no contact order is a key piece of information in assessing child protection needs.*

5. Establish more directive guidelines regarding collaborative planning for children with special needs, to identify the types of ministry, medical, school and community programs, Aboriginal agencies and other supports that should be involved.

**Presiding Coroner Comment:**

*The jury heard evidence that the Ministry was not aware of the perspectives of all of the agencies and individuals providing services. More directive guidelines would ensure that the Ministry collaborates with all of the appropriate agencies and service providers to ensure the needs of children and youth with special needs are being identified and met.*

6. Review discharge planning practices and implement an action plan for Child and Youth with Special Needs clients when respite and/or other support services are cancelled or suspended.

**Presiding Coroner Comment:**

*The jury heard evidence that revoking respite services without an alternative plan created significant stress and hardship.*

7. Establish a protocol to ensure the First Nations Health Authority is involved in planning for First Nations and Aboriginal children and youth with special needs.

**Presiding Coroner Comment:**

*The jury heard evidence with respect to the role and mandate of the First Nations Health Authority in providing health services and supports to members of First Nations and to the importance of involving the First Nations Health Authority in planning for children and youth where health issues exist.*

8. Consult with First Nations Bands and appropriate Aboriginal agencies with respect to planning for First Nations and Aboriginal children and youth with special needs.

**Presiding Coroner Comment:**

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*The jury heard evidence on the importance of community in supporting health and well-being holistically and the need to explore how to best involve First Nations Bands and Aboriginal Agencies when providing Child and Youth with Special Needs services*

9. Ensure autism training in rural and remote communities, including Applied Behavioural Analysis and other research based therapies, at no cost to a child's funding allowance.

**Presiding Coroner Comment:**

*The jury heard evidence that autism funding to access training and therapy can be easily exhausted on travel costs and the need bring the training to rural and remote communities to ensure greater equity for all British Columbians.*

10. Review delegation training (Child Protection [C-6], Guardianship [C-4] and Resources [C-3]), by working collaboratively with an Indigenous Delegated training agency to provide culturally sensitive practice.

**Presiding Coroner Comment:**

*The jury heard evidence that a lack of understanding of First Nations and Aboriginal issues by social workers can negatively impact service planning and engagement with First Nations and Aboriginal clients.*

11. Review the autism funding cap of six thousand dollars per year for children six years and over and consider increasing the funding in order to ensure higher needs individuals are being accommodated.

**Presiding Coroner Comment:**

*The jury heard evidence that all children and youth with autism were eligible to apply for autism funding up to the amount of $6,000 per year. The jury also heard evidence the $6,000 funding limit could quickly be exhausted in providing services for children and youth with severe autism and consideration should be given to providing higher funding levels for those children and youth.*

To: The BC College of Physicians and Surgeons and to Northern Health:

12. Alert members and health care workers regarding the role of the First Nations Health Authority in providing health services to First Nations patients.

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**Presiding Coroner Comment:**

*The jury heard evidence regarding the mandate of the First Nations Health Authority in providing health services to First Nations individuals and that many physicians and health care workers were unaware of the role of the First Nations Health Authority.*

To: Community Living BC:

13. Implement policy regarding consideration of early entry of transitioning youth whose needs may better be met in an adult setting.

**Presiding Coroner Comment:**
*The jury heard evidence regarding the arbitrariness of planning for special needs youth based solely on their chronological age rather than addressing their specific individual needs.*