Ministry of Public Safety and Solicitor General
Coroners Service
Province of British Columbia

File Number: 2020-0391-0214

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

DESJARLAIS	TRAEVON THOMAS KEITH
SURNAME	GIVEN NAMES

An Inquest was held at Burnaby Coroners' Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates: November 28, 2022- December 8, 2022

before: Margaret Janzen, Presiding Coroner.

into the death of Desjarlais (Last Name) Traevon (First Name) Thomas Keith (Middle Name) 17 (Age) [X] Male [ ] Female

The following findings were made:

Date and Time of Death: September 13, 2020 (Date) PM Hours (time)

Place of Death: 2258 Ware St. (Location) Abbotsford, BC (Municipality/Province)

Medical Cause of Death:.

(1) Immediate Cause of Death: a) Asphyxiation

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 8th day of December AD, 2022

M. Janzen
Presiding Coroner's Printed Name

M. Janzen
Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Margaret Janzen
Inquest Counsel:	John McNamee and Steven Liu
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Sarah Rauch and Marion Buller, counsel for Samantha Chalifoux Thea Hoogstraten and David McEwan, counsel for Abbotsford Police Department Rolf Warburton and Ira Tee, counsel for the Ministry of Attorney General and Ministry of Public Safety and Solicitor General representing the interests of the Ministry of Children and Family Development William Smart and Chantelle van Wiltenburg, counsel for the Fraser Valley Aboriginal Children and Family Services Society Tamara Dewar and Emilie Ptak, counsel for Rees Family Services Inc.

The Sheriff took charge of the jury and recorded 24 exhibits. 24 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. This is to assist in understanding, but does not replace, the jury verdict and recommendations. This summary is not evidence.

Traevon Thomas Keith Desjarlais was a 17-year-old Cree youth. He was known as a quiet, kind, and polite person who enjoyed gaming, cooking, and spending time with his family, especially his younger brother.

His medical history included fetal alcohol spectrum disorder (FASD), attention deficit hyperactivity disorder (ADHS), chronic complex post-traumatic stress disorder (PTSD) complicated by cannabis-related quasi-psychotic phenomena, an unspecified neurodevelopmental disorder, unspecified learning disorders, and an unspecified anxiety disorder. He also had a suspected attachment disorder with major depressive episodes. He had experienced suicidal ideation and had previously attempted suicide. He had also displayed symptoms of obsessive-compulsive disorder.

Traevon reported a history of having experienced abuse and violence but did not want to disclose the details. His first known suicidal ideation occurred when he was 10 years old. Traevon's family had a history of inter-generational trauma associated with colonization.

Traevon had been in foster care since his birth. Over the next approximately 15 years he lived with three different extended family groups. Following this, he stayed with a friend briefly, and then went to live with his mother and younger sibling for a few months. This placement broke down primarily due to his problematic behavioural issues. His mother testified that that she had never received supportive services that would allow him to live with her. After that placement broke down, Traevon agreed to be placed elsewhere and was placed in a Delegated Aboriginal Agency contracted residence managed by Rees Family Services Inc. He moved to that residence in June 2019.

By the time he was placed in the residence, Traevon had several recorded instances of self-injury, suicide attempts, and homicidal and suicidal ideation. He had reported having visual hallucinations. He had displayed problematic behaviour, including disappearing for extended periods of time, sometimes days, and using drugs, primarily cannabis. He was frequently absent from school. While the basic information about Traevon was conveyed to the care workers at the residence, the full details of his mental and behavioural issues were not conveyed to them. They were warned that he would likely go missing sometimes.

Traevon's social worker was employed by Xyolhemeylh (Fraser Valley Aboriginal Children and Family Services Society). He had a good relationship with her and met with her regularly. She first connected with him in September 2018, but did not take full conduct of his case until August 2019. Not all of the contacts with him were reflected in the notes on his file.

An Aboriginal Child and Youth Mental Health (ACYMH) worker who was assigned to Traevon in October of 2019, testified that they had a reasonably cordial but "surface level" relationship and that Traevon was resistant to treatment. Traevon had frequently expressed his desire for female support workers; the ACYMH worker was a non-Indigenous male. The Care plan for his mental health was not completed until four months after his arrival at the residence.

Shortly after he was placed in the residence, Traevon began to go missing on a fairly regular basis. At the time of his death Traevon had gone missing many times according to group home records. He would often text or call to advise where he was (usually at a friend or family's residence). If he did not return by curfew (10:00 PM), the Child and Family Services hotline would be advised and if he had not returned by the next day, police would be notified. Residence staff and his social worker believed that they had to wait 24 hours to report him missing to police.

Because of Traevon's learning disability and verbal communication difficulties, he was placed in a special school. His written communications skills were far superior to his verbal communication skills and one of his poems had been featured in the school paper. People who texted with him often remarked on the difference. Even so, he found school and crowds difficult and frequently did not want to attend.

In approximately October of 2019, Traevon reported being 'maced' by other youths on two separate occasions. On one of those occasions, his social worker happened to be driving by and witnessed a youth in distress. She stopped her car to find that it was Traevon and she took him to the hospital for treatment. Traevon was reluctant to say who had assaulted him and neither incident was reported to police. The social worker did file incident reports and arrangements were made for the residence's care workers to drive him to and from school. The workers testified that this did not always happen.

Following these incidents, residence care workers would hear banging coming from Traevon's room, which was in the basement. Upon investigation they observed that he had made holes in the drywall of his bedroom. This was referred to and reported as "head-banging" but no one saw him make the holes, he never had drywall dust on his person, and he did not have any injuries. This behaviour persisted until the time of his death. At one point the residence care workers paid him $5.00/week to not make the holes; this met with limited success. The social worker instructed them to report the matter to police if on any occasion they could not get him to stop. This occurred once but the officers responding determined that he was not a danger to himself or others and took no further action.

Traevon was first seen by a psychiatrist in November 2017 following a referral from his school when he expressed suicidal and homicidal thoughts. He was thought to have depression and was prescribed medication. He was using cannabis and the psychiatrist advised him to stop. He was seen twice more and seemed to have stabilized. Psychotherapy was recommended in follow up.

He was next seen in September 2019 when he described hallucinations, anxiety, and trouble sleeping. He was prescribed a different medication and advised again to stop using cannabis but was resistant to that idea. He was seen again in October 2019 and on this occasion disclosed that he had been maced by a family member.

He was seen again in November 2019 and seemed to be doing better. He said he had stopped using cannabis and was doing ok in school. The psychiatrist advised Traevon's case manager to bring him back if there was a deterioration in his condition. They connected in March 2020 when the case manager reported that Traevon was doing all right but had stopped taking his medications the previous month.

The psychiatrist saw Traevon next in July 2020. The case worker and support workers thought he was struggling. He had been putting holes in his bedroom walls and seemed anxious and depressed. He was not taking medications but was using cannabis daily. When he was seen, he denied suicidal ideation. He was advised to follow up with psychotherapy and return in two weeks. The last time he was seen was by Zoom appointment. He seemed much the same. He did not relay active suicidal ideation but continued to have anxiety, depression, and grief. He did not meet the criteria for involuntary admission to hospital. He agreed to take his prescription medication quetiapine and to be seen again in three weeks.

The residence was a rental and was for use of Indigenous children in care. There were two staff who generally worked three 24-hour shifts in a row. Another staff member did occasional shifts there as well. Staff of the home did not receive any training regarding issues specific to Indigenous persons. Traevon was the only resident apart from the workers for most of his stay there. A cousin stayed there for a while. Traevon expressed concern about that because the cousin, although younger, was bigger than Traevon and Traevon reported he had been bullied by him in the past. Traevon started making holes in the walls after the cousin moved in. Workers testified to difficulties in making a genuine connection with Traevon.

The social worker and the ACYMH worker received limited training regarding issues specific to Indigenous persons. Traevon received some offers to attend cultural events but generally did not do so and was not connected to elders. The Rees personnel received almost no training on issues with respect to Indigenous persons.

The Covid 19 pandemic was declared in March 2020. Many of his contacts with workers, counsellors, friends and family took place by phone or computer for some time. This led to difficulties in establishing and maintaining meaningful connections.

Traevon was last seen alive on September 14, 2020, at approximately 1300 hours. At that time, he made himself a sandwich then went to his room. Shortly thereafter a banging noise was heard coming from his room. On the morning of September 15, 2020, a different worker came on shift at the residence. They texted Traevon to see if he wanted to go with him to get some groceries but received no answer.

When Traevon could not be located later, staff attributed the noise heard on the afternoon of September 14 to him leaving the house. When Traevon was not seen for the remainder of the day, his room was checked, and finding it vacant, the worker reported him missing to the Provincial after-hours line. He was reported missing to the Abbotsford Police at approximately 2:30 PM on September 15.

Traevon had been reported missing to police fourteen times previously. Information received from the residence care worker did not include information that he was a danger to himself or others. The officer was advised that Traevon did not have a cell phone. He did not contact Traevon's mother or go to the residence where Traevon was living. The officer connected with some of Traevon's known contacts, but no one knew where he was. As the officer was going off shift, they updated the file with their new information and put it over to the night shift for follow up.

The next day an officer from the missing persons unit continued to investigate. They spoke to other family members and friends and initiated checks with hospitals and transit police. A 'be on the lookout for' bulletin was issued to all police. At approximately noon, they received a call from the group home that the school had reported that he may be suicidal, according to a friend who had come forward. The friend said that he had previous ideation and attempts. The officer spoke to Traevon 's social worker and the friend who had reported the suicidal ideation. Other standard tasks for locating a missing person were undertaken.

On September 18 at approximately 10:05 AM patrol officers were dispatched to the group home to try to collect DNA evidence. When they arrived, the worker told them that there was an odor coming from Traevon's room. The officers went to Traevon's room and opened the bifold closet doors to find Traevon hanging by his neck with a belt attached to the closet rod. A small stool was located near his feet. There were several pieces of paper located in the bedroom, including one that appeared to be a suicide note. The officers reported to dispatch that they had located Traevon deceased and requested that a supervising officer attend. The supervising officer attended and shortly thereafter, given all of the circumstances, requested that a Major Crimes officer attend the scene.

The Major Crimes officer attended and investigated. After discussion with staff, review of the scene and circumstances, including that the room was secure with the window locked from the inside when Traevon was located, it was determined that the hanging was self-inflicted.

An autopsy was conducted which determined the cause of death to be asphyxiation due to hanging. No evidence was found to suggest it was other than self-inflicted. Forensic toxicology found that Traevon had previously used cannabis. There were no prescription medications detected.

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The jury heard evidence that a new model, based on family-based services as opposed to residential care services, was to be implemented. This would bring services more in line with the model used by Teddy's Homes, a family-based care model. Policy and legislation were being updated as a result. The jury also heard evidence that a new Information Technology system was being implemented that would allow workers to access information more easily and more quickly regarding children in care. There was testimony that it was difficult to employ and retain Indigenous staff, possibly due to remuneration and the stressful nature of the work.

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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: Minister of Children and Family Development (MCFD)

1. Expedite the policies and legislation regarding the new approach favouring family-based services versus contracted staff-led residential services.

   Presiding Coroner Comment: *The jury heard evidence that MCFD has created new initiatives and policies. There is a recognition that the best outcome for children in care is when they have a sense of belonging to community and family.*

2. Redirect funding from staff-led residential services and allocate resources supporting the new four tier model of family-based services.

   Presiding Coroner Comment: *The jury heard evidence that staff-led residential homes do not work well for children and youth. MCFD are revisiting using residential contracted homes and instead using those resources to provide support for families.*

3. Expedite the implementation of the new IT System for all children in care.

   Presiding Coroner Comment: *The jury heard evidence that MCFD will be implementing a new IT system.*

4. Ensure that the new IT System is accessible by all team members providing services to the child.

   Presiding Coroner Comment: *The jury heard evidence that the mental health clinician did not have all current information from the guardianship social worker and psychiatrist. They also heard testimony from the investigating constable that he received information from a care home worker that Traevon was not suicidal.*

To: Ministry of Children and Family Development (MCFD) and Xyolhemeylh (Fraser Valley Aboriginal Children and Family Services Society)

5. Consult with family, care team, and Indigenous communities in support of ongoing re-assessing of placement.

   Presiding Coroner Comment: *The jury heard evidence that Traevon was not best placed and that on-going reassessment is required.*

6. Collaborate with Indigenous communities to re-assess current and future placement for Indigenous children in care to create a culturally appropriate and safe environment.

   Presiding Coroner Comment: *The jury heard evidence that the staff of REES have no knowledge or understanding of colonization.*

7. Implement a new model of care in the interim to reflect the Indigenous model of care provided to children, for example Teddy's Home model of care.

   Presiding Coroner Comment: *The jury heard evidence that residential contracted homes were not working.*

8. Increase the complement of qualified Indigenous staff offering direct services to clients.

   Presiding Coroner Comment: *Multiple witnesses testified that there is a lack of representation of Indigenous people among staff.*

9. Share with children in care the same cultural opportunities provided to staff.

   Presiding Coroner Comment: *The jury heard evidence that multiple opportunities are provided to staff and their families to attend ceremonies and events.*

10. Create a policy to ensure staff are aware that missing children are to be reported immediately to the police.

    Presiding Coroner Comment: *The jury heard evidence that illustrated a common misperception that a person must be missing for 24 hours before their absence could be reported to police. Testimony from the Abbotsford Police was that this was not the case, nor was it the case at the time of Traevon's death. Each case is/was examined based on its circumstances and, especially in the case of a vulnerable person, including a child or youth, early reporting is encouraged.*

11. Share information in real time with other services providers on the care team.

    Presiding Coroner Comment: *This recommendation is based on testimony about the Central IT System.*

12. Report each point of contact with each child and have comprehensive notes on file.

    Presiding Coroner Comment: *Some witnesses could not recall details of their contacts with Traevon.*

13. Provide alternative therapy methods, for example, visits with therapy horses or dogs to better promote connection to the child.

    Presiding Coroner Comment: *Witnesses reported that other forms of therapies could have been introduced.*

To: Rees Family Services Inc.

14. Evaluate existing direct service staff to determine appropriate cultural competence in consultation with the Indigenous communities.

    Presiding Coroner Comment: *The jury heard evidence that the staff of Rees have no knowledge or understanding of colonization.*

15. Create policy for cultural competence standards for staff, in consultation with Indigenous communities.

    Presiding Coroner Comment: *Multiple witnesses reported that there has been minimal contact with Indigenous communities and there is little to no cultural awareness among staff.*

16. Create policy that requires that current and future staff members can demonstrate a comprehensive understanding of Indigenous People's history in Canada.

    Presiding Coroner Comment: *See recommendation 15 above.*

17. Contract Elders, in consultation with Indigenous communities, to be available in the homes where Indigenous children reside.

    Presiding Coroner Comment: *The jury heard evidence that connection with Elders is key to a successful outcome for Indigenous children in care.*

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18. Create a policy, in consultation with Indigenous communities, that will promote the holistic wellness of Indigenous children who reside in a Rees house.

    Presiding Coroner Comment: *The jury heard evidence that there was little or no attempt to incorporate a wellness model that was Indigenous-based.*