



8. Findings and Recommendations

This investigation is not a fault-finding process. The key motivation is to improve the system of support for children today. This can be done by identifying enduring lessons that need to come back to the front-lines of the system. Thus, it is not appropriate in reaching our findings to look backward at actions taken or not taken and judge them out of context or on a piecemeal basis. The conclusions drawn are based on a careful evaluation of what was reasonable and diligent given the circumstances and the information provided. The Representative took the perspective of workers at the time and asked what they should have done given the facts, policies and context in which they were working. The Representative again recognizes the difficulty of the task of social workers, as noted recently:

Child welfare staff are typically so harried and preoccupied with investigations and paperwork that they have little time to provide support and counselling. Their response is to refer clients to voluntary agencies that provide short-term programs such as parent education, anger management, and budget preparation. Although they are well-intentioned, such referrals mean that clients are spun like tops between the staff of a number of agencies what they need is constant, reassuring, friendly, and practical person in their lives (Foster, L. T., Wharf, B., 2007, p. 7).

The Representative also recognizes that removing children from their homes or stable placements can have adverse consequences for them. This recognition informs these findings and conclusions as the emphasis is on what were the reasonable standards of practice at the time and allowing for the benefit of the doubt on delicate practice decisions. These findings are anchored in the context described and the reasonable expectation that the judgment of those in the system be disciplined, professional and objective.

Given this context, the key deficiencies relate to:

- recognizing and responding to child abuse and neglect
- conducting thorough child protection investigations as required by the Ministry's own service standards and as required for by quality assurance findings
- providing appropriate placement of an Aboriginal child in care to secure her identity and attachment to her family and community, and
- sharing information with partner agencies and community members, and making full use of the information the Ministry did receive.

Overall finding

The Ministry must strengthen practice and supervision in assessing child safety in the North region to prevent injury or deaths of children in circumstances similar to those of Amanda, Savannah, Rowen and Serena.

Learning from preventable deaths is essential. This investigation found that current safety assessment and planning practices for children have not shown marked improvement since these children died.

During the period within which these four child deaths occurred, the North region was struggling to maintain adequate practice while it was engaged in significant efforts to recruit, train and retain qualified practitioners and supervisors. These efforts did not always succeed.

The investigation also found that during this time, front-line social workers were frequently asked to embrace sudden shifts in policy and to employ new tools and ways of working, often without adequate supervision.

Significant deficiencies in guardianship practice are also noted, especially in the development and regular review of comprehensive plans of care for children in care. A particular problem in this regard was the lack of attention paid to suitably protecting an Aboriginal child's identity and connection to family and community.

The investigation identified serious weaknesses in the medical assessment of vulnerable children and, in some instances, their caregivers.

The investigation found an inability on the part of the Ministry to learn from valuable lessons. Even internal Ministry reviews of these deaths provided lessons that were not returned to the front lines of the system.

In the death of Serena, the child safety practice issues include safe sleeping concerns. The Representative's office will review and report separately on measures to support safe sleeping practices for those children and families served by MCFD. Specific findings or recommendations in relation to this area will be reserved to that future report.

A note about the recommendations

Two years ago, in the *BC Children and Youth Review*, the Honourable Ted Hughes, QC made 62 recommendations to strengthen child welfare services in the province. Many of the recommendations made by Mr. Hughes have direct relevance to these four cases. In the preparation of the current report, an attempt has been made to avoid reiterating each of these important and sound recommendations, made two years ago and accepted by government. (This will be discussed further in the Representative's 2008 progress report on the implementation of recommendations of the Hughes Review, later this year.)

The Representative for Children and Youth reported in 2007 that the change called for and accepted following the Hughes Review had not been taken up with the determination required to support better practice at the front lines of the child-serving system. The current investigation provides many examples of the importance of a strong commitment to improving the system at the level of practice, and the importance of taking strong steps to avoid the risk of maintaining a child-serving system with inadequate accountabilities and an ineffective program of quality assurance.

Practice

This investigation has found abundant evidence that the basic elements of child welfare work were not consistently carried out to the level reasonably expected or as called for in the Ministry's service standards. Taking into account the difficult issues of judgement and professionalism, the cases investigated clearly demonstrate practice falling below reasonably expected standards. Most importantly, children were erroneously found not to be in need of protection and this is largely attributable to shortcuts taken in investigative processes.

An analysis of the evidence provides several possible explanations of why these shortcuts were taken: inexperienced social workers, staff turnover and high caseloads, insufficient supervision, ineffective training, and over-reliance on personal intuition when careful fact-finding was required. Each of these factors is supported to some degree by the evidence. It follows that improving practice in the North region, and sustaining excellence once achieved, will require a multifaceted strategy. The investigation leads to the conclusion that all of this work is not yet in hand. There is much to be done to incorporate the learning that is possible from the results of this investigation into the deaths of these children.

¹In the 2006/07 fiscal year, the North region had 64 completed mediations and 24 completed family group conferences. In 2007/08 to date, the region had 54 completed mediations and 43 completed family group conferences, with 47 more as "active." (Data provided by Director of Integrated Practice, North region, and not independently verified.)

It is possible that three of these cases would have benefited from recourse to relatively newer elements in the child welfare tool kit: family group conferencing and child protection mediation. Either of these services could have been expected to result in an improved plan of care for Savannah, and might have made Serena and Rowen safer at home. It is possible that families like Amanda's, which are very well known to the Ministry for a very long time, might find the more collaborative and less adversarial approach better suited to strengthening their capacity to be good parents. These collaborative processes allow for less antagonistic relationships between frequently served families and the Ministry. For Aboriginal families, these approaches could hold great promise if trained mediators and conference facilitators from Aboriginal communities can be supported. However, there is still much work to be done, including training and adequate resourcing, for the successful implementation of the processes.

Some of these new practices need to be supported and developed in the North region, as the uptake has been limited.¹⁰ Positive and important collaborative efforts by the Ministry for Attorney General and Ministry for Children and Families and the Carrier Sekani Tribal Council may build this capacity in the very near future. The Representative is encouraged by this and our investigation of these deaths provides strong evidence that frequently served children and families may be better supported through investigations and approaches which embrace collaborative planning. This will be the case provided these approaches include clear guidance to practitioners to ensure child safety needs, as has been done in other jurisdictions. Front-line staff will need to be trained and re-trained to apply these tools and strategies in engaging families in longer-term planning for success. Children may still have to be removed from their families, but with planning the family may be assisted to support a return of the child and future safety for them and other children.

Critical incidents, such as injuries to or deaths of children, will need to be thoroughly examined to ensure that new approaches also protect vulnerable children. Furthermore, we will need to know the impact of these new approaches on overall outcomes for children. Are these processes working better than others? We will only know that if the recurrence of maltreatment is reduced and well-being is strengthened. Regular reporting and monitoring of the children will be essential for excellent practice. The standard should not be adequate or good practice, but *excellent* practice.

Supervision and training

A major theme in this report is that effective supervision was below the acceptable standard in these cases, in part because inexperienced social workers had been asked to serve as team leaders on an acting basis.

Improved training practices can pay substantial dividends in terms of improved child welfare practice and outcomes. But these dividends do not automatically result from training programs. To be effective, training must respond directly to observed needs, and must be targeted at places where the problems are greatest, however isolated and remote the location. Training must be promptly delivered after the need is identified, and carefully evaluated after delivery. Programs must be evaluated, as must the tools provided for front-line workers expected to intervene in situations where child safety is at issue.

Social workers, medical staff and police officers should be better supported through training to understand more fully the impact of abuse and neglect on the health and well-being of the children they serve.

Recommendation 1(a):

That the Ministry of Children and Family Development review its training activities to align them with their quality assurance program and make them more immediately responsive to observed issues in practice.

Detail:

Practice issues are identified through:

- case reviews
- audits, and
- by field managers.

Recommendation 1(b):

That a comprehensive training plan for front-line staff of the Ministry and Delegated Aboriginal Agencies be developed within six months of the release of this report.

Recommendation 1(c):

That the Ministry of Children and Family Development report annually on the program of training offered for front-line staff of the Ministry and Delegated Aboriginal Agencies.

Detail:

Annual reporting should include:

- response to practice shortcomings noted in this report
- participation in the training by region and staff position
- evaluation of the training program to ensure that it promotes best practice, including a strong focus on keeping children safe from harm.

Recommendation 1(d):

That the Ministry of Children and Family Development and Delegated Aboriginal Agency team leaders and potential acting team leaders (supervisors) in child welfare programs be provided as soon as possible with enhanced appropriate training in management practices and clinical supervision.

Detail:

This could include surveys of team leaders to inform the development of training.

Recommendation 1(e):

That the Ministry of Children and Family Development report annually on the program of supervisor training.

Detail:

Annual reporting should include:

- participation in the training by region and staff position
- evaluation of the training program to ensure that it promotes best practice on the frontlines of the child-serving system
- adjustments made to the training program to ensure that it promotes best practice on the front lines of the child serving system.

Recommendation 1(f):

That the Ministry of Children and Family Development examine the possibility of using alternative methods of training delivery, such as online or self-paced training packages, where travel from remote locations would otherwise be required, provided these allow for equally strong learning outcomes.

Detail:

Training programs must consider the unique needs of front-line staff in the North region and must be accessible to them.

Recommendation 1(g):

That the North region of the Ministry of Children and Family Development, Delegated Aboriginal Agencies, the RCMP and the Northern Child and Family Suspected Child Abuse and Neglect (SCAN) Clinic undertake joint training events.

Detail:

These should focus on:

- recognizing and responding to child abuse and neglect
- when to use medical consultation with the clinic
- how to coordinate activity during child protection investigations
- training in working as a team, in order to promote effective collaborative work on behalf of children at the local level.

Resources and staffing

The lack of qualified and trained staff in key child protection positions in the North region during the period under investigation contributed to the inconsistent quality of practice, and the fact that for these children the practice fell below reasonably expected standards. While progress has been made in this area, there is abundant evidence that more is required. Some programs that met with a degree of success were discontinued and replaced by others with less success.

Recommendation 2(a):

That the Ministry of Children and Family Development, as part of its current recruitment and retention activities, undertake a comprehensive study to determine whether staff turnover remains a barrier to high-quality service delivery in the North region and MCFD to publicly report on this by April 2009.

Detail:

If staff turnover is determined to be a barrier to high-quality service, the Ministry must identify measures required to deal with this long-standing problem. In doing so, the Ministry should involve partners such as the B.C. Public Service Agency, B.C. Government and Service Employees' Union, Delegated Aboriginal Agencies, the University of Northern British Columbia, and others who can contribute to developing and implementing innovative approaches to meeting Northern staffing needs.

It was strongly hoped that the establishment of a social work program at the University of Northern British Columbia would significantly improve the recruitment and retention of well-trained staff. The results have apparently been mixed, with some new graduates leaving the Ministry after a year or two of employment. The university has an important role to play in developing the social capital of northern British Columbia. If better results are to be achieved in the system of supports and services for vulnerable children, then more careful monitoring and evaluation is required of the placement of graduates, program content, and human resource issues.

Recommendation 2(b):

That the Ministry of Children and Family Development and Delegated Aboriginal Agencies develop a comprehensive recruitment and retention plan for human resources in the child-serving system in the North region and publicly report by April 2009.

Detail:

Development of this plan should also include any trends determined from the following recommended activities:

- collaboration by the Ministry and the Social Work Program at the University of Northern British Columbia on "exit interviews" with recent social work graduates who have left the Ministry or Delegated Aboriginal Agencies, to determine the causes of and possible remedies for this situation
- that the Ministry also conduct a similar study of child protection social workers recruited between 1999 and 2005, who have now left the Ministry, to determine why they left their positions
- a comprehensive recruitment and retention plan for the North to include recruitment strategies designed to increase the proportion of staff that are Aboriginal.

Service standards

Ministry service standards guide staff in day-to-day work with vulnerable children and their families, and form the foundation for clinical supervision. They also underpin the Ministry's audit and case review programs. It is essential that they are aligned squarely with current policy, and particularly with the Ministry's current "Transformation Process."

This investigation raised examples of practice where service standards are not aligned, as well as instances where the failure to meet those standards may not have brought any meaningful consequence. Discussions with focus groups of front-line workers suggested confusion and uncertainty as to where practice is going, particularly with child safety. Service standards on child safety must be strong and front-line staff must be equipped to know the practice associated with prescribed tools (i.e., risk assessment) and the professional standards expected in child protection investigations. The front-line staff must be supported to align their practice with policy and standards. This investigation suggests that weakness in this process is likely greater than the misjudgement of a few individuals. It appears to have been and continue to be systemic.

Recommendation 3:

That the Ministry of Children and Family Development review current Child in Care Standards, Child and Family Service Standards, and Aboriginal Operational and Practice Standards and Indicators (AOPSI) alongside current policy, by October 2008 and affirmed or amended by April 2009. It is further recommended that the results of these reviews be reported publicly when they have been completed and where changes are made, appropriate training follow as recommended above.

Detail:

The review should include an evaluation of the risk assessment tool and any new approaches to assessing child safety.

Quality assurance

In the *BC Children and Youth Review*, Mr. Hughes wrote:

The Ministry needs a strong quality assurance function to ensure compliance with its standards and practices, to evaluate internal performance against those standards, and to continuously improve systems and individual case practice, so that it can achieve better results for children, youth and their families. A commitment to quality assurance based on regular measurements and audits, standards, and training, will be particularly critical as the Ministry continues to move toward greater decentralization. A strong commitment to quality assurance, coupled with sufficient resources, will promote consistency and standardization across the system and will allow us to understand how well each region is performing individually, and as part of the child welfare and child protection system in the province (Hughes, 2006, p. 80).

The connection between quality assurance and improved practice is a very important theme in this investigation. The Director's case review of Amanda Simpson's death provides a good example of a Ministry review leading to far-reaching change efforts. There are other examples where quality assurance activities did not seem to have much impact at all.

The multiple objectives of quality assurance include ensuring that services are effective in their operation, responsive to client needs, and accessible and timely in their operation. Quality assurance seeks to foster continuous improvement through the identification of areas of excellence and areas that require strengthening. Quality assurance in a major child welfare organization such as this Ministry is not simply about process; it is also about outcomes for children. The limited robustness of the audit program, the lack of learning from critical incidents, and the apparent lack of progress made toward change in this area, despite numerous reports prior to this one, is troubling. The program of quality

assurance falls below that which would be reasonably expected in an effective child welfare system, during the entire period covered by this investigation (1995–2005) and, particularly in the period since 2006.

In child welfare, a well-rounded quality assurance program would include:

- **Quality assurance standards** – provide benchmarks against which programs and services can be evaluated
- **Clearly identified client outcomes** – inform the design of services and programs (As noted in the Hughes Review, MCFD has responsibilities with respect to both child safety and child well-being, although the current quality assurance arrangements and practices are heavily weighted towards the former.)
- **Policy, standards and guidelines** – help translate legislated requirements into guidance on case-handling and decision-making for the on-the-ground use by practitioners and their supervisors, and express the organization's expectations about timeliness, thoroughness, and required approvals
- **Audits** – (analyses of completed files) determine the extent to which practice has been compliant with policy, standards, and guidelines, together with observations and recommendations to promote improved practice
- **Case reviews** – (reviews of individual or aggregated cases) determine whether practice and outcomes were in line with organizational expectations and, if not, what remediation may be required
- **Clinical supervision** – focuses on the actions, responses and decisions of the caseworker in providing services to clients, and is used to provide workers with guidance and direction on their cases
- **Organizational learning** – uses evidence to identify lessons and best practices arising from the pursuit of continuous improvement in performance
- **Program evaluation** – formally and rigorously examines whether a program or service is meeting its objectives and producing desired outcomes, with its cost also considered
- **Research** – promotes better understanding of what has worked and what has not.

Today the Ministry of Children and Family Development cannot speak with specificity or confidence about the outcomes achieved in relation to children it is serving or in its care. Nor can it provide the public with adequate assurance as to the beneficial impact of the interventions it undertakes directly or funds at the community level. The weakness of current arrangements requires a vigorous response. This was evident after Mr. Hughes's review in 2006, and two years later it is still evident. The current Ministry standards covering quality assurance should be strengthened to guide regions and Ministry Provincial Office in the months and years to come.

The deaths of these four children, and the 22 other deaths reviewed, along with the fact that none of these other deaths during this same period received a comprehensive internal review (rather than simply a paper review) to promote learning or change, suggest that much work remains to be done to ensure practice is strengthened and lessons are returned to those who can best give meaning to them at the front-lines of the child-serving system.

Recommendation 4:

That the Ministry of Children and Family Development immediately strengthen quality assurance standards and publicly report on these activities beginning October 2008.

Detail:

This should include the following:

- monitoring of and annual public reporting of recurring issues as raised in the Ministry's complaints resolution processes
- monitoring "reportable circumstances" reports, aggregating them, and reporting semi-annually on recurring findings and circumstances
- tracking of and annual public reporting on the disposition of every relevant recommendation made:
 - in a coroner's report
 - in a verdict at a coroner's inquest
 - by the Representative for Children and Youth
 - by other public bodies
- conducting annual surveys of children in care, their birth parents, and their caregivers addressing satisfaction with services and supports provided by the Ministry
- providing for the regular conduct of external program evaluations and the public reporting of their results, and
- adding requirements for developing recommendations and ensuring their implementation.

Case reviews

The Ministry's case reviews of deaths did not serve as a stimulus for organizational learning in the period covered by this report, and it is clear from investigating these matters over the course of a decade of practice that a system to support learning has not been implemented to address this deficiency. It is interesting that the most frequently made recommendation in case reviews undertaken in the North region called for the sharing and debriefing of reports with staff. This is still not regional practice, and Provincial Office oversight is minimal and has not effectively sparked that learning.

In response to the recommendations of the Hughes Review, the Ministry has recently prepared a working "Integrated Case Review Framework Document" to guide the conduct of reviews across its various program areas. The Representative has had the opportunity to assess the framework and has sought additional clarification from the Ministry with respect to how it would work.

The Representative is of the respectful view that the new framework does not demonstrate enough detail to serve the interests of public accountability and continuous organizational learning, and is not fully responsive to Mr. Hughes' recommendations in this area. It is quite possibly a step backward in terms of defining when to conduct a review. For example, although there is great value in conducting a robust and complete review of the non-natural deaths of all children in care, the framework does not include this as a core principle. Decisions about such matters are left to discretion, and decisions made about a child death or injury review are left to those same officials in the regions who were responsible for the oversight of their guardianship.

The investigation has provided ample evidence that the Ministry must situate leadership responsibility for the conduct of Director's Case Reviews for the North region (in all program areas) in the Provincial Office, so that decisions are not being made by those who may bear direct responsibility for the services offered to the child or their family in the region. The perceived conflict of interest is a matter of concern outside the North region as well. Since 2003 when the responsibility for quality assurance including case reviews was devolved to the region, 13 case reviews have been completed in the North region of which one was a full review (Director's Case Review) on a serious incident. The remaining 12 were file reviews (deputy director's reviews) of child deaths, a critical injury and a serious incident. Case review policy should be guided by strong and clear criteria, rigorous methodology and knowledge transfer back to the front lines.

Limited public information about death reviews has been available since Case Review Summary Reports were posted, with the most recent data appearing for 2006. In the interests of public accountability, more robust and timely reporting is required. (While this investigation focuses on the North region, it has been noted that no information has been posted for any of the other regions either.)

Recommendation 5(a):

That lead responsibility for Director's case reviews be situated in the Provincial Office of the Ministry of Children and Family Development.

Detail:

This responsibility would include:

- deciding to conduct a review
- development of the terms of reference for the review
- preparing the review report
- development of recommendations
- tracking of recommendations for implementation
- ensuring the report is reviewed by an Integrated Management Review Committee
- dissemination/distribution of the review report.

Recommendation 5(b):

That Director's case reviews be conducted in every case in which a child receiving services from the Ministry of Children and Family Development or in its care dies or is critically injured in unusual or suspicious circumstances.

Detail:

Clear criteria are required for when fuller reviews of those served by the system are to be conducted, and less reliance must be placed on narrow or paper-only reviews of the files.

Recommendation 5(c):

That the Ministry of Children and Family Development require that the methodology for Deputy Director's reviews of critical injuries and deaths be amended to include interviews with staff, family, caregivers and community members who can contribute information required for an effective review.

Recommendation 5(d):

That the Ministry of Children and Family Development share all case reviews with involved Ministry staff, families and caregivers of the child fully and promptly.

Recommendation 5(e):

That a version of the case review edited to preserve privacy be posted on the Ministry of Children and Family Development's website promptly after completion and subsequently aggregated into a semi-annual report.

Recommendation 5(f):

That the Ministry of Children and Family Development immediately post on its website summaries of each North region review, as well as reviews from all regions, completed since June 2007 for the public to review.

Detail:

Posted individual summaries should include:

- sufficient facts and circumstances of the case for the public to know what happened, without identifying the child or youth, including
 - date of death, type of death, age, services or support received
- practice matters identified and recommendations made
- steps taken to improve the system of supports where required.

Audits

Performance audits are likely to be the backbone of Ministry quality assurance activities, at least until new tools and methods have been implemented that are more in keeping with the Hughes Review. The audit process used by the Ministry very likely does not match the usual understanding or definition of an audit process, in that it is not rigorous, comprehensive, objective or regularized. The audit tools in use have not been externally evaluated and have not changed for many years. The investigation demonstrated that the Ministry's current audit program does not allow for a clear or objective understanding of practice on the ground and it must be thoroughly reviewed, strengthened and used to gauge performance of the Ministry's responsibilities to children and families.

In addition to the development of a robust audit program, better outcomes data for children is also needed for providing the full picture of how children are served and determining whether they are safe and well.

Recommendation 6:

That the Ministry of Children and Family Development immediately take steps to strengthen its audit program and report to the Representative for Children and Youth on progress by October 2008.

Details:

This should be done by:

- increasing the minimum number of files examined in any local office to ensure statistical confidence in results
- boosting the frequency of rotational audits to three years (including Delegated Aboriginal Agencies)
- conducting additional audits – annually and randomly choosing one on child protection and one on guardianship practice, in two local offices per each region
- sharing audit results and findings with staff
- requiring that senior management in the region sign off on all audits and each recommendation before forwarding to Ministry Provincial Office for aggregate analysis
- ensuring that each recommendation made is promptly implemented and evaluated to determine whether it has demonstrably improved local office performance
- adding the components of the plan of care, e.g. health and education as critical measures
- preparing semi-annual reports of aggregated audit findings to identify where results within and across regions are less than fully compliant with any applicable service standard
- ensuring that appropriate remedial action results from any finding of inadequate performance on each service standard
- documenting that remediation has proven effective in improving practice in annual public reports
- developing and implementing an audit tool to measure compliance to the quality assurance standards
- conducting an external evaluation of the audit process to identify how it can be strengthened to support better practice and meet provincial and professional standards for audit programs.

Reporting on children in care

When children are placed in the care of the Ministry of Children and Family Development, the Ministry implicitly assumes the responsibility to provide for the needs that are generally filled by parents. The available evidence does not allow a conclusion that these responsibilities are being adequately met. In particular, there is too little information in the public domain that key elements of child well-being, like achievement at school and treatment of observed health limitations and delays, are being attended to promptly and effectively.

It is ideal if the number of children in care decreases because they are safely placed with families or relatives who can and are meeting their developmental needs. However, Ministry strategies, that are interpreted by many as having an objective of decreasing the number of children in care, may have sometimes been used inappropriately and may have jeopardized children's safety. Preventing the factors that lead to a family crisis like child abuse and maltreatment, such as socio-economic disadvantage and addictions, and providing better knowledge and support for enriching environments for children are all laudable and vital strategies. A strong child protection system is also required for those children who are not safe.

The driver for strategies and performance measurement for the child-serving system must be the health, safety and well-being of children. The paramount consideration should be how the children are doing – not processes aimed at getting them out of the system in order to bring numbers down.

The current standard of reporting on children does not allow us to effectively determine how well they are doing, or whether they are being well-served when family placements or safe options are not immediately available, or whether out-of-care placements were suitable given their vulnerability. As Mr. Hughes suggested:

Recommendation 23: The Ministry should establish a comprehensive set of measures to determine the real and long-term impacts of its programs and services on children, youth and their families and then monitor, track and report on these measures for a period of time.

Reason: Measurements that are based on actual results will give the Ministry and the public a better understanding of the children and young people in its care, and what effects its programs are having on their lives (Hughes, 2006, p. 78).

Two years after this recommendation was made, these comprehensive measures have not yet been formulated. The evidence from the current investigation supports a conclusion that at least an interim step toward a more comprehensive program of reporting outcomes is essential. The Representative recommends that as an interim step, more robust and regular accounting for the children be commenced.

Recommendation 7(a):

That the North region of the Ministry of Children and Family Development begin to publicly report on the safety and well-being of children in care semi-annually. The first such report should be prepared by December 2008.

Detail:

These reports should include:

- progress at school, including receipt of support services geared to promoting academic achievement where needed
- participation in early childhood education
- health status, especially comprehensive assessments of possible delay and the provision of needed therapies and supports, in keeping with the recommendations made recently by the Canadian Paediatric Society
- preparation of comprehensive Plans of Care and Permanency Plans
- the number of face-to-face visits by guardianship workers in the preceding six months
- the number of moves while in care
- the proportion suffering a recurrence of maltreatment, and
- advocacy services sought and received.

Recommendation 7(b):

That the Ministry of Children and Family Development prepare the same semi-annual public report for children in the care of a Delegated Aboriginal Agency in collaboration with the Agency.

The need for improved public reporting on well-being is especially acute for the Aboriginal children who form some 70% of the North region's children in care. Demographic trends suggest that this cohort may increase. The region's success in dealing with Aboriginal children is a matter of the highest importance, and better reporting could very well be helpful in promoting better results for the Ministry, Delegated Aboriginal Agencies and all of those who support Aboriginal children. Reporting out to those who share the responsibility for the health, safety and well-being of Aboriginal children will help focus our efforts on changing what has been and continues to be an unacceptable situation.

Recommendation 7(c):

That the Ministry of Children and Family Development, beginning in September 2008, publicly report on key measures for Aboriginal children in care or receiving services by the North region.

Detail:

This reporting should include:

- the number of Aboriginal children in care receiving services
- Aboriginal identity of the children and notification to community (i.e, First Nations, band membership, Métis)
- the particular measures taken to ensure that the perspectives, support, and assistance of Aboriginal communities have been actively encouraged and used in the preparation of safety assessments
- measures to sustain cultural heritage, and preparation of plans of care for these children
- planning for the adoption of an Aboriginal child by a non-Aboriginal family and the cultural plan approved by the Exceptions Committee allowing the adoption of the child according to the Practice Standards for Adoption.

Recommendation 7(d):

That the Government of British Columbia, after community consultation, establish an Aboriginal Children's Council for the North region. This Council should provide a focal point for the analysis of the safety and well-being of vulnerable Aboriginal children, including Aboriginal children in care, in order to implement broad based and practical supports to improve their safety and well-being.

Detail:

The Council should:

- consist of representatives of First Nations and Métis governments, service providers and others from the main systems of support for children, including education and health
- include municipal representatives where appropriate
- be provided with detailed information as outlined in recommendations 7(a), 7(b), 7(c) and 7(d)
- have an explicit objective to consider more collaborative approaches to support better outcomes for the vulnerable Aboriginal children in the North region.

Partners

The Ministry of Children and Family has not been asked to achieve its goals and objectives without the support of other elements of the child-serving system. However, as the Multi-Disciplinary Team has observed, inter-agency communications and information-sharing were insufficient in the four cases in areas where better practice could have led to better outcomes.

Recommendation 8:

That the Ministry of Children and Family Development review in the North region each of its protocols with its partner agencies in the health, education and police systems, and ensure that they are up-to-date and meet the complex operational needs of information-sharing for child safety and well-being.

Health and medical care

The investigation has found that all four children, and in two cases their parents, had identified and unidentified medical needs that required fuller medical assessment and better ongoing treatment. Reasonable standards were not met. Similar findings have been identified in Ministry reviews and in investigations by the Coroners Service, the former Children's Commission, and the former Office for Children and Youth.

To improve planning and monitoring of the health status of children served and children in care, it is recommended that more consistent and regular medical follow-up occur whenever children are being assessed for any type of maltreatment – neglect, physical abuse, sexual abuse or emotional abuse. Because the impact of neglect can be more difficult to identify than injuries resulting from physical or sexual assault, it is imperative to obtain a full medical assessment of a child under investigation for neglect in the early stages of involvement with a family. When a child is admitted to care, early and continuing medical assessments of his or her immediate and future health needs will provide a more solid foundation for planning and ongoing monitoring.

The current Children in Care Standards do not provide discrete clinical guidance around the medical care of children in care. They are also silent on the medical requirements of children under investigation.

To be sure, in the North region there are geographic barriers to accessing medical expertise to detect maltreatment of children. Building and developing local area medical expertise is essential to support the investigative work of front-line social workers. Social workers, physicians, other health professionals and police should have ongoing training in the recognition of and intervention in child maltreatment.

Recommendation 9(a):

That the Ministry of Children and Family Development review standards of practice for children served and children in care to include explicit clinical guidance to Ministry staff regarding the health needs of children who are being assessed or who have been admitted to care for child maltreatment by October 2008 and to be implemented fully by April 2009.

Detail:

This guidance should promote comprehensive assessments including medical examination, assessment, and ongoing planning to address immediate and future health requirements.

Recommendation 9(b):

That the Ministry of Children and Family Development, when planning for children in care, include plans to meet the child's medical needs.

Detail:

Available health care providers should be identified and made intrinsic to this planning. New practice guidelines on the medical care of children would represent a useful clinical tool to support the standards.

Recommendation 9(c):

That the Ministry of Children and Family Development and the Northern Child and Family SCAN Clinic in Prince George update their protocol to improve collaboration, communication and planning for the children and families they both serve.

Detail:

Roles and responsibilities of each agency should to be set out in the protocol, especially to identify responsibility for follow-up, ongoing treatment requirements, and how disputes or differences will be addressed.

Recommendation 9(d):

That the Ministry of Children and Family Development, Delegated Aboriginal Delegated Agencies, the Northern Health Authority, and the Northern Child and Family SCAN Clinic evaluate the need for access to medical expertise on maltreated children, and develop and implement a plan to rectify any issues in this regard.

Detail:

This can be done through building capacity and expertise at the local SCAN clinic, and with local area family practitioners in the North region.

Recommendation 9(e):

That the Ministry of Children and Family Development, and the Ministry of Health jointly examine recommendations of the Canadian Paediatric Society cited in this report, and evaluate and report by October 2008 on any barriers or roadblocks to their full implementation, with a process update by July 2008.

Detail:

In doing so, the Ministries should consider involving leadership partners such as the British Columbia Medical Association and the College of Physicians and Surgeons of British Columbia.

The Canadian Paediatric Society recently observed:

Children and youth in foster care have higher than average medical, emotional, developmental and educational needs. These special needs are often chronic, under-recognized and neglected. There are many barriers to health care including lack of or inadequate medical records, lack of consistent care or follow-up due to temporary placements, and difficulty accessing services. There are no practice guidelines specifically designed to meet the health care needs of children and youth in foster care. Despite that most pediatricians will encounter foster children within their practices (CPS, 2008, p. 130).

The Society calls for more collaboration among child welfare staff, foster parents and natural parents to provide a more complete medical history of the child. The Society goes on to make a number of valuable recommendations, which, in partnership with the Provincial Health Officer, the Representative will promote vigorously in the child-serving system in the coming months.

The Representative fully endorses the recommendations made by the Canadian Paediatric Society, and finds them very relevant to this report:

1. Physicians should recognize that children and youth in foster care have a higher incidence of special needs including chronic medical conditions, mental health disorders, and developmental and academic delays.
2. Physicians should collaborate with child welfare professionals, foster parents, group home staff and, when appropriate, parents and family members to determine the urgency for assessment and to provide optimum health care to foster children and youth in Canada.
3. On placement in foster care, children and youth should have an initial medical visit, including a physical examination, to screen for and treat health conditions requiring prompt medical attention such as acute illness, infection, pregnancy or chronic conditions requiring medication and significant developmental delays or mental health disorders. The need for vision, hearing and dental screening should be assessed.
4. During the initial assessment, physicians should evaluate the infant, child or youth's need for screening tests such as complete blood count, ferritin, lead level, HIV, hepatitis B and C titres, b-hCG, cervical or urethral swabs for sexually transmitted infections, and Papanicolaou smear on a case-by-case basis. Routine ordering of tests is not recommended.
5. A follow-up medical visit should be arranged to review the medical history including immunization status, perform a complete physical examination, complete or review referrals for developmental and mental health assessments as required, and ensure dental follow-up has been arranged. Laboratory investigations that were part of the initial screen should be reviewed.
6. Physicians should be aware of and sensitive to the unique cultural, emotional, spiritual and physical needs of children and youth of all ethnic groups, including Aboriginals.
7. Physicians should evaluate the need for referral for psychoeducational assessment and support on admission and throughout foster care placement. This could include liaising with teachers, principals, special educators and tutors.
8. Physicians should partner with child welfare professionals to establish and maintain thorough medical records to provide consistent care and follow-up. Health care records should follow the child or youth throughout and beyond foster care placement.
9. Children and youth who are either currently or have previously been placed in foster care should be monitored more frequently than the general pediatric population.
10. Physicians should advocate for permanency planning including placement stability and personal intervention plans which establish a child or youth's long-term life goals.
11. Physicians should be aware of community resources to assist the fostering caregivers in the care of these special needs children and youth.

(CPS, 2008, p. 130-131)

Recommendation 9(f):

That the Ministry of Children and Family Development and the Ministry of Health provide a plan to implement the Canadian Paediatric Society recommendations cited in this report.

Coroners Service

In its processes to review the deaths of these four children, the Coroners Service has played an important role in fostering public accountability. However, for various reasons, its investigations and public inquests have not met the requirement of timeliness. Some of the delays in investigating child deaths were attributable to unique organizational challenges faced by the Coroners Service.

Many of the difficulties the Coroners Service faced in dealing with backlogged cases appear to have been related to shortcomings in legislation, for example, not being able to compel witnesses outside of the inquest process. Inadequate resources may also have been a contributing factor. After the Hughes Review's report and subsequent Chief Coroner's report on the 955 transition files, changes were put in place to rectify many of these difficulties. The Representative is aware from working closely with the Coroners Service that measures have been taken to strengthen the service and collaborate with other public bodies to provide an effective and timely review of child deaths.

Recommendation 10(a):

That the Coroners Service report more regularly on the status of its current investigations of child deaths.

Recommendation 10(b):

That the Coroners Service make public the criteria that are used to make decisions about whether or not to conduct an inquest into a child's death.

RCMP

The investigation of the deaths of Amanda, Savannah and Rowen by the police is not within the legislative mandate of the Representative for Children and Youth.

Major crimes expertise, with training in child injuries and deaths, must be immediately available throughout British Columbia when there is a suspicious death.

Recommendation 11:

That the Ministry of Public Safety and Solicitor General examine the feasibility of developing a specialized investigation resource to provide training, consultation and assistance to police investigating suspicious deaths of children.

Conclusion

The investigation into the deaths of Amanda, Savannah, Rowen and Serena has identified important lessons for the child-serving system. The legacy of these children must be that we learn those lessons, and move forward.

The legacy of these children's lives must be a better system.