REPRESENTATIVE FOR
CHILDREN AND YOUTH

So Many Plans, So Little Stability:

A Child's Need for Security

September 2011

September 13, 2011

The Honourable Bill Barisoff
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Mr. Speaker,

I am pleased to submit the report "*So Many Plans, So Little Stability: A Child's Need for Security*" to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of critical injuries and deaths of children receiving reviewable services.

Sincerely,

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Mr. Craig James
Clerk of the Legislative Assembly

Ms. Joan McIntyre
Chair, Select Standing Committee on Children and Youth

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Executive Summary

This is a report of the Representative for Children and Youth's investigation into the death of an infant. This First Nations boy died unexpectedly at the age of four months, on April 16, 2007. The Ministry of Children and Family Development (MCFD) and a delegated Aboriginal agency (DAA) were involved in planning for the care and custody of this infant before and during his short life. Planning began when the mother, in her mid-twenties, was in early pregnancy. Her two older children had been previously removed from her care.

The mother of the infant had extensive involvement with MCFD as a child and had herself been in the ministry's care. As an adult, the mother's involvement with MCFD and a DAA was as a result of concerns about her substance abuse and her ability to provide adequate care for her young children.

Despite the DAA and MCFD being involved in proceedings to obtain custody of two older siblings, neither the DAA nor the ministry took steps to intervene when private custody of the infant was applied for and granted to a relative by a family court judge.

The ministry had knowledge of the pending custody hearing, and yet no one from MCFD appeared to communicate the ministry's concerns or contest the application.

This was despite the fact that MCFD had repeatedly told this relative they would not support her custody application due to past child protection concerns, her alcohol use and the fact that the she did not have a consistent place to live. MCFD had also made repeated assertions that the infant would be removed if that particular caregiver was granted custody.

Beyond the mother's consent, there was no information before the court that would enable a meaningful assessment of whether the guardianship transfer was in the child's best interests. The court was not made aware of the ministry's concerns or that the infant had moved from home to home or that multiple placement decisions for the baby had been made and then abandoned.

The *Family Relations Act (FRA)* in British Columbia has not been revised in more than 30 years. For the past five years, B.C.'s Ministry of Attorney General has been reviewing this important statute. In this report, the Representative makes a recommendation that British Columbia follow Ontario's lead and introduce amendments to help ensure that court decisions regarding guardianship of a child are made with the advantage of critical information about the capacity and background of any proposed non-parent guardian.

Also in this report, the Representative makes recommendations calling for clearer direction for staff when good case management is put at risk because of unstable custody arrangements or staff changes, as well as for clearer accountabilities for Aboriginal child welfare services.

Following the custody hearing for this infant that granted legal custody to the relative, ministry social workers shifted their focus from a child protection-based approach to assessing the relative as a caregiver. It is of serious concern that the caregiver, who was informed by the ministry that she was an unsuitable caregiver for this infant due to historical child protection concerns, a criminal background and an unstable home, could then be deemed competent to care for the infant a few weeks later, despite no fundamental change in those facts.

The precise circumstances giving rise to the infant's death in April 2007 are unclear. There were different reports of the events by various family members and individuals who were involved in responding on the night of the infant's death.

Upon returning to the home that evening, the caregiver relative discovered the infant unresponsive. The baby was pronounced dead in hospital a short time later. The coroner classified the infant's death as a sudden unexpected death in infancy (SUDI). The fact that there is no demonstrable link in this case between the caregiver and the child's death does not minimize the concerns raised in this report. This case is illustrative of troubling issues involving the organization of services and represents another example in a disturbing pattern. Previous investigations completed by the Representative have identified similar issues.

In this case, many plans were made. Few were carried through. Sixteen social workers touched this case before the infant's death, as did lawyers and the family court. Eleven different placement decisions for the infant's care were made over a four-month period, ranging from the infant being cared for by various different relatives to the infant being brought into the legal care of the ministry. Most of these decisions were later abandoned. The infant's file was transferred between MCFD and the DAA five times. Generally speaking, interventions were episodic, and there was an overall failure to see the big picture.

In this report, the Representative makes a recommendation calling for clearer expectations and actions when good case management is put at risk because of frequent changes in custody arrangements, locations, child protection offices or workers.

The Representative cannot conclude, in this particular case, whether the death was preventable. However, it is clear that practice in this case generally fell below reasonable expectations. Case management was chaotic, and in many instances there was no observable logic to decisions that were made. This child's best interests were not adequately considered, and decisions made or not made, and the resulting system of supports and services were not child-centred.

The needs of vulnerable children must always be at the heart of any child-serving system. The challenge of the future is to continue to find better ways to coordinate responses and share information. The Representative urges all involved in the child-protection system to remain committed to examining ways to build a system of excellence, enhancing the ability of front-line individuals to make decisions based on their experience, knowledge and on-the-ground observations.

This investigation points to ways to help improve the child-serving system. Rather than descending into chaos and confusion when increasingly challenging issues appear in the life of a vulnerable child, a strong child-serving system must rise to function at its best in these dire situations. Change that results from individual reflection and systemic learning through these independent investigations by the Representative can eventually profoundly improve the lives of vulnerable families.

Introduction

The objective of an investigation by the Representative for Children and Youth is to examine whether the policies or practices of a reviewable service or public body may have contributed to the death or critical injury of a child.

A Representative's investigation looks at these key questions:

- What happened?
- How and why did this happen?
- Has anything changed as a result of this?
- What can be learned to prevent this from happening again?

There is a significant opportunity to learn from what happened during this infant's life. However, as must rightfully happen before beginning in-depth examinations of child protection issues, child protection workers and others on the front lines of the system must be given recognition for the immensely challenging jobs they take on.

The Hon. Ted Hughes, in his *BC Children and Youth Review*, applauded social workers for their "toughness, warmth, intelligence, compassion, decisiveness and determination." The Representative also expresses her genuine admiration for the individuals involved in this field. It is important to emphasize that although these investigations can understandably cause much concern and anxiety, the intent is not to look backward and examine whether the actions of individuals were ideal, but to consider whether they were reasonable in the circumstances at the time.

An examination of the systems within which these individuals work sometimes leads to criticism of how a specific case was handled. This is sometimes necessary to achieve the goals in the Representative's investigations – learning lessons that endure and ultimately result in system improvements.

The Representative also thanks the relatives and community members of this infant for their participation in this investigation.

In this report care has been taken to avoid identifying the infant and his family members by name or location. This is out of respect for the privacy of surviving members of this infant's family and community, and respect for the grief they have and undoubtedly continue to suffer. It is asked that others also respect their privacy.

The Representative's Legislative Context

On Dec. 11, 2007, the Select Standing Committee on Children and Youth referred this case to the Representative for Children and Youth for investigation under section 12(2) of the *Representative for Children and Youth Act (RCY Act)*. A thorough file review was undertaken. The infant and his family had received services from the ministry within the 12 months prior to the infant's death, and the infant's unexpected death had occurred in unusual or suspicious circumstances. Following the review, the Representative's investigation was initiated on Oct. 29, 2009.

A number of factors contributed to the length of time it took to complete the investigation, including complications in retrieving some critical records, the number of individuals and offices involved with the case in several communities and the associated challenges of arranging interviews.

In January 2011, the Representative released *Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Infants,* which was an aggregate review examining the deaths of 21 infants under the age of two years. Although the circumstances of the infant who is the subject of this investigation were aligned with the age, timeframe and characteristics of the infants included in the aggregate review, the Representative determined that the issues involved in this child's circumstances warranted an independent investigation.

The Representative is not a court of law and has no jurisdiction to make findings of legal fault. The fundamental purpose of the Representative's Office and Part 4 of the *RCY Act* is very different from that of a court. That purpose was concisely described in the *BC Children and Youth Review* ("Hughes Review"):

> *....In addition to any other investigations into a child's death by police, a coroner or in legal proceedings, we have the right to expect that every suspicious or unexpected death of a child in the child welfare system be reviewed in a timely, thoughtful and impartial manner, with a view to learning lessons that can guide protection, parenting and care giving practice in the future, so that similar tragedies can be avoided.*

Methodology

This investigation focused on a one-year time period – from April 2006, when the mother of the infant was in early pregnancy, to the days immediately following the infant's unexpected death on April 16, 2007, at four months of age. During the prenatal period, social workers from the ministry and a delegated Aboriginal agency (DAA) were involved with the family in planning for the child's birth and planning for who would be the primary caregiver for the child. The infant's mother was in her mid-twenties. The ministry and the DAA did not consider her to be capable of adequately caring for a new baby, and her other two children had previously been removed from her care.

Section 12 of the *RCY Act* outlines the basis for investigations. It places the focus of investigations on services and circumstances preceding a death. For this investigation, interviews were conducted with many members of the infant's extended family, MCFD front-line staff and regional management, and staff and management of the local DAA.

Interviews were conducted in accordance with Section 14 of the *RCY Act*, which empowers the Representative to order witnesses to appear and give evidence. Witnesses were sworn in and their evidence recorded. The Representative's investigation included 32 interviews.

The Child's Family and Community

The infant's mother and relatives resided primarily in four communities, one of which was on-reserve. The infant's mother and some of the relatives frequently moved among these communities.

The infant's mother was raised in a reserve community. The infant was a member of a First Nation that participates with other local First Nations in governing a DAA, which is further described later in the report.

The family's First Nations community continues to struggle with significant issues of addictions, violence, inadequate housing and intergenerational poverty.

The mother and her own birth family came into frequent contact with the ministry and other social service organizations over the years, and the mother herself was placed permanently into government care when she was an adolescent.

The infant's mother struggled with addictions, which affected her capacity to parent. Her older children were removed from her care a few years prior to the birth of the infant who is the subject of this report. During the period covered by the investigation the DAA was pursuing placement of the siblings in permanent care. In the year after the death of the infant the siblings were placed in permanent government care.

Chronology

Prior to the Infant's Birth

July – November 2006

On July 10, 2006, when the mother was about four months pregnant, a social worker with a DAA opened up a new intake in the mother's family service file. The social worker documented concerns regarding the mother drinking alcohol while she was pregnant. The file at that time also noted that the DAA was in the process of placing the other two children in the family in permanent government care.

At the time the DAA's intake was opened, the mother was living with a relative in a community off-reserve, which meant that the community was outside the DAA's jurisdiction and within the jurisdiction of MCFD. The DAA social worker consulted with the team leader for the DAA office, who contacted the MCFD office in the community where the mother was living and prepared to transfer the file. Two weeks later, on July 25, the mother's file was transferred from the DAA to the MCFD office.

On August 8, the file was assigned to an MCFD social worker. This social worker worked specifically with expectant mothers who were considered high risk. The MCFD region where the mother lived had a guideline social workers used when working with high-risk expecting parents (see Appendix C). The social worker made a number of attempts to contact the mother and was unsuccessful.

On August 28, the worker found out that the mother was back living on-reserve, which meant that the mother's file would have to be transferred back to the DAA office because the DAA had jurisdiction to provide services to families living in reserve communities included in the Delegation Agreement.

Delegated Child and Family Service Agencies

The ministry has a variety of initiatives underway to address the number of Aboriginal children in care. These include the development of agreements between the province and First Nations communities to return historic responsibilities for child protection and family support to Aboriginal communities. These agreements are known as delegation agreements.

Through delegation agreements, the Province gives authority to Aboriginal agencies, and their employees, to undertake administration of all or parts of the *Child, Family and Community Service Act (CFCS Act)*. The amount of responsibility undertaken by each agency is the result of negotiations between the ministry and the Aboriginal community served by the agency, and the level of delegation provided by the Director.

Source: Ministry of Children and Family Development

www.mcf.gov.bc.ca/about_us/aboriginal/delegated/index.htm

The DAA that was involved with this family was fully delegated. This means it was delegated under the *CFCS Act* to provide all child welfare services to children and families living on-reserve, including all aspects of child protection, and the authority to investigate reports and legally remove children and place them in government care.

The mother's file was not transferred back to the DAA until three weeks later, on September 18, because the DAA social workers involved with the case were on vacation. The high-risk pregnancy guideline had not been completed by the ministry when the file was transferred because the worker had been unable to make contact with the mother.

Family Group Conferencing

The family group conference, which is also known as family group decision-making, is one type of shared decision-making process for families who are receiving child welfare services. It is a formal meeting where members of a child or youth's family come together with extended family, close friends and members of the community to develop a plan for the child. A family group conference coordinator helps families to identify and invite people who will support them in developing a plan for their child. Family group conferences are designed to promote cooperative planning and decision-making and to enhance a family's support network.

Source: Ministry of Children and Family Development

www.mcf.gov.bc.ca/child_protection/mediation.htm

The DAA social worker consulted with her supervisor and was advised to meet with the mother to complete a comprehensive risk assessment and to apply the high-risk expecting parents' guideline to her work with the mother.

In a conversation with the social worker, the mother said that the father of the unborn baby had contacted her requesting to be involved in the child's life once the child was born but that she had not included him in her plans regarding the baby. However, when the father was interviewed for this investigation, he said that he had not been approached to take part in planning.

The following month, on October 13, a family group conference was arranged by the DAA to plan for the custody of the two older children. Ten days before the conference, the DAA had filed a court application to place the siblings in permanent government care. It is unclear why the DAA arranged the family group conference when they had already applied to place the siblings in permanent care.

A number of family members, the foster parents of the unborn infant's older siblings and social workers from the DAA attended the conference.

The outcome of the family group conference meeting was four different potential plans regarding the care of the siblings. The meeting also established that whoever became the caregivers for the siblings would also be the caregivers for the new baby at birth. The plans were as follows and were outlined in order of preference:

- Caregiver* A – one set of relatives, a couple, to apply for custody. A condition of that plan was that they seek drug and alcohol counselling and attend a treatment program.
- Caregiver B – a different relative to apply for custody.
- Caregiver C – another set of relatives, another couple, to apply for custody.
- Caregiver D – another family member to care for the children, but not seek custody, if the three other caregiver plans did not work out.

** For the purposes of this report, the term "Caregiver" is used to describe one or more people.*

The relatives would apply to the courts for custody under the *FRA*, the provincial law that governs child custody, guardianship and access between private persons. The ministry can only "trump" an order made under the *FRA* by taking child protection action under standards and procedures of the *CFCS Act*.

File information from the meeting also indicated that a court date for a hearing under the *CFCS Act* to place the siblings in permanent care would be scheduled in the next month. However, file information also noted that the long-term plan was for the mother to eventually resume care of all of her children, so it is not clear what the actual long-term plan was.

On October 18, five days after the family group conference, a social worker from the DAA met with the mother on the reserve in order to assess the risk to the child if it were to be in the mother's care after birth. File information indicates that the mother expressed some concern regarding the first plan for the children's care (Caregiver A), due to substance use by those relatives. The social worker's recollection of the meeting was that the mother said she planned to keep the baby but did not know where she would live and that her plans were very unclear.

Because the mother's plan seemed unclear, the DAA social worker decided to hold off on completing the assessment until the mother had a more concrete plan. The worker said that those issues could be left unresolved until closer to the birth of the baby. The worker said that she could not recall what planning occurred between that meeting with the mother and the baby's birth two months later.

On November 2, about two weeks later, DAA social workers learned that the mother had moved off-reserve and was living in a nearby community with an extended family member.

On November 8, Caregiver A, identified at the family group conference, submitted an application under the *FRA* for custody of the children. Nine days later a social worker from the DAA filed a reply to the application, disagreeing with the children being in the care of the Caregiver A, due to the relatives' substance use.

On November 17, the case was transferred again, this time to the MCFD office in the community where the mother had moved to and was residing.

On December 4, an MCFD social worker visited the home of Caregiver A. The purpose of the visit was to discuss the plan for when the baby was born. The mother was at the meeting and told the social worker that following the baby's birth, she planned to return to the reserve community to reside with the baby and Caregiver B.

The MCFD social worker thought that planning for the baby and management of the case was chaotic and didn't appear to be well thought out. Two days after that meeting, on December 6, the MCFD social worker consulted with a supervisor and was directed to follow the plan that the DAA had made as a result of the family group conference. It is not clear what direction the worker was told to follow.

The DAA social worker was the social worker responsible for the mother's other children who were in care at the time. The MCFD social worker informed the DAA social worker of the mother's plan to return to the reserve community with the baby and informed the worker that it meant that the mother would be again within the jurisdiction of the DAA.

On December 8, two days later, the DAA social worker informed the MCFD social worker that the baby would be placed with the relatives on reserve who had been identified as Caregiver C in the family group conference, and those relatives would make an application to the courts for custody under the *FRA*. It is not clear why the placement decision was shifted from Caregiver B to Caregiver C.

On the same day, the MCFD social worker consulted with a supervisor about this plan for the baby. The supervisor confirmed that the baby would not be removed at birth as a result of the DAA's support for the family plan to place the baby with Caregiver C relatives who would eventually apply for custody. The baby would only be removed if the mother did not comply with that plan.

The Infant's Life

December 2006

The baby boy was born on December 10, 2006. According to the birth records, he was healthy and no medical concerns were noted. The mother contacted Caregiver C relatives who were planning to care for the baby and informed them of the birth. These relatives came to the hospital and took the baby home to their remote reserve community. The

baby's mother also went with them, which was not part of the plan. The following day, Caregiver C relatives filed their court application for custody of the baby under the *FRA*. However, until that application was dealt with, the mother had legal guardianship of the child, subject to any removal by the ministry.

Two days after the baby's birth, the MCFD social worker consulted with a hospital social worker and learned that the baby had been discharged to Caregiver C and had returned to the reserve community with the mother. It is not clear why the MCFD worker contacted the hospital when the family's file was being managed by the DAA.

Less than a week later, the MCFD intake was closed because the baby was living with extended family on-reserve. Despite the mother also moving in with the relatives and the baby, the mother was not considered to have the infant in her care.

Rather than following the usual procedure of forwarding the intake to the DAA, MCFD closed the intake, citing a lack of jurisdiction because the mother and the baby had returned to the reserve community in the jurisdiction of the DAA. This was the fourth time jurisdiction of the file changed.

January 2007

About three weeks later, on January 8, an extended family member called the DAA to report that the relatives who were caring for the baby (Caregiver C), could no longer do so because they were having trouble managing the behaviour of the infant's mother.

In interviews for this investigation, the Caregiver C relatives who had been caring for the baby said the mother would show up inconsistently and the baby would get upset, and this worried them. They said that the behaviour of the mother and her substance abuse became too challenging for them and that they decided they could no longer care for the baby as a result.

While the baby was in their care, the relatives said that he was generally healthy but that they noticed he would vomit after each feed, more than what an infant would normally spit up.

Caregiver D called the DAA and said she had the baby and would care for him on a short-term basis. A social worker with the DAA opened a child protection intake on the mother's file to investigate the safety of the infant in the mother's care.

It is not clear why the decision was made to investigate whether the child was in need of protection when the mother had been informed previously that her baby would be removed if she was found to be caring for the child.

On January 9, when the baby was four weeks old, a meeting was held with the mother, two extended family members (including Caregiver D, who was caring for the infant at the time) and two social workers from the DAA. One of the social workers at the meeting was

the worker responsible for the baby's siblings. This worker reported that although she was involved in planning for the baby and was the worker for the baby's siblings, she did not have any contact with the baby and never actually saw him. It is not clear why.

The other social worker at the meeting was working to complete a field placement component of the social work training and had not yet received full delegation as a social worker under the *CFCS Act*.

According to file documents, another plan for the baby's care was developed as a result of this meeting. This new plan was that the baby would remain with Caregiver D until the investigation regarding the mother had been concluded. The mother was told by the social workers that she must not attempt to take the baby. The mother said she would stay with another relative and make an effort to attend counselling.

The two social workers at the DAA had different recollections of decisions arising from the meeting. One of the social workers said this plan was agreed upon so that the DAA would not have to remove the baby. But the other social worker said the family did not emerge from the meeting with any plan to care for the baby.

It is not clear why the DAA was continuing with efforts to avoid removing the baby, despite the number of breakdowns in the family planning process. It is also not clear how each worker could have a completely different understanding of the outcome of the same meeting.

The home of Caregiver D was located off-reserve. A decision was made by the DAA to transfer the file back again to the MCFD office.

The following day, on January 10, another member of the extended family contacted MCFD to report concerns about Caregiver D's ability to care for the baby. The caller reported that Caregiver D had health problems, that the baby's mother was living in the home and that the situation was too stressful for the caregiver.

In addition to caring for the infant, Caregiver D was also an approved foster parent for the DAA. As a foster parent, the caregiver had a social worker, known as a resource worker, assigned to her home. The resource worker was responsible for conducting home visits and assessing the fostering capacity of the home. It is not clear why, despite being cared for by a foster parent for the DAA, the file for the baby was not managed by the DAA.

The resource worker was interviewed for this investigation and was unable to recall whether she knew that Caregiver D was caring for the baby. That worker also indicated that although the caregiver had a good reputation as a foster parent, she had a number of serious health issues which frequently required her to be in the hospital. The resource worker also said that Caregiver D did not notify her that the baby was in her home.

Residential Resources Protocol

According to the Residential Resources Protocol between MCFD and the delegated Aboriginal agency (May 2008) a foster caregiver can choose to have their file managed by the DAA or the local MCFD office in their community. Management of foster homes is not geographically restricted by the homes being located on- or off-reserve in the same way that child protection services are.

Source: Ministry of Children and Family Development, May 2008

On January 11, one social worker from MCFD and one from the DAA visited the home of Caregiver D. The infant's mother was also there. Which agency was the lead at this home visit was unclear to all, because a file transfer had been discussed but not yet taken place. The MCFD worker thought she was going in a supportive capacity. This confusion may have been because she thought the file had been transferred to the DAA office and was no longer the responsibility of the MCFD office.

Caregiver D told the workers she was concerned that the baby was frequently spitting up and that she was also concerned about the type of milk the baby was being fed. She told the social workers that she needed assistance with learning how to care for the baby and that she was not confident in her ability. The caregiver also said that she did not have money to care for the infant.

The DAA social worker picked up the baby and noted a white film in his mouth, which the worker thought may be thrush. In response, the social workers advised the caregiver to take the infant to see a doctor and provided the caregiver with the contact information for the local public health nurse.

The MCFD social worker told Caregiver D that she may have to continue caring for the infant for a few months until another family group conference could be organized and another family plan could be developed. It is not clear why this was the MCFD social worker's direction, because Caregiver D had expressed a number of concerns about her own ability to care for the infant. The reason for the lack of urgency to find a suitable caregiver for the baby is also unclear.

Caregiver D agreed to continue caring for the baby in the short term. The mother was told by the social worker that she could not live in the home and that she needed to follow through with the agreed plan from their last meeting, which was that she would move into the home of another relative.

One week later, on January 18, Caregiver D informed the DAA worker that she could not care for the baby much longer. The DAA supervisor recommended that the ministry and DAA workers coordinate another family meeting to develop another plan for the baby's care.

Over the next 10 days, Caregiver D contacted the DAA and MCFD offices at least three times to request an update on when the family meeting would be. She informed the workers that she was becoming worn out and that she was having difficulty because the infant's mother was again residing in her home.

On January 29, Caregiver D contacted the DAA and reported that the infant was sick and that she had taken him to the hospital. The social worker who took the call was the worker for the baby's siblings. The worker reported that the caregiver sounded stressed but interpreted the purpose of the call as the caregiver calling for moral support and not needing any help or response beyond that.

The social worker did not respond further to the call. She said that she did not take action as she believed that Caregiver D would do what was required in order to care for the baby, because that was what the caregiver had said she would do when she agreed to care for him. The social worker also said that it was not necessary to respond to the caregiver's call because the baby was being cared for in a family-led plan and was not in the care of the DAA. At this time, the baby was seven weeks old, and he had been moved twice since birth.

The intake information indicates there was ongoing confusion regarding whether the DAA or MCFD was leading the investigation into the mother's ability to care for her baby. It is also unclear why the decision was made to investigate when it was previously decided that the mother could not adequately protect the child if he was in her care.

It was determined that the DAA would take the lead in the investigation and would contact MCFD if it became necessary to take the infant into care. It is not clear how this decision was made or why the decision was made to contact MCFD if the infant would be removed. The DAA was fully delegated at the time and had jurisdiction within the *CFCS Act* to take the baby into care if necessary.

During this period of time (between December 2006 and February 2007), three MCFD social workers in the local office had gone on various forms of leave from their positions, and there was turnover of supervisors. At the same time, there was turnover of supervisors at the DAA. In fact, during interviews for this investigation, some social workers at the DAA and MCFD could not recall who their supervisors were during the period of their involvement.

Also on January 29, the MCFD social worker contacted the Caregiver C relatives. These were the relatives who had cared for the infant immediately after his birth. The social worker asked that they take the baby back into their care. This was the seventh plan made for the infant in less than four months.

Caregiver C informed the social worker that they could not take the baby back into their care again but suggested another couple, also relatives, as potential caregivers. The couple, who resided on-reserve, had not been part of the family group conference or part of any of the planning until this time. This new plan (Caregiver E) would be the eighth plan made for the baby's care.

The DAA worker consulted with her supervisor, and it was determined that the file would again be transferred back to the MCFD office because the infant was currently residing off-reserve.

On January 31, Caregiver D reported to the DAA that the infant had been admitted to hospital the previous day and was sick with a fever in the intensive care unit. During the conversation, Caregiver D informed a worker at the DAA that another relative, a woman, had recently been staying with Caregiver D and had taken over caring for the infant. The relative (Caregiver F) intended to apply for custody of the infant when the infant was discharged from hospital. That relative had not been a part of the planning for the baby prior to this time.

The infant was diagnosed with cellulitis (a bacterial skin infection) and sepsis. While in the hospital, he had a temperature of 40.6 C and was described as drowsy and lethargic. He was treated with antibiotics and released on February 1 back into the care of Caregiver D.

February 2007

On February 1, Caregiver E (the new couple that had been suggested to care for the infant), contacted the DAA to discuss their plan to apply for custody under the *FRA*.

When these relatives were interviewed for the Representative's investigation, they said that they met with social workers from the DAA and MCFD to begin the process of applying for custody of the baby. The Caregiver E relatives also said that they had begun the process of obtaining criminal record checks and references from members of the community, and that one of the social workers had told them they would be notified of the date they would be required to attend court to have their application for custody of the baby considered. Since the ministry does not control *FRA* applications, it appears there was a misunderstanding or a miscommunication at this time, because it would have been unusual for a ministry worker to have notified the couple of the date of their applications. Further, a criminal record check is not required as part of an application for custody under the *FRA*.

The DAA social worker conducted a check into their history with the ministry and noted there had been contact eight years ago. The DAA worker informed the couple that in order to apply for the infant's custody, they would need consent of the infant's mother because she was the infant's legal guardian.

On February 2, Caregiver E submitted an application to the court for custody of the baby. The same day, Caregiver F, the relative who had recently begun providing care for the infant, also submitted an application for custody to the court.

That day, Caregiver D called the social worker to say that the infant's mother would not consent to the custody application made by Caregiver E and that she would only consent to the application by Caregiver F, the relative who had recently begun caring for the baby.

Also on February 2, the file was transferred back to the local MCFD office. This was the fifth time the file had been transferred in eight months.

On February 14, a risk assessment for the baby was completed by the MCFD social worker. The assessment noted that before MCFD would support the custody application made by Caregiver E, MCFD workers needed to complete a home visit and interview everyone living in the home. The assessment also noted that MCFD would remove the baby if Caregiver F was successful with her custody application. The overall risk rating of the baby was assessed as high.

Also on February 14, Caregiver F met with a social worker to discuss her custody application. This relative's own children had been removed in the past. The last child protection report was received in 2003, when her youngest child was 18 years old. In previous years she had applied twice to become a foster parent. One of her applications to become a foster parent in 1993 was not approved by MCFD because she had a lengthy police record, which included 14 criminal convictions. She made a second application 10 years later but did not complete the application process.

The worker informed Caregiver F that MCFD would not support her custody application due to past child protection concerns, her alcohol use and the fact that the she did not have a consistent place to live. The social worker entered this information in Caregiver F's file.

The social worker also informed Caregiver F that if her custody application was successful in court, MCFD would remove the baby from her custody. By this time, this plan was the eleventh plan made for the baby in four months.

The social worker told Caregiver F that for any family member to be considered, they would need to have a stable life for at least two years. The social worker consulted with the acting supervisor, who had been supervising workers in the office for approximately one month. The supervisor told the social worker that he had met with Caregiver F previous to this current meeting and that the relative had agreed to delay her custody application to allow MCFD time to assess whether she was a suitable caregiver for the baby.

The custody hearing took place on February 21 and was attended only by Caregiver F and her lawyer. The MCFD social worker recalled finding out about the hearing more than one week beforehand. However, the worker could not recall the source of that information. The worker did recall speaking with the MCFD legal counsel in the days before the hearing and recalled being advised that due to the mother's support for Caregiver F's custody application, the judge may approve that application even if MCFD did not support it.

Despite MCFD's non-support for Caregiver F's application and MCFD's stated warning to Caregiver F that the infant would be removed if she was granted custody, no one from MCFD appeared at the hearing, and the child was not removed either before or after the application was granted.

Later on February 21, Caregiver F contacted MCFD and reported that the judge had awarded custody to her by written consent of the mother, who did not appear in person at the hearing.

Caregiver E, the couple who resided on-reserve and had also submitted an *FRA* application for custody of the infant, said they received a message on their answering machine from a worker with the DAA informing them that the hearing was the same day. They were both out of the home at the time and didn't receive the message until later in the day. By then, custody of the baby had been granted to Caregiver F.

The transcripts of the custody hearing indicate that Caregiver F's custody application proceeded very rapidly. As noted, Caregiver F and her lawyer were the only people present at the hearing. The lawyer informed the judge that he had only met his client that morning. The mother of the infant did not appear, though the judge had the mother's signed consent supporting Caregiver F's application.

The transcript shows that Caregiver F's suitability or adequacy as a caregiver was not an issue addressed at the hearing. The entire matter was decided based solely on the consent of the mother. The judge gave Caregiver F discretion in determining reasonable access to the infant by the infant's mother.

As part of the MCFD child protection investigation arising from the child being in the care of Caregiver F, which began prior to the *FRA* custody hearing, the MCFD social worker and the acting supervisor reviewed that relative's history with the ministry. It was noted and considered significant that five years had elapsed since MCFD had been involved with the relative in a child protection capacity. The fact that the relative's youngest child had become an adult five years prior did not appear to have been considered as an explanation for the lack of current involvement.

The acting supervisor told the worker that some of the intakes on Caregiver F's file were not serious. In light of this information and the fact that Caregiver F was residing with the infant in a home which was approved as a foster home (Caregiver D's home), the supervisor suggested that the worker conclude the child protection investigation of Caregiver F and instead assess her as a caregiver. The worker recalled that the plan was then to complete a background check, a criminal record check and obtain references and assess the relative in accordance with the MCFD Out-of-Care Providers Guide. The reason for the decision to assess Caregiver F as a "caregiver" is unclear given that Caregiver F now had full legal custody. There was nothing for the ministry to "approve" unless it was prepared to take child protection action.

On February 23, two days after Caregiver F received custody of the child, the MCFD social worker visited the home. At the visit, Caregiver F provided consent for a criminal record check and background check. She told the social worker that she had no concerns regarding her past and that at one time she had worked for the DAA. This information could not be confirmed during the Representative's investigation.

The other relative in the home (Caregiver D) reported that there were no concerns regarding Caregiver F's ability to care for the infant. The relatives informed the social worker that the baby had seen the doctor that day and was determined to be healthy.

On February 28, MCFD received a letter of reference in support of Caregiver F. The letter was written by a professional in the community who had known her for about six weeks. A second reference was later obtained over the phone by the MCFD social worker. That reference was provided by an employee of the DAA who said that the relative had babysat children about five years prior and that no concerns were noted at the time.

The MCFD social worker conducted a check of Caregiver F's criminal background and found a criminal history which dated back many years and included theft, assault, failure to appear, breaches of probation orders, operating a motor vehicle while disqualified and being unlawfully in a dwelling. The last criminal charge had been eight years prior.

March 2007

According to the file, on March 15 the MCFD social worker visited the home of Caregiver D, where Caregiver F lived with the infant. The social worker noted that the baby appeared content and was sleeping in a crib in a bedroom. The social worker reviewed the caregiver's criminal record information with her, and the relative stated one of the charges, for assault, had not happened, and she planned to check into it. Caregiver F also reported that she was on a waitlist for her own house.

April 2007

On April 3, the MCFD social worker concluded the investigation of Caregiver F and determined that there were no protection concerns regarding the infant while in her care, as long as the infant and Caregiver F resided in the home of the other relative, who had the approved foster home. There was no mention of the fact that Caregiver F planned to move to her own house. The social worker determined no services were required.

Further, the MCFD acting supervisor approved Caregiver F as a caregiver using the approach outlined in the "Assessing Suitability for Out-of-Care Care Providers" document. File information does not indicate why the relative was approved as a caregiver. However, the acting supervisor indicated during the interview for the Representative's investigation that the five-year period of time in which Caregiver F was not involved with MCFD was a significant factor in the approval.

The acting supervisor also said that MCFD relied on the information gathered to date by the DAA since the DAA had the most recent involvement with the baby and his family. The DAA information did not indicate any concerns for the baby in the care of that caregiver. On April 4, Caregiver F's file was closed.

Sometime during the following week, Caregiver F moved with the baby to a different community to live with other relatives. The baby died on April 16, 2007, 12 days after the MCFD file was closed.

Circumstances of the infant's death

According to Caregiver F, the baby was unusually cranky after his dinner feeding on the evening of April 16. She said the infant wouldn't take a bottle and after being held for a while, he slept briefly, awoke and fell back to sleep around 8 p.m.

Caregiver F said the infant was placed in the bassinet where he normally slept. The infant was placed on his side because he had been throwing up earlier that day, and the caregiver was concerned.

The caregiver said she then left to go to the grocery store. Two adults and three children were at home with the baby, but it is not clear whether anyone was specifically left in charge of looking after him. Caregiver F said she was out of the home for 15 to 30 minutes.

She said that when she returned home, she put groceries away, went upstairs to check on the baby and found him lying on his stomach. He was, she said, a blue colour. She said she moved him to the bed and began CPR, and then told one of the relatives in the home to call 911.

There were different reports of the events by various family members and individuals who were involved in responding on the night of the infant's death. It is not clear what time Caregiver F left the home, how long she was away from the home or where she went when she left the home.

The fire department and ambulance services arrived and took the baby to hospital. Police were notified by ambulance personnel that the infant was being taken to the hospital. A police officer attended the hospital and observed the efforts to resuscitate the baby. That officer requested a second, more senior officer to also attend.

While resuscitation efforts continued, the first officer to arrive at the hospital spoke to Caregiver F. The officer said that she appeared "visibly distraught" and also said that there was no attempt to take a formal statement from Caregiver F because she appeared too distraught at the time. The officer could not recall speaking to Caregiver F again. This infant's death was the first child death the police officer had experienced.

BC Coroners Service

It is the responsibility of the BC Coroners Service to confirm the identity of the deceased and investigate the circumstances of the death — the how, when, where and by what means. A Coroner is a quasi-judicial investigator, independent from all law enforcement agencies and health authorities. Coroners come from a range of backgrounds, including medical, legal, investigative and social sciences.

When a death is reported to the Coroner, he/she has the authority to collect information, conduct interviews, inspect and seize documents, and secure the scene. The Coroner will determine the identity of the deceased and the cause of death and will classify the death as natural, accident, suicide, homicide or undetermined.

The facts, as determined by the Coroner's investigation, are released in a written Coroner's report which incorporates information from all agencies involved in the death and also contains the findings of the autopsy.

The Coroner does not assign fault or blame, but conducts a fact-finding investigation into deaths that are unnatural, unexpected, unexplained or unattended.

Source: The BC Coroners Service

www.pssg.gov.bc.ca/coroners/about/docs/coroner-role-english.pdf

The baby was pronounced dead within an hour of arriving at the hospital. An attending pediatrician and the second senior officer viewed his body. No visible signs of physical trauma or injury were observed. The attending physicians called the on-duty coroner to report the baby's death.

The police officers informed the coroner by phone that they thought the infant's death was not suspicious, based on their observation of his body and the caregiver's emotional distress. Information had also been provided by a second person at the hospital with the caregiver, which the officers believed was consistent with information provided by the caregiver.

The coroner told the physicians that he did not think it was necessary to attend the scene and view the body of the infant and said that arrangements would be made the following day for an autopsy. The coroner also told the physicians that based on the information provided on the phone, the infant's death would not be considered suspicious. At that point, police closed their investigation.

The following day, a different coroner contacted MCFD's After Hours service and informed them that she was investigating the infant's death. The coroner requested that a social worker come with her to the home where the infant had resided in order to assess the safety of the other children living in the home.

The After Hours worker looked up the information regarding the family and took note of the recent ministry involvement in the previous community where the caregiver and baby had lived.

That evening, nearly 24 hours after the infant's death, the coroner, a police officer and an MCFD After Hours worker went to the home. The police officer's understanding was that he was attending the home in a supportive capacity to the coroner and that he was not there to investigate the details of the infant's death as a criminal matter. The After Hours worker recalled that Caregiver F's recollection of the timeline around the infant's death was inconsistent with that of other residents in the home and also inconsistent with the recollection of a neighbour.

Sudden Unexplained Death in Infancy

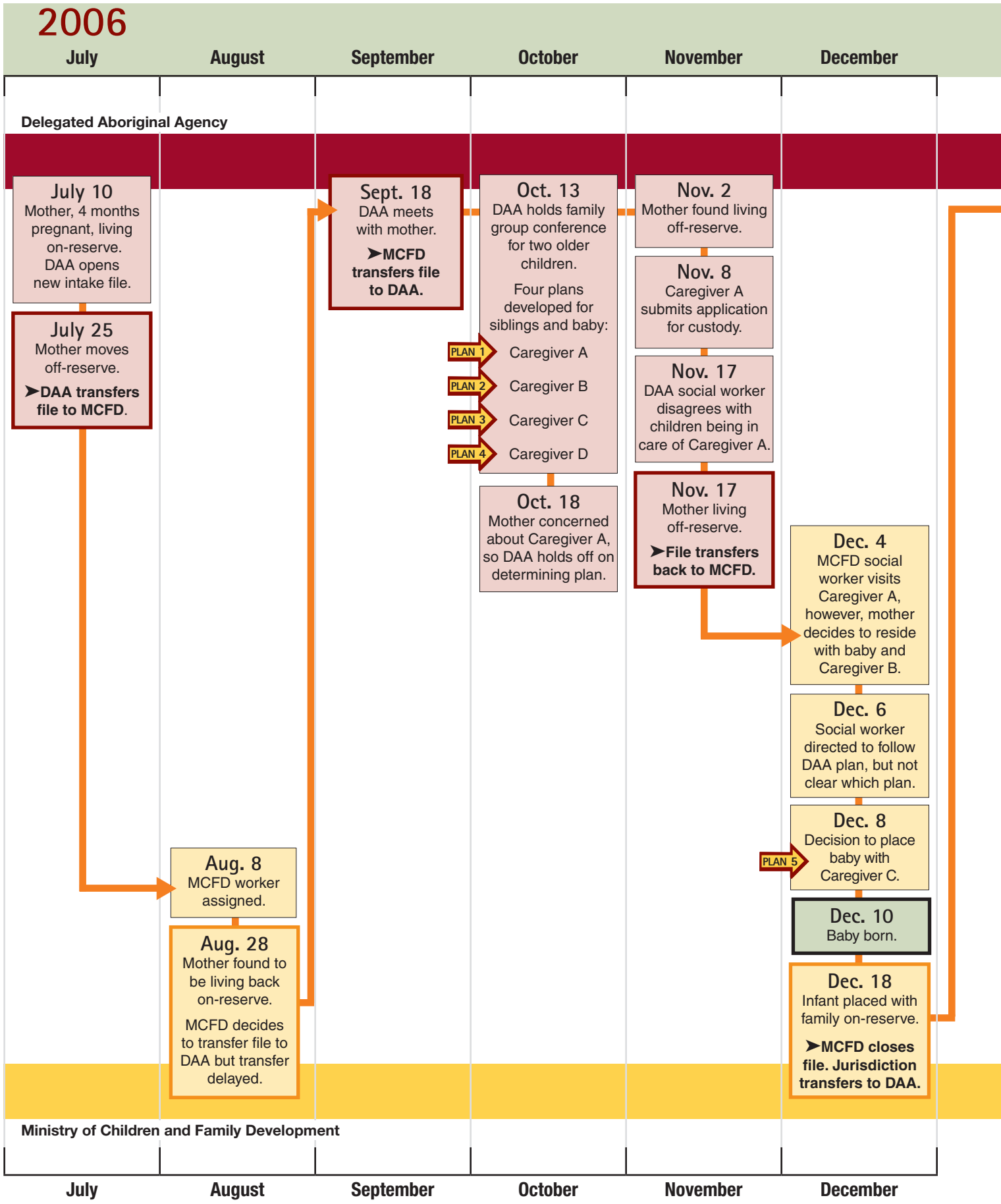
In 2004 the Coroners Service adopted the term "sudden unexplained death in infancy" (SUDI), also called "sudden unexpected death in infancy," to reflect the sudden, unexpected and unexplained death of an infant under one year of age where there is no anatomical cause of death at autopsy, but known external risk factors are identified that could have been contributory to the death. Examples of risk factors include sleep position, sleep environment and sleep surface.

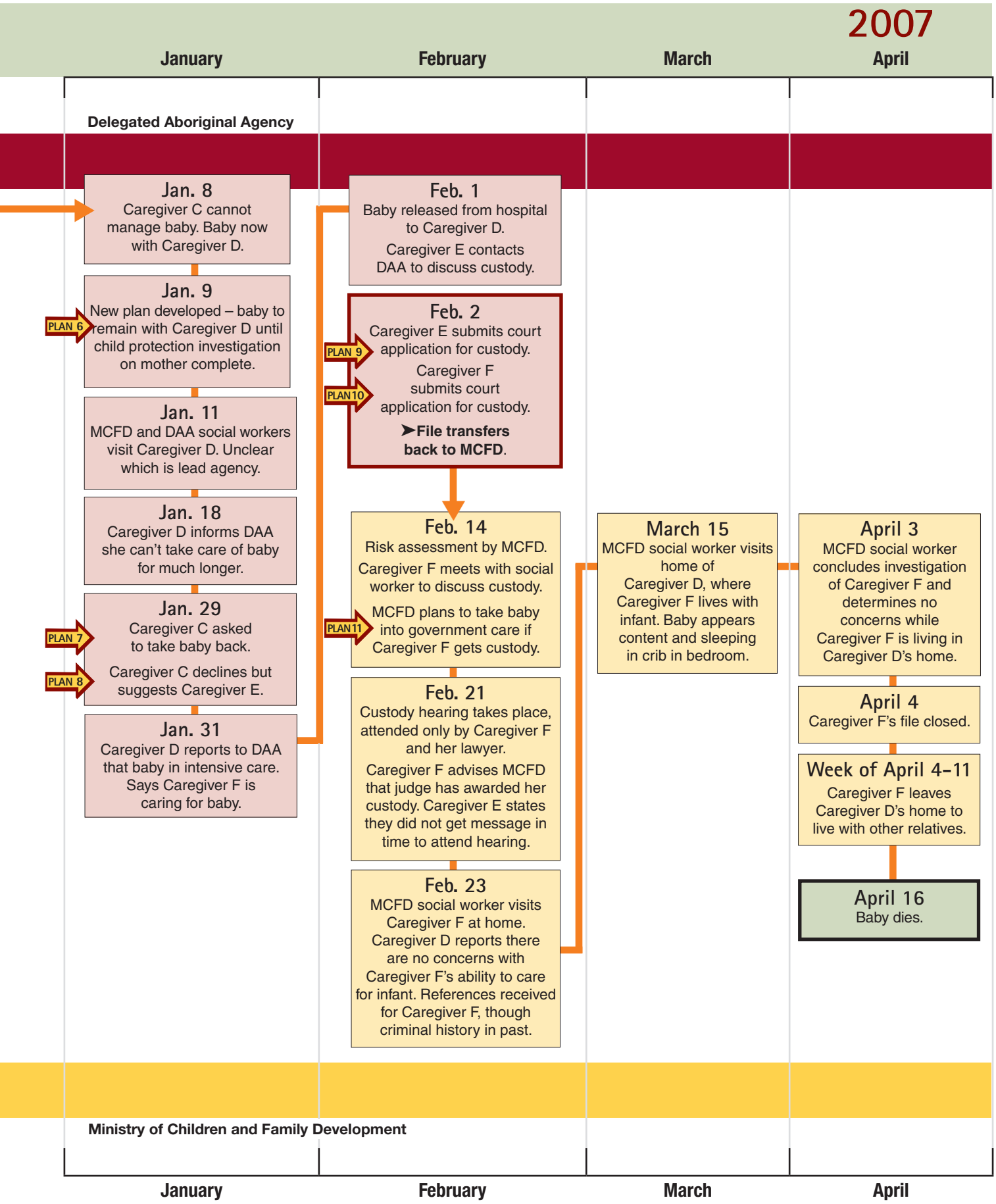
When they spoke to Caregiver F, she said she had been caring for the baby for the past three months and that she had moved with him to this home three weeks earlier. She said she usually shared the same bed with the baby, but on the evening of the death, she had placed him to sleep in a crib. According to the coroner's investigation, the baby had been placed to sleep in a wooden crib with a blanket folded on the crib bottom, in place of a mattress.

A post-mortem examination was conducted. The pathologist found evidence of middle ear infection and patchy bronchopneumonia. Though not considered sufficient to have caused the infant's death, they were determined to be contributing factors. The coroner classified the infant's death as a sudden unexpected death in infancy (SUDI).

Despite interviews with Caregiver F, the residents of the home, police investigators and MCFD staff and an analysis of the coroner's file information, the circumstances regarding the infant's death remain unclear to the Representative.

Timeline of Significant Events




2007
January
February
March
April
Delegated Aboriginal Agency
Jan. 8
Caregiver C cannot manage baby. Baby now with Caregiver D.
Jan. 9
PLAN 6
New plan developed – baby to remain with Caregiver D until child protection investigation on mother complete.
Jan. 11
MCFD and DAA social workers visit Caregiver D. Unclear which is lead agency.
Jan. 18
Caregiver D informs DAA she can't take care of baby for much longer.
Jan. 29
PLAN 7
Caregiver C asked to take baby back.
PLAN 8
Caregiver C declines but suggests Caregiver E.
Jan. 31
Caregiver D reports to DAA that baby in intensive care. Says Caregiver F is caring for baby.
Feb. 1
Baby released from hospital to Caregiver D.
Caregiver E contacts DAA to discuss custody.
Feb. 2
PLAN 9
Caregiver E submits court application for custody.
PLAN 10
Caregiver F submits court application for custody.
➤File transfers back to MCFD.
Feb. 14
Risk assessment by MCFD.
Caregiver F meets with social worker to discuss custody.
PLAN 11
MCFD plans to take baby into government care if Caregiver F gets custody.
Feb. 21
Custody hearing takes place, attended only by Caregiver F and her lawyer.
Caregiver F advises MCFD that judge has awarded her custody. Caregiver E states they did not get message in time to attend hearing.
Feb. 23
MCFD social worker visits Caregiver F at home. Caregiver D reports there are no concerns with Caregiver F's ability to care for infant. References received for Caregiver F, though criminal history in past.
March 15
MCFD social worker visits home of Caregiver D, where Caregiver F lives with infant. Baby appears content and sleeping in crib in bedroom.
April 3
MCFD social worker concludes investigation of Caregiver F and determines no concerns while Caregiver F is living in Caregiver D's home.
April 4
Caregiver F's file closed.
Week of April 4–11
Caregiver F leaves Caregiver D's home to live with other relatives.
April 16
Baby dies.
Ministry of Children and Family Development
January
February
March
April

Analysis and Recommendations

Overall Finding

Although this investigation finds no evidence that links this baby's death to the care he received, it does report on troubling inadequacies in planning, case management and decision-making. The focus was not on the needs of this infant, and there was no observable logic to what happened. There was a systemic failure to consider what was in his best interests and limited consideration of the safety, stability and consistency required for a newborn to thrive. Instead, chaos and confusion prevailed throughout his short life.

Child Welfare Practice

Finding: ***Practice in this case generally fell below reasonable expectations. Case management was chaotic. Numerous plans came and went, and as a result, there was no observable logic to decisions that were made.***

Social workers with the DAA became aware of the mother's pregnancy when she was about three months pregnant. On a number of occasions during her pregnancy the mother was advised that if the baby was found in her care after the birth, the ministry would take the baby into care. However, file materials stated that the long-term plan was that the infant and the two siblings would eventually be returned to the mother's care at some point, despite the fact that the DAA was actively engaged in a court process at that time under the *CFCS Act* to have the siblings brought into care permanently.

It was also confusing that social workers made efforts to complete a risk assessment to determine the risk to the baby if the baby were to be in the care of his mother. This work was done despite the mother being told numerous times that MCFD did not consider her capable of caring for any of her three children. One would not expect them to have told her that unless a risk assessment was already complete.

Following the infant's birth, he was taken by relatives to reside in a remote community. The mother also went to live in the same home. This arrangement quickly broke down. Despite this information, social workers did not follow through on the previously stated plan to remove the infant.

A relative then agreed to become the temporary caregiver for the infant. The mother also moved into this relative's home with the infant. In response, the ministry began an investigation to determine the risk to the child in the mother's care. It is unclear why this

decision was made when the ministry had already informed the mother that the infant would be removed if he was found in her care and had already drawn conclusions about her capacity to adequately care for the child.

Despite knowing that the infant's mother was residing in the relative's home after being told not to, neither the DAA or MCFD did anything about it. The mother continued to be told by workers not to care for her infant, yet no action was taken when workers became aware that she was living with the infant. It appears that the ministry and the DAA were operating as if the risk to the child was diminished as long as other adults were present in the home.

In a three-week period, seven phone calls to the DAA and MCFD were made by Caregiver D herself and family members regarding Caregiver D's challenges in caring for the infant. However, another placement was not arranged, and no viable plan was put into place. Decision-making for the child was left up to the family without any helpful guidance or direction from the DAA or MCFD.

During the period of time covered by this investigation, the DAA was pursuing formal court applications under the *CFCS Act* to place the mother's two older children in permanent legal custody of MCFD. In fact, the application to obtain permanent custody of the two siblings was dated two weeks before a family group conference was held. It is unclear why two opposing child protection approaches were used for a sibling group and why there was no effort made to keep the three siblings together.

The importance of maintaining a child's ties to his or her family is set out in the guiding principles of the *CFCS Act*, and this should be the primary consideration as long as those ties support the child's safety and well-being. The *CFCS Act* also states that the safety and well-being of children are to be the paramount considerations.

Section 2 (a) of the *CFCS Act* states that "children are entitled to be protected from abuse, neglect and harm or threat of harm."

During the four months of this infant's life, 11 different decisions about his placement had been made. By the time of his death at the age of four months, he had resided in three different communities and had been in care of four different groups of relatives. The infant was vulnerable even before birth. Inconsistency in caregivers, multiple moves and lack of stability increased his vulnerability.

Jurisdiction over this case transferred five times between MCFD offices and the DAA.

In November 2006, the MCFD region where this child resided implemented a policy called Transferring Services under the *Child, Family and Community Service Act.*

Part 11 of the policy states:

> *When a child and family are transient (move more than once every three months or more over one year) within the region, an identified social worker will maintain case management responsibilities until the family maintains a stable residence for a minimum of six months. The team leaders (supervisors) having the most recent involvement with the family will consider where the family has best been established and decide which district office will manage the case. The purpose of this policy is to promote continuity of services, avoid disruption of planning and the loss of information that can occur with frequent file transfers.*

This policy clearly indicates the ministry's awareness of the consequences of numerous file transfers. However, the policy was not followed in this case. The ministry's internal review of the child's death did not refer to this policy, and while it noted that the "numerous file transfers resulted in the work being focused on concerns related to jurisdiction...which detracted, to some extent, from the focus on child protection and collaborative planning with the family," it placed responsibility for the number of file transfers on the "transient lifestyle" of the mother.

One of the social workers pointed out that the people of the First Nation that this infant and his family were from tend to move frequently between homes of their family members. The worker indicated that during a file transfer, "things really get lost" and suggested greater cooperation between MCFD and DAAs, rather than multiple file transfers, would result in improved services for vulnerable families.

A second social worker stated that any time there are file transfers and transitions between workers and offices, there are time delays, and information is missed.

A third worker commented that "transition points are terrible." This worker also said that even four years after the child's death, "there is never a key worker" with responsibility for a vulnerable child and/or family case file.

A fourth social worker stated that there is an "us and them mentality" that existed at the time and continues to exist between the DAA and MCFD offices. The social worker also said that this negative working relationship between the two agencies has a detrimental effect on the efficiency of file transfers and the overall service to children and families.

The MCFD internal review concluded that planning, responsiveness, decision-making and services were consistent with MCFD legislation, policy and service standards, yet found that the focus on planning and assessment for the infant was lacking and that the focus was on the family's needs "over the needs and best interest of [the infant]."

In simple terms, this conclusion just doesn't make sense. No reasonable child-serving system sets out to lose children in a chaotic and bureaucratic web.

The Representative does not accept that this case was conducted in a manner consistent with the intention of legislative and policy requirements, particularly when the guiding principles of the legislation clearly state that the "Act must be interpreted and administered so that the safety and well-being of children are the paramount considerations."

Two MCFD offices and a DAA were involved in the planning for the care of the infant, both during the prenatal period and after the child's birth. In this context, it was especially important that the policy regarding file transfers was followed. Yet certain realities regarding ministry and DAA staffing made it extremely difficult to follow this policy, even if it been considered important. It is important to understand the context of the MCFD and DAA offices during this time.

In the MCFD office that had the most involvement with the infant, one social worker and three supervisors were associated with the file. Two of those supervisors were in "acting" positions. Five of 12 social workers on staff in that office were on some form of leave or vacation from the time of the infant's birth until his death, a period of four months.

In the other MCFD office, one social worker and five supervisors were involved. Three of those supervisors were in "acting" positions.

In the DAA, three social workers and two supervisors were involved with the file. During this period, there were frequent changes and turnover in supervisors at the DAA. One worker said that in a 1½ -year period, there had been at least four different supervisors. This worker also indicated that staff turnover in general was a significant issue within the DAA.

A total of 16 social workers were involved with this infant and his family in the 12-month period from before he was born until he died. Five were acting in supervisory positions. Any one worker would have required immense focus and attention to this case to maintain even basic knowledge of it, considering all the changing factors and individuals involved. The involvement of a revolving door of workers was a recipe for an inconsistent and ineffective response. With this number of individuals in and out of case management, it would not have been practically possible for them to remain focused on the needs of this vulnerable infant, let alone to really understand the dynamics of the case.

Directors of child welfare in each region are presently accountable to the Provincial Director and ultimately to the Minister. The system would have had more safeguards and it would have been more likely that a single, coordinated plan would have been developed if one director had been overseeing the case.

The confusion that resulted from numerous file transfers in this case points out a weakness in division of accountabilities between MCFD and the delegated agencies, which did not serve the best interests of this infant.

Recommendation 1

That MCFD make necessary organizational changes to establish clarity of accountabilities for child welfare services delivered by delegated Aboriginal agencies.

Details:

- Each regional director of child welfare should be responsible for the delegated agencies in the region.
- The role of the headquarters Director of Delegated Aboriginal Agencies should be to coordinate and facilitate communications, policy and training and standards for delegated Aboriginal agencies across the province.

Organizational changes should be implemented by March 16, 2012.

Recommendation 2

That MCFD take concrete steps to ensure that staff have clear direction to ensure effective case management when children move between communities/offices due to unstable custody arrangements or family relocations, or where there are frequent staff changes.

Details:

MCFD should consider the following in addressing this recommendation:

- building on the 2006 MCFD policy titled Transferring Services under the *Child, Family and Community Service Act*
- the needs and well-being of the child take precedence over jurisdictional issues
- the Director's authority, as outlined in the *CFCS Act*, governs all transfers, including those involving delegated Aboriginal agencies
- consistency of practice across offices and regions
- specific triggers for immediate review and planning, and who has responsibility for leading those processes
- an evaluation process to determine whether steps taken are resulting in improvements in practice.

This recommendation should be fully implemented by March 16, 2012.

Legal Custody of the Infant

Finding: ***The infant's best interests were not given sufficient consideration when custody decisions were made.***

The *Representative for Children and Youth Act* does not limit the Representative to making recommendations to the public body whose services prompted the investigation. Consistent with the reality that numerous public systems have the potential to affect the safety and well-being of children, an investigation report may also make recommendations to "any other public body, director or person that the representative considers appropriate.": s. 16(4)(a)(ii).

What follows is a recommendation to the Attorney General. Nothing in what follows is directed to, or intended as a criticism of, any court or judge.

The *FRA* expressly states that when an order is made transferring custody from one private person to another, the best interests of the child are paramount:

Best interests of child are paramount

24 (1) When making, varying or rescinding an order under this Part, a court must give paramount consideration to the best interests of the child and, in assessing those interests, must consider the following factors and give emphasis to each factor according to the child's needs and circumstances:

- *(a) the health and emotional well being of the child including any special needs for care and treatment*
- *(b) if appropriate, the views of the child*
- *(c) the love, affection and similar ties that exist between the child and other persons*
- *(d) education and training for the child*
- *(e) the capacity of each person to whom guardianship, custody or access rights and duties may be granted to exercise those rights and duties adequately*

(1.1) the references to "other persons" in subsection (1) (c) and to "each person" in subsection (1) (e) include parents, grandparents, other relatives of the child and persons who are not relatives of the child.

(2) If the guardianship of the estate of a child is at issue, a court must consider as an additional factor the material well being of the child.

(3) If the conduct of a person does not substantially affect a factor set out in subsection (1) or (2), the court must not consider that conduct in a proceeding respecting an order under this Part.

(4) If under subsection (3) the conduct of a person may be considered by a court, the court must consider the conduct only to the extent that the conduct affects a factor set out in subsection (1) or (2).

Despite this legal requirement, the *FRA* does not give judges the necessary tools to make a meaningful decision regarding the child's best interests, particularly where custody is being transferred from a natural parent to a non-parent by consent. The *FRA* does not require information to be given to the court about the potential non-parent caregiver's capacity to provide adequate and safe care in the child's best interests, including that person's criminal history or involvement in prior child protection proceedings. Nor is there a mechanism for the court to be told that there are active child protection proceedings in play involving that child or siblings of that child.

As this case demonstrates, a simple written "consent" is all that is required for child custody to transfer from a parent to a non-parent. It is hard to avoid the conclusion that this approach to transferring custody makes it seem like a child is a piece of property rather than a person whose best interests are to be considered before a guardianship decision is made.

Adults working with children in schools, sports teams and community organizations are required to undergo criminal record checks before they will be allowed to work or volunteer with children. Yet the law provides no similar requirement before the court makes the much more profound decision to change a legal guardian. In fact, it allows a court to transfer a child's custody from one private person to another private person with no requirement that the court be informed by the parties, the ministry or even existing court records as to whether the "receiving" person, even if a non-parent, has a criminal record or a history of child abuse or neglect which may impact on child safety.

Some might take the view that courts do not need all this information, because if there is a child protection concern, the ministry will act. In the Representative's view, that response is inadequate. It ignores the "best interests" test in the *FRA* and it ignores the reality that it is impossible for the ministry to be aware of, let alone fully respond to, all child protection concerns. In the Representative's view, if a person, especially a non-parent, is applying for private custody or guardianship of a child, the least that person should be required to do is to put sworn information before the court regarding a criminal history and any past or present involvement in child protection proceedings.

None of the information known to the ministry was placed before the court. Apart from the written consent of a mother not capable of caring for the child, none of the information relevant to a child's best interests, or even the child's safety, was before the court.

The ministry was so concerned about the relative's ability to care for the infant to the degree that they threatened to remove the infant if the custody application was successful. Despite their concerns as well as their knowledge of the hearing, no one from the ministry appeared before the judge to communicate the ministry's concerns or contest the relative's application.

Following the custody hearing, MCFD was operating as if it had jurisdiction under the *CFCS Act*, when in fact private custody had been granted under the *FRA*. MCFD efforts to complete checks and assess Caregiver F after the custody hearing, as if Caregiver F were being approved as a ministry resource, were futile when Caregiver F now had full legal custody. These actions on the part of MCFD are also unexplainable because they had previously assessed Caregiver F as an unsuitable placement for the baby.

Guardianship includes the full bundle of parental responsibilities and decision-making affecting all aspects of a child's life and all aspects of that child's emotional, physical and psychological health and well-being. Therefore, decisions made by the court with respect to guardianship of a child must be made with the advantage of all available information regarding the capacity and background of the proposed guardian. The child's best interests must be primary, and full information is required in order for that principle to be implemented.

Currently, Section 8 of the *FRA* allows for the court to join matters which fall under other legislation, prior to hearing the *FRA* matter or at the same time. Under Section 8, the court may hear the matters together or place the *FRA* matter on hold until the matter within the other legislation is heard or decided upon.

In this case, had MCFD pursued removing the child, it would have provided an opportunity for the child protection concerns to be brought forward to the court. Then, the judge presiding over the custody hearing could have held the matter over until the child protection matter had been heard. Alternatively, the judge could have joined the *FRA* and *CFCS Act* matters and heard them together. Both options would have provided the judge with additional information to consider before deciding on guardianship of the child.

However, it is of concern that in its current form, the *FRA* may prevent a thorough and complete consideration of the child's best interests because there was no mechanism in place to notify the court of multiple potential applicants for guardianship of this child. Furthermore, there was no process for information regarding child protection or criminal history to be brought forward and considered by the judge.

This gap means that judges can be in the position of making decisions regarding custody and guardianship of children without having a comprehensive knowledge of the potential caregiver's involvement with the child protection system. This investigation found no demonstrable link between the guardian and the death of the infant. However, what close examination of this case illustrates is a weakness in our system that could easily result in a child being placed in an unsafe home.

The *Family Relations Act* in British Columbia has not been revised in more than 30 years. For the past five years, B.C.'s Ministry of Attorney General has been reviewing this important statute. The Attorney General has proposed amendments to the *FRA* in the *White Paper on Family Relations Act Reform* (July 2010). Topic areas being considered for reform relevant to this investigation include legal guardianship and access orders and children's best interests.

However, the proposed amendments do not include a requirement for the court to be advised of information necessary to be considered as part of the best interests of the child test. They do not address the notification of MCFD or a check with MCFD child protection services when a non-parent is applying for guardianship of a child.

As is clear from this investigation, knowledge of relevant child protection records for non-parent applicants would provide additional information to help all decision-makers determine the greatest possible protection of the child's physical, psychological and emotional safety.

The Ministry of Attorney General has expressed the view that its *White Paper* proposals for a new *Family Law Act* will give judges "authority" to require parties to give the Court information necessary to determining best interests. The problem with this position is that courts depend on parties to provide the information they need to ensure children are safe. If critical information is not presented, as happened in this case, the judge has no way of taking it into account in decision-making. And they have no way of knowing in advance what information to require from parties.

The solution is for basic, essential and standardized information to be placed before the court. Ontario's recent family law reforms take this approach. The *Family Statute Law Amendment Act*, 2009, in force March 1, 2010, amended the *Children's Law Reform Act (CLRA)* and now requires that non-parents (e.g., relatives, friends) applying for guardianship of a child undergo the following process with the courts:

a) a parenting affidavit that includes the person's plan for the child's care and upbringing; information about the person's involvement in any family, child protection or criminal cases; and any other defined by the CLRA

b) a report from the Children's Aid Society (CAS) in each area the person has lived since age 18, with the dates of files opened and closed if the person was a subject of a protection investigation or received services from CAS

c) a current police record check and any associated case reports (e.g., other family proceedings in which the person was involved).

It is unlikely that such a requirement will deter legitimate individuals from applying to the courts. It will improve the court's ability to make a fully informed decision in the best interests of the child with respect to the background of the person applying for custody.

The Representative supports this approach and believes that it will help ensure vulnerable children are placed with appropriate and safe guardians.

Recommendation 3

That the Ministry of Attorney General recommend to Government that in amendments to the *Family Relations Act* or, if it proceeds, in the proposed new *Family Law Act*, standard information be placed before judicial decision-makers in every case where a non-parent is applying for custody of a child, even if the application is by consent.

Details:

The governing Act should state clearly the requirement that the court be provided with necessary information from parent, the ministry and court registry records. However, the specific requirements could be either in the Act or the Rules. They should include the following:

- a parenting affidavit that includes the person's plan for the child's care and upbringing
- a criminal record check
- information about the person's involvement in any past or present family, child protection or criminal cases
- any other information known to the person that may be relevant to the child's best interests as defined by the *Family Relations Act*
- a report from MCFD indicating whether the person has been the subject of a child protection investigation or received other services from the ministry, and pertinent details that enable conclusions to be raised about their suitability to provide a safe and appropriate home
- a means for family or child protection court registry records involving the applicant or the child to be brought to the court's attention.

Finding: ***The process used to assess the adequacy of the baby's legal caregiver was inadequate and did not consider the best interest of the child.***

Following the hearing, ministry social workers shifted their focus from a child protection-based approach to assessing the relative as a caregiver. In completing the assessment, workers found it sufficient to rely on references from one individual who had known the relative only a few weeks and another who worked for the DAA and could speak only to babysitting services provided by the relative five years prior. These references were weak at best and did not appear to provide relevant knowledge of the relative's ability to care for a vulnerable newborn.

It is of serious concern that the relative who was informed by the ministry that she was an unsuitable caregiver for the baby due to historical child protection concerns, a criminal background and an unstable home could be deemed competent to care for the infant a few weeks later, despite no fundamental change in those facts. This is an unacceptable standard to use in assessing a caregiver for any child, particularly a vulnerable infant.

The mother's other two children were in care of the DAA at the time of the hearing. The DAA was pursuing orders to place them in care permanently because they had determined that the mother was not able to adequately care for them. The DAA therefore had requisite knowledge of the issues and dynamics of the family.

In fact, court transcripts of the hearings for the permanent custody orders for the siblings show that one of the social workers with the DAA told the court that the DAA workers had been unable to find suitable caregivers for the siblings within the family. It is not clear why this infant was bounced around within the family when no suitable caregivers were found in the same family for this infant's siblings.

The DAA was so concerned about the mother's capacity that it was pursuing permanent care for her other two children. Why then was the decision made to investigate the mother's ability to care for her newborn infant? Furthermore, if she was not considered to have adequate capacity to care for any of her children, would she necessarily have the capacity to decide who would be the most appropriate caregiver for her infant?

MCFD has developed agreements to delegate responsibility for service delivery to vulnerable Aboriginal children and families to Aboriginal agencies. While both the ministry and agencies need to be accountable for their judgments and exercise of authority, ultimate accountability for discharging those services remains with the ministry as the body responsible for delegating authority. The ministry has an ongoing responsibility to oversee each agency's ability to fulfill its legislative mandate and take action when issues arise.

Investigations by Other Agencies

Finding: ***Important investigative opportunities were missed in the hours following the infant's death.***

When faced with the tragic loss of a vulnerable infant, the circumstances of the child's death must be investigated and understood so that future deaths can be prevented when similar circumstances arise. This requires that all agencies, including MCFD, police and the BC Coroners Service, collaborate and work in a thorough and thoughtful manner.

The first police officer who attended the hospital had not previously investigated a child death. The on-duty coroner decided not to attend the hospital after the unexpected death of this infant was reported to him by a hospital physician over the phone and based on a preliminary discussion with a police officer who was also at the hospital. No one went to the baby's home until the evening after he died. Conclusions were reached based on observed reactions of surviving relatives and a lack of visible injuries on the baby's body.

Later investigation of the circumstances revealed inconsistencies in information about events and lack of effective communication between MCFD and the police. The files show, and one of the social workers said during the RCY investigation, that there were at least three attempts to contact one of the officers to share concerns regarding the infant's death, and no response was received back from police.

In this case, the Representative has no grounds to conclude that this baby died as a result of criminal acts. However, the Representative takes the view that all unexpected child deaths deserve close and careful investigation to obtain a clear picture of what happened. This will help ensure that an opportunity is not lost to prevent future deaths based on what is learned. That means that all unexpected child deaths must be treated as suspicious and fully investigated, no matter how challenging that might be in the context of trauma and difficult circumstances.

The Representative will follow up with the BC Coroners Service, the BC Association of Chiefs of Police and the RCMP to share these findings and encourage them to promote these practices.

Conclusion

Months before this infant was born, the DAA determined that his mother would not be able to properly take care of him. This determination did not result in a coherent and decisive approach to ensure a stable home for him. Instead, the system and the many workers involved with this family were challenged by crisis or unpredictable events. The facts of this case paint a picture of a system that generated its own unpredictability and was not able to rise above that and place the child at the centre.

Despite this infant's short life of four months, his life circumstances were formed by three different offices and 16 different social workers and supervisors, and he lived in three different homes.

One of his primary caregivers was a relative who repeatedly expressed that she was having trouble coping with the situation. This did not result in supports being put in place, nor did it result in urgent efforts to find another home for the baby. Many extended family members expressed interest in caring for the baby. Ultimately, his placement came about as a result of a court decision on the initiative of a caregiver deemed unsuitable by MCFD. The placement did not occur as a result of a thorough and careful consideration of the suitability of caregivers by a team of social work professionals. And once the caregiver obtained legal custody contrary to MCFD's advice, MCFD did not carry through on its advice that it would remove the child.

This case also raises troubling issues about the organization of services. Even before this baby was born, a process began of the case bouncing back and forth between different agencies. This only accelerated and became more complicated over time. It is inevitable that when this happens, effective case management is at risk.

The Representative cannot conclude that this case represents an isolated example; instead, it represents another example in a troubling pattern. Previous investigations completed by the Representative have identified similar issues. For example, in the 2009 report *Housing Help and Hope: A Better Path for Struggling Families*, the Representative recommended that MCFD work with stakeholders in delegated Aboriginal agencies, First Nations groups, and Aboriginal Affairs and Northern Development Canada to ensure that sections 3(b) and 71 of the *CFCS Act* are fully realized and that the purpose and intent of Delegation Confirmation Agreements are fulfilled.

The ministry has delegated agencies throughout the province. The challenging issue of how to keep the focus on the child when intersecting jurisdictions and agencies become involved must be examined with greater urgency and resolved. All child protection staff, whether they work in an MCFD office or in a delegated Aboriginal agency, need a clear road map on proper interventions when planning for a vulnerable child begins to bounce around between offices.

Finally, the interests of the child must remain front and centre to support our courts in making decisions about who will have custody of a child. The *FRA* promises that the child's best interests will be primary. For this promise to be realized, law reform is required to ensure that courts have the information they need to be able to make these decisions and to prevent courts being used to place children in the legal custody of persons who may be unsafe, based merely on a parental "consent."

No system of child welfare can be considered effective if it is a disjointed collection of disparate parts. The exercise of delegation of authority means exactly what it says – the agencies are acting under the delegation and supervision of the Director of Child Welfare. They are not wholly separate or autonomous units. Their policies must be consistent with and perfectly aligned with those of their provincial counterparts. An effective and vigilant system of oversight is necessary to ensure that the sorts of gaps seen in this case do not become entrenched in agency or ministry practice. Nobody doubts the value in bringing communities and families together to safeguard children. That value can only be realized if the agencies charged with the responsibility for action fully understand their roles, limitations and accountabilities. In the end, accountability must flow back to the vulnerable child who should be the centre of our concern.

Similarly, the interests of the child must always remain front and centre. The Representative encourages all front-line workers to reflect on the difficult cases they are involved in where continuity of planning and case management becomes a challenge, and ask how, case by case, they can help shape the system to do a better job. Just as importantly, legislators and government leaders are challenged to ensure that laws and provincial policies reflect the on-the-ground realities of vulnerable children and their families.

Glossary

Child in care: any child under 19 years of age living under the custody, care or guardianship of a Director under the *Child, Family and Community Service Act.*

Child protection report: a report received about a child's need for protection due to abuse or neglect. Every report received is assessed to determine the most appropriate response. Responses include taking no further action, referring the family to support services, providing a family development response, providing a youth response if the child is a youth or conducting a child protection investigation.

Child protection investigation: a process of inquiring into or tracing through inquiry, collection of information, and interviews with parents and others who have knowledge of or are working with a child and family, including teachers, daycare providers, public health nurses, physicians and extended family members to evaluate whether a child is in need of protection.

Child protection social worker: provides support to families, collects information, responds to child protection reports, conducts child protection investigations, removes children, attends court and works with families to plan for the return of children or for continuing custody.

Comprehensive Case Review: a comprehensive internal review conducted by MCFD that involves the examination of case files as well as interviews with relevant staff, caregivers and service providers. The decision to conduct a Director's case review is based on the severity of the occurrence, the potential link between case practice and outcome, and the level of response required for public accountability.

Comprehensive Risk Assessment: a process and document that describe the risk of harm to a child and the mitigating strengths of the family. Risk assessment includes a review of previous child protection reports regarding the family, identification of risk factors and the potential for future harm to the child. A comprehensive risk assessment is completed whenever a child is found in need of protection.

Delegated Aboriginal Agency: through delegation agreements, the Provincial Director of Child Protection (the Director) gives authority to Aboriginal agencies, and their employees, to undertake administration of all or parts of the *Child, Family and Community Service Act (CFCS Act).* The amount of responsibility undertaken by each agency is the result of negotiations between the ministry and the Aboriginal community served by the agency, and the level of delegation provided by the Director.

Family Relations Act: The B.C. statute that covers child custody, guardianship, access, spousal and child support, and the division of property as between private persons**.**

Family service file: the MCFD legal record of services provided to a family through the *Child, Family and Community Service Act and Adoption Act.*

Foster care: a form of substitute care for children who have been removed from their own homes. This is usually a temporary arrangement, lasting until a child can return home or a family plan for caring for the child can be made. In some situations the child is in foster care until the age of majority (19 in B.C.). Effective foster care ideally includes services for the child, natural parents

and foster parents, and periodic review of the placement. Service expectations are guided by the Caregiver Support Service Standards, and Standards for Foster Homes. The foster home program is organized into different levels reflecting the skills and abilities of the foster parent, who is an independent contractor. Foster homes are managed through local ministry offices by a resource team or by a DAA.

Home study: an assessment process that all prospective foster parents are required to complete, to be approved as a foster home. As part of the process, prospective foster parents must have a medical assessment completed by their physician, checks of prior involvement with the ministry, criminal record checks, criminal records review, references and assessment interviews conducted by a social worker.

Hughes Review (*The BC Children and Youth Review*): the 2006 independent review of British Columbia's child protection system by the Hon. Ted Hughes, QC. It was this review that recommended the appointment of an independent Representative for Children and Youth.

Intake: the process by which cases are introduced into an agency office. Workers are assigned the role of intake worker to receive phone calls or interview persons seeking help in order to determine the nature and extent of the problems.

Permanent Care/Permanent Government Care: a child is in the continuing custody of a director under the *CFCS Act.*

Restricted foster home: a family approved by MCFD or a DAA to provide care for a child in care who is known or related to them. Most commonly, the caregivers are members of the child's extended family. This type of family care home has been recruited because of their connection to the child concerned and is only available for a specific child or sibling group.

Documents Reviewed during the Representative's Investigation

Ministry of Children and Family Development Records

- The mother's Family Service file: 3 volumes
- The mother's Child Service file: 3 volumes
- The siblings' Child Service Files: 6 volumes
- The relatives' Family Service and Resource files: 10 volumes
- MCFD Provincial Office file for the infant: 1 volume

Other Records

- Medical records for the infant
- Medical records for the mother
- Police file
- Coroner file
- Corrections Service Canada files

Interviews Conducted in this Investigation

- Twelve family members
- Six social workers from the DAA
- Eight MCFD social workers
- Regional Director of Practice, MCFD
- Executive Director, DAA
- Acting Director of Child Welfare Policy, MCFD
- Three police officers

Legislation

- British Columbia *Family Relations Act.* (1996). Victoria, B.C.: Queen's Printer.
- British Columbia *Representative for Children and Youth Act.* (2006). Victoria, B.C.: Queen's Printer.
- British Columbia *Child, Family and Community Service Act. (1996).* Victoria, B.C.: Queen's Printer.
- Ontario *Children's Law Reform Act,* R.S.O. (1990)
- Ontario *Family Statute Law Amendment Act.* (2009)

Appendix A: Representative for Children and Youth Act

Section 12 of the *Representative for Children and Youth Act* authorizes the Representative for Children and Youth to conduct reviews of critical injuries and deaths of children in care or receiving services from the Ministry of Children and Family Development. Section 15 authorizes the establishment of a Multidisciplinary Team to provide advice respecting reviews and investigations.

Investigations of critical injuries and deaths

12 (1) The representative may investigate the critical injury or death of a child if, after the completion of a review of the critical injury or death of the child under section 11, the representative determines that

(a) the reviewable service or the policies or practices of the ministry or other public body responsible for the provision of the reviewable service may have contributed to the critical injury or death, and

(b) the critical injury or death

(i) was, or may have been, due to one or more of the circumstances set out in section 13 (1) of the *Child, Family and Community Service Act*,

(ii) occurred, in the opinion of the representative, in unusual or suspicious circumstances, or

(iii) was, or may have been, self-inflicted or inflicted by another person.

(2) The standing committee may refer to the representative for investigation the critical injury or death of a child.

(3) After receiving a referral under subsection (2), the representative

(a) may investigate the critical injury or death of the child, and

(b) if the representative decides not to investigate, must provide to the standing committee a report of the reasons the representative did not investigate.

Multidisciplinary team

15 In accordance with the regulations, the representative may establish and appoint the members of a multidisciplinary team to provide advice and guidance to the Representative respecting the reviews and investigations of critical injuries and deaths of children conducted under this Part.

Appendix B: Multidisciplinary Team

Under Part 4 of the *Representative for Children and Youth Act* (see Appendix A), the Representative is responsible for investigating critical injuries and deaths of children who have received reviewable services from the Ministry of Children and Family Development (MCFD) within the 12 months before the injury or death. The Act provides for the appointment of a Multidisciplinary Team to assist in this function, and a regulation outlines the terms of appointment of members of the team.

The purpose of the Multidisciplinary Team is to support the Representative's investigations and review program, providing guidance, expertise and consultation in analyzing data resulting from investigation and reviews of injuries and deaths of children who fall within the mandate of the Office, and formulating recommendations for improvements to child-serving systems for the Representative to consider. The overall goal is prevention of injuries and deaths through the study of how and why children are injured or die and the impact of service delivery on the events leading up to the critical incident. Members meet at least quarterly.

The Multidisciplinary Team brings together expertise from the following areas and organizations:

- Ministry of Children and Family Development, Child Protection
- policing
- BC Coroners Service
- BC Injury Research Prevention Unit
- Aboriginal community
- pediatric medicine and child maltreatment/child protection specialization
- nursing
- education
- pathology
- special needs and development disabilities
- public health

Multidisciplinary Team Members

Dr. Evan Adams – Dr. Adams is the Aboriginal Health Physician Advisor for the Office of the Provincial Health Officer, as well as a family physician. He is a Masters candidate at the Johns Hopkins Bloomberg School of Public Health, a past-president of the Rediscovery International Foundation and a Youth Advisory Committee member at the Vancouver Foundation. He is a member of the Coast Salish Sliammon First Nation.

Lucy Barney - Lillooet Nation, RN, completed her Master of Science in Nursing from the University of British Columbia, and she is currently employed as a perinatal nurse consultant with Perinatal Services BC. She is the Vice-President of the Native and Inuit Nurses Association of BC and is a member of other advisory committees. Ms. Barney has assisted in investigations with other provincial and national agencies. Ms. Barney's expertise is Aboriginal Health, and she developed the braid theory, which looks at the mind, body and spirit and demonstrates a holistic view on health.

Karen Blackman – Ms. Blackman is currently the Senior Director of Practice Support and Quality Assurance with the Ministry of Children and Family Development. She has 21 years of experience including work as a social worker, team leader, practice analyst and community services manager in the ministry. Ms. Blackman holds a Bachelor of Social Work degree and a Master of Arts in Leadership and Training.

Beverley Clifton Percival – Ms. Percival is from the Gitxsan Nation and is a negotiator with the Gitxsan Hereditary Chiefs' Office in Hazelton. She holds a degree in Anthropology and Sociology and is currently completing a Master of Arts degree at UNBC in First Nations Language and Territory. Ms. Percival has worked as a researcher, museum curator and instructor at the college and university level.

Ruby Fraser – Ms. Fraser is Regional Director, Quality and Risk Management for the Northern Health Authority, monitoring health care incidents across the continuum from community to acute care.

Jim Gresham – Supt. Gresham is the Superintendent and Officer in charge of the RCMP E Division Major Crime Section. He has been a plainclothes investigator involved since 1991 in the investigation of crimes against persons, including homicides and historical unsolved homicides. He is a member of the E Division Major Case Management Committee, and an accredited Team Commander for the investigation of Major Crimes.

Dr. Jean Hlady – Dr. Hlady is a clinical professor in the Department of Pediatrics at the University of British Columbia's Faculty of Medicine. She is also a practising pediatrician at BC Children's Hospital and has been the Director of the Child Protection Service Unit for 21 years, providing comprehensive assessments of children in cases of suspected abuse or neglect. Dr. Hlady also served on the Multidisciplinary Team for the Children's Commission.

Norm Leibel – Mr. Leibel is the Deputy Chief Coroner for the BC Coroners Service. He has 25 years of policing experience and 17 years as a coroner. Mr. Leibel has examined the circumstances around child deaths in criminal and non-criminal settings, with the goal of preventing similar deaths in similar circumstances in the future. Mr. Leibel was a member of the Multidisciplinary Team for the Children's Commission.

Sharron Lyons – With 32 years in the field of pediatric nursing, Ms. Lyons currently works as a Registered Nurse at the BC Children's Hospital, is past-president and current treasurer of the Emergency Nurses Group of BC and is an instructor in the provincial Pediatric Emergency Nursing program. Her professional focus has been the assessment and treatment of ill or injured children. She has also contributed to the development of effective child safety programs for organizations like the BC Crime Prevention Association, the Youth Against Violence Line, the Block Parent Program of Canada and the BC Block Parent Society.

Dr. Ian Pike – Dr. Pike is the Director of the BC Injury Research and Prevention Unit and an Assistant Professor in the Department of Pediatrics in the Faculty of Medicine at the University of British Columbia. His work has been focused on the trends and prevention of unintentional and intentional injury among children and youth.

Dr. Dan Straathof – Dr. Straathof is a forensic pathologist and an expert in the identification, documentation and interpretation of disease and injury to the human body. He is a member of the medical staff at the Royal Columbian Hospital, consults for the BC Children's Hospital and assists the BC Coroners service on an ongoing basis.

Appendix C: High-risk Expecting Parents Guidelines

Under section 16 of the *CFCS Act*, the intake was coded an Offer of Support Services as per the region's High-risk Expecting Parents Guidelines.

The regional guideline provided direction to social workers who provided services to women whose pregnancy was considered high risk due to factors such as:

- history of unwanted pregnancies
- previous child protection concerns
- isolated from the community and/or support services
- insufficient prenatal care
- behaviour puts the baby at risk
- refused to consent to further diagnostic tests or treatment when advised by a health care professional that these tests are required for the safety and well-being of the unborn baby
- demonstrates hostility, impulsiveness and/or lack of responsibility to the extent that the baby/baby's safety is endangered
- environment problems such as poor housing, overcrowding, repeated financial crisis, unemployment or frequent moves that lead to extreme family crisis
- suspected of or is known to be using/abusing substances (cocaine, methadone, heroin, marijuana, methamphetamine, cigarettes, alcohol, PCP, prescription drugs)
- adolescent or youth parent
- language barrier
- newly located to community with no supports
- domestic violence or abuse issues

When a social worker became aware of a high-risk pregnancy, the guideline directed the worker to assess the report or intake for the above risk factors and to determine whether there was reason to believe that once the child was born, he or she may be harmed if there is no intervention.

The *CFCS Act* defines a child as "a person under 19 years of age and [including] a youth."

Under the guideline, the social worker was to complete the assessment within five calendar days and determine the appropriate course of action, which due to the fact that the child was not yet born, was limited to only "no action" and "referring the family to informal and formal support services," in accordance with the ministry's Child, Family and Community Service Standards.

The guideline encourages workers to engage the expectant parent in accessing supports and to work with the parent using an integrated approach, including other service providers, family members and health professionals to facilitate the parent getting the appropriate services to decrease the risks posed to the unborn child.

Other steps for the social worker to follow when utilizing the guideline include identifying reporting process to facilitate open communication between agencies and family members involved with the parent, identifying a case manager to facilitate coordination of the appropriate services and contacting the hospital where the child will be born to place an alert on the system to indicate the risk(s) and/or concern(s).

The guideline suggests collecting information from direct contact with the parent(s), reviewing the previous file information, utilizing risk assessment documents (CRA and RRSP), speaking to individuals who are familiar with the family, observing other children and examining the living situation of the parent(s).

Social workers are to consider possible interventions when the child is born, such as placement options and planning for discharge from the hospital.

With regards to predictions of harm, the guideline states: "The best predictor that harm will reoccur is past history. The greater the evidence of problems in the past, the higher the risk associated with the factor. History, therefore, is a significant consideration as clinical judgment is applied in weighing the levels of risk of future harm."

Once the child is born, the *CFCS Act* enables the social worker to apply a child protection approach and directs the social worker to apply a regional screening tool to determine whether a family development response or child protection investigation is most appropriate.

Source: Ministry of Children and Family Development

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